Handbooks of Sociology and Social Research

Richard A. Settersten, Jr.
Jacqueline L. Angel
Editors

Handbook of Sociology of Aging

Springer

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Handbook of Sociology of Aging

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Scholarly Foreword

Sometime in the relatively near future, the human species will reach a watershed moment in which people over the age of 60 outnumber children. This is a world in which there are both low birth rates and declining death rates at all ages, and in which people live much longer than had ever been true in the past. Technological advances and scientific discoveries over the past few centuries have resulted in a near doubling of life expectancy in developed regions of the world – increases estimated to be roughly 3 months per year since 1840 in most industrial societies (Oeppen and Vaupel 2002). In areas where low levels of mortality are combined with low levels of fertility, population aging is a demographic fact of life – and an unprecedented social achievement.

In the modern context, these profound trends demand new knowledge on the *social* forces and factors that shape aging patterns and processes and on the *social* consequences of aging patterns and processes. And this first *Handbook of Sociology of Aging*, co-edited by Richard Settersten and Jacqueline Angel, provides that knowledge. It provides a comprehensive and in-depth view into a wide range of social phenomena and reveals just how vibrant the sociology of aging has become. Its chapters also show that the contributions of sociologists are crucial for fostering interdisciplinary research on aging.

At present, the study of older age and older people is a burgeoning industry in all contemporary industrialized countries, due in part to increases in population aging. This has not always been the case. This is not only because of lack of good demographic data, but also because of the phenomenon itself. Historical demographers can tell us little about the lives and social roles of the elderly population over the past several centuries, and yet the consideration of age and aging is not a new phenomenon, even if the study of older people (i.e., gerontology) may not have existed. Indeed, social theorists from the eighteenth and nineteenth centuries pointed to the significance of understanding the social meanings and consequences of age and the succession of generations. This handbook, centuries later, is a testament to these early theorists of age and generation.

This handbook is also a testament to the legacy of twentieth-century pioneers of the field of aging, such as Bernice Neugarten, Matilda White Riley, Anne Foner, Norman Ryder, Glen Elder, and others. These scholars articulated the importance of understanding not only the age structuring of society, but also the processes of individual-level changes associated with biological maturation and change, along with the events and transitions associated with the life course. The range of topics included in the present volume eclipses what early sociological researchers on age and aging probably imagined, including scores of new topics and contributions by both stalwart members of the field and many younger scholars who are reshaping its contours.

Health, aging, and mortality present some of the most profound puzzles in modern human science, and sociologists of aging have crucial roles to play in helping to solve those puzzles. The demographic realities of population aging will substantially increase the number of elderly persons with disability and in need of long-term care over the next several decades. We will have unprecedented numbers of people living longer, but more often living with chronic disease and disability.

We do not necessarily expect future generations of the "aged" to experience aging (e.g., physical, psychological, cognitive, social) and later life development as their parents did. Hence, we might expect a decreasing prevalence of dementia and other types of low or impaired cognitive functioning in the worlds of the future. However, keeping people alive for longer through improvements in medical technology may create some unanticipated consequences, what some have called the *failure of success* (Vaupel and Yasin 1985). Health advances allow frailer, more vulnerable individuals to live longer. We do not know the consequences of this for levels of cognitive performance and physical well-being among the aged in future worlds. Nor are we doing enough to anticipate their consequences for families, work, education, policies, or the welfare of a society. Many of the chapters in this handbook help us begin to undertake these challenges.

These possibilities may raise the specter of massive limitations in daily and social roles in the vast numbers of postage 65 citizens who will inhabit our future world. But it may also raise an entirely different set of possibilities, once we consider cohort differences in how the lives of the future and past aged have played out. How much can our current knowledge of the post-World War II birth cohorts (e.g., their health, nutrition, activities, work lives) be extended to future cohorts? The research of sociologists of aging and the life course is crucial in making historical changes such as these visible, and in tracing the legacies of these historical changes on individuals, families, and social institutions. Similar questions can and should be asked about many other domains of aging.

Despite our collective interest in the consequences of population aging, not enough is known about why some individuals live to middle age and others to extreme old age; nor is enough known about why some people develop dementia in old age and others do not. One area sociologists have been studying for decades, for example, involves the study of disability, which is an interdisciplinary study of loss of physical and cognitive function. The study of disability is, thus, an increasing focus of studies of aging, and new formulations, such as the concept of "disability-free life expectancy," have been introduced to distinguish among statuses along a quality of life dimension. Another new development involves the study of components of "successful aging."

The chapters of this handbook repeatedly show that aging involves a complex interplay of multiple layers of potential and experience that are often anchored in the social world. Its publication is also a sign of the need to explicitly treat the social aspects of aging in interdisciplinary research and to incorporate it alongside biological, neurological, and psychological factors that influence processes involved in differential aging. The chapters of this handbook also show how the social processes that affect aging interact with the life course – events, transitions, and trajectories of roles and relationships. They bring to life the essential proposition that in order to understand the nature of human aging, it is imperative to take into account the many layers of social context in which it occurs, from interpersonal relationships all the way out to historical and demographic parameters.

Indeed, the monotonic and irreversible trends associated with the first demographic transition led to the inevitable second-order growth in the proportion of elderly people in modern day populations. That is, it is the dramatic declines in mortality, morbidity, and fertility that have *permitted* a long and generally healthy old age. Increasingly, individuals at the early end of "old age" are considered to have entered a new "third age" in their lives. This term came from France in the 1970s and 1980s, where "Universities of the Third Age" were designed for the enrichment of the lives of pensioners, making reference to a new life stage viewed "as distinct from both the second age [adulthood] and the fourth age [old age]." The emergence of this new life stage – between the traditional age of retirement and what many consider to be "old age" – challenges many of our preconceptions about the "expected" life course (Moen and Spencer 2006). This is a new area for research, inasmuch as the traditional blueprints for how persons pattern their lives are diverging from the ways in which future cohorts will develop their later life choices. Many of the chapters in this handbook deal directly with these issues.

As the proportion of the world's population in the older age ranges continues to increase, there is a need for new and improved information about the factors that contribute to health and longevity – a need to reconcile current bodies of knowledge with the changing experiences of an aging population. This handbook, with each chapter providing a 30-year window on the topic, is not only exemplary of present-day knowledge, but also the necessary foundation for moving our field forward.

Age continues to be the greatest risk factor for most major chronic diseases, and there are new policy challenges as well, although a focus on social policy is not part of my mission here. Suffice it to say that in order to preempt what some see as a major "global aging crisis," it may be necessary to avert the negative consequences of population aging, by intervening in the lives of aging humans to "retard, arrest and even reverse aging damage" (Rae et al. 2010). With their focus on the social explanations and consequences of human aging, the chapters of this handbook contain important insights for translational research and for possible interventions meant to improve human aging. In bringing "the social" back, and in putting it front and center, the *Handbook of Sociology of Aging* will be an invaluable resource for research on aging for many years to come.

Duane F. Alwin

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Policy Foreword

The field of sociology has certainly gone through significant changes over the past half century. As an undergraduate sociology major in the 1960s, I gained great insights about the challenges facing individuals and groups, and I was touched by the conditions of vulnerable populations. While I was deeply affected by my course work, I found myself continually asking: what are we going to *do* to deal with these challenges? And how have our social policies affected these individuals? Too often, my courses stopped short of assessing policy options, or the implications of policy actions, to improve the lives of real people.

During my graduate school training in public policy, I often relied on the base of my undergraduate coursework in sociology to provide "real world" content to compliment my analytical policy skills. I remember thinking during my graduate education that a closer interconnection between sociology and policy-making would make both better.

The *Handbook of Sociology of Aging* shows how far we have come over the past half century in connecting the field of sociology to policy. To mark the thirtieth anniversary of the American Sociological Association's Section on Aging and the Life course, the editors have mobilized nearly 80 scholars to highlight scholarship on over forty topics. One thing that makes this handbook so special is the recurrent focus on policy matters. The contributors have been asked to emphasize how each of their topics is affected by social phenomena, the life course, and social policy. These three prongs bring much-needed attention to the social forces and factors that shape aging patterns. For me, it is this third prong – social policy – that makes this handbook so distinct and important, as contributors make explicit how the phenomena being considered are affected by and have implications for policy and practice. Because the chapters rest on cutting-edge research, the work of the authors will help guide policy-makers in the formulation and implementation of policy. As such, this handbook provides a rich and clear roadmap for future policy-makers, especially in the United States.

I have spent the better part of the past three decades focusing on social policy, with a large share of that time directed at aging policy. Over all those years, I carried with me both my sociology background as well as my skills in policy analysis. Without both, my ability to shape and influence policy would be lessened. Indeed, I find it hard how policy can be effectively shaped without the voices of sociologists.

Examples of the linkage between sociology and policy abound. What are the benefits of establishing a solid system of home- and community-based care for the elderly, as well as respite care services for their caregivers? How do we provide a secure foundation of economic support for vulnerable populations? What are the implications of establishing a strong hospice benefit for Medicare beneficiaries? What are the individual, family, and societal implications of requiring more work later in life? How should changes in race and ethnicity characteristics as well as family composition shape future policy? And how have social policies related to older Americans shaped our definition of who we are as a people, and how we define our collective responsibilities to one another?

Over my career working on Capitol Hill or at the U.S. Department of Health and Human Services and the Office of Management and Budget, or during my service as the Commissioner of the Social

Security Administration, I used sociological research and analysis to help shape policy options. And it should be clear from this volume that I was certainly not alone: sociological research is now deeply integrated into the policy-making process. How could one "do" good policy without it?

Given my own background, I am especially pleased to see sizable attention in the handbook devoted to health and retirement security, which I see as two of the most pressing domains for public policies related to aging. The United States faces major challenges in financing the retirement and healthcare needs of the elderly while also financing defense, infrastructure improvement, and the education of future generations, and in stimulating economic growth more generally. The challenges of meeting the retirement and healthcare needs of the elderly will only grow in the future. Let me highlight just a few issues.

Pension Security: Balancing Adequacy and Affordability

As America ages, we face twin public pension challenges that need to be addressed, and fortunately, the work of sociologists is being used to address both challenges. The first challenge is to finance our public pension systems. There are currently about three workers for every person receiving Social Security, and within a generation, a retiree will depend on the contributions of about two workers. Much has been written on the dimensions of the long-term fiscal challenge of Social Security, and the work of sociologists is used by Social Security actuaries in their projections because understanding societal trends is a critical part of those models.

The second Social Security challenge is one that receives considerably less attention but is equally compelling: to ensure the adequacy of income supports, particularly for vulnerable populations. The work of sociologist is even more important in addressing this policy challenge. As just one example, how should we think about the progressivity in our social insurance system? We know that people are living longer lives, but more substantial gains are taking place at upper income levels. As the share of benefits increases over time to white collar and higher income beneficiaries, our social insurance system becomes increasingly less progressive. Sociologist can clearly help policy-makers think through the myriad of underlying issues, which require an understanding of the combined effects of minority group status, occupational disadvantage, and demographic transitions on the labor force's carrying capacity, as well as the sources of support for elderly Americans.

Other issues abound. How can we assess the needs of the oldest old, whose sources of non-Social Security income erode over time? How will family composition change the outlook for widows and single elderly women? What are the future needs of persons with low lifetime earnings, given the near absence of substantial sources of private retirement income? Since low income workers experience greater risk of becoming disabled prior to retirement, what policies are needed to assist these individuals if the retirement age is increased? And how should our social insurance system deal with the reality that our working-age population is becoming increasingly minority, while the older retired population remains predominantly non-Hispanic and White? All of these issues have profound consequences for individuals, families, society as a whole, and the social contract between generations. Sociologists can and do influence the policy development process in these areas.

Health Care: Balancing Access to Care and Controls on Cost

Most immediately, aging populations raise issues of critical importance to health policy-makers. Sociologists can play critical roles in framing and providing practical information to inform the social, ethical, and legal implications of healthcare issues. For example, with continuing advances in medical

care, and the extraordinary price tag with which they come, the potential cost of health care could bankrupt the nation. Within this context, the need to control healthcare budgets grows – and, with it, proposals for the rationing of care emerge. In an economic and political environment in which some form of rationing is deemed necessary, weak political or social groups are vulnerable and certain to lose. These concerns seem especially likely to emerge in times of great economic retrenchment, like now. It is critical to understand the intended and unintended consequences of healthcare cost-control decisions.

Nations also face big challenges in developing resources and infrastructure to promote intergenerational health equity in communities. The volume addresses several topics that are pertinent to this issue, including how to improve health policies and practice for the most vulnerable elderly groups and curb inequalities in health care and health insurance.

Caregiving and Long-Term Care

Responses to the challenges of long-term care also require the contributions of sociologists. Aging brings pervasive caregiving demands for spouses and middle-aged children. These responsibilities can jeopardize financial resources, make it impossible to maintain paid work, strain psychological well-being, and have ripple effects on younger generations. Sociological research emphasizes the need to develop "family friendly" policies to offset some of this burden and make it more possible for family members to manage their caregiving responsibilities alongside other work and family responsibilities. Policies related to paid leave, sick time and vacation time, and flexible hours are just a few of many examples.

Aging also brings significant challenges for a range of long-term care settings – from continuing care retirement facilities, assisted living facilities, nursing homes, hospice, and others. Policies that govern the organization and finance of these institutions have a direct impact on the quality of care received in these settings. The volume addresses several topics that are pertinent to this issue, in particular, averting the "old-age welfare crisis," the hidden costs of caregiving, politics of aging and disability, and the role of civil society and nongovernmental actors in eldercare. Quality of care is also, of course, directly affected by the care workforce – and the adequacy and quality of that workforce are, in turn, shaped by policies related to the compensation and training of nurses, paraprofessionals, and other staff in long-term care facilities.

Social Policy in a Globalized World

Approaches to aging policies in the United States must also be understood within an international context. Sociological research raises our awareness of the interdependence of policies in a global world and of the lessons we can learn from other nations, and vice versa. We often assess comparative policies primarily with an eye to European experience. But lessons can be learned by casting our lenses even wider, and again the role of sociological research becomes essential in understanding how:

- Aging processes in Latin America influence social policies in this important part of the world. For example, Chile recently adopted new social assistance programs for poor elderly to make up for some of the glaring inadequacies of their privatized pension system. There are lessons from Chile's recent experience to help guide U.S. policies in an effort to provide stronger protections for poor elderly.
- Immigration poses multiple challenges to aging. Given high levels of immigration to the United States, many Latin Americans will age in the United States and draw upon social services here. The aging of older immigrants in the United States will have a major influence on social delivery

here, and the movement of elderly persons both ways across national boundaries needs careful policy examination. As our labor markets become more globalized – with more workers moving across borders for parts of their careers – we also need to consider how to better integrate pension and health systems with other countries, such as Mexico. This is a natural extension of efforts now underway to integrate the trade of goods and services across borders.

- In Asia, with rapid declines in fertility and a history of early retirement, many countries will in the near future face massive problems related to the financing and care of the elderly. An oft-repeated quote in Asian social policy circles is that "Asia is becoming old before it becomes rich." Systems are not in place to deal with looming aging challenges. Countries such as China have yet to establish a foundation of economic support for the elderly, and the small share of workers who are pension-eligible in China have overly generous pension systems as well as a very early retirement age. Understanding family and work changes and immigration patterns within China is an essential precondition in assessing the policy challenges. In addition, the experiences of other countries can help countries such as China develop appropriate policy solutions. For example, there are important lessons that China can learn about the design and implementation of the universal Social Security system in the United States, as well as our efforts to encourage more work later in life.

Policy in an Increasingly Diverse World

The new diversity of the U.S. population poses direct challenges to aging policies now and in the future. This new diversity not only relates to race and ethnicity, but also to assumptions reinforced in our policies about gender roles, the stability of marriage, and the definition and functions of "family." As the editors also note, these old assumptions need to be revisited and brought into alignment with the realities of contemporary life, and we must also be more future-oriented as we make policies today. We can do this by keeping a more careful watch on younger generations, whose lives do not and will not fit the molds of generations past. They will surely arrive at and move through old age in ways that are different from what we have known until now. Policy-makers need to understand these trends, and policy-makers need sociologists to help understand these trends. Several of the chapters shed light on the implications of the ethnic age grading of the U.S. population. The work force of tomorrow will become disproportionately minority and more specifically Hispanic, and this has the potential for ethnically based intergenerational conflict. The spiraling cost of the old-age welfare state will inevitably affect the healthcare entitlements for future generations.

A Wide Range of Other Issues for Policy and Practice

Besides the issues I have already noted, policy and practice audiences will find a remarkable range of pressing concerns in the pages of this handbook. These include how work organizations, educational institutions, and communities can be redesigned to better respond to the challenges of aging and to better nurture productivity, learning, and social experiences for older people. Other chapters highlight crucial social problems to be solved, including elder mistreatment, how elders are affected by or involved in crime, how elders manage natural disasters such as hurricane Katrina, the social isolation of those with fragile or fractured family relationships, or the significant physical or mental health needs of veterans, of those who are obese, have mental illnesses, or live with or are at risk of contracting HIV/AIDS. There are so many ways in which policies and practices can be developed to address these problems.

Final Thoughts

The chapters in this handbook, written by top sociologists who are acute observers of the world around us, repeatedly return to this simple truth: that the social world is rapidly changing and our policies must keep pace with those realities. It is our task as policy-makers to not only refresh our policies to better match current realities, but also to keep one eye to the future so that we can better prepare for the world tomorrow. This handbook leaves us well positioned to make our way. If it had been published a half century ago, when I was an undergraduate sociology major, it would have had a much smaller link to policy and practice. But as this volume makes clear, sociologists are now firmly connected to the policy world. One can only imagine the contents of the handbook that will be published in the future, say a half century from now. Predictions of the future are never easy, but my hunch is that sociology and policy will be even more deeply connected than they are today. And our world will be the better for it.

Kenneth S. Apfel

Preface

The idea for this handbook was sparked in anticipation of the 30th anniversary of the American Sociological Association's Section on Aging and the Life Course (SALC) in August of 2009. We received an invitation from Howard Kaplan at Texas A&M University to edit a *Handbook of Sociology of Aging* as part of Springer's series on *Handbooks of Sociology and Social Research*. We both have long histories with SALC and, at the time, we were both in leadership roles (with Jacqui as Immediate Past Chair and Rick as a member of Council and, today, Chair-Elect). The two of us had always hoped we might one day have the chance to collaborate – our respective areas of scholarship and skills are complementary and our professional conversations often turned to the need to ensure a vibrant future for our field, especially in nurturing leadership and finding ways to bridge generations of senior and junior scholars. The invitation to edit a handbook presented that opportunity.

Far more important, though, was the fact that the 30-year anniversary of SALC offered a perfect moment to reflect on the history of the field, trace the evolution of ideas, synthesize knowledge, and offer compelling new directions for its future. Indeed, one of the greatest strengths of the sociology of aging and the life course is the wide range of topics and methods that characterize it. Yet the breadth and depth of the field had not been considered, let alone well represented, in a single volume.

To this end, we mobilized top scholars in the field – both long-standing and more junior ones, even doing some collaborative match-making along the way – to turn much-needed attention to the *social* forces and factors that shape aging patterns and processes and to the *social* consequences of aging patterns and processes.

In our opening chapter as well as in our final chapter, we take a "birds-eye" view of the field, with the former describing important trends in scholarship on the sociology of aging over the past three decades, and the latter highlighting some of the most exciting new prospects for the decade ahead. In between, readers will find chapters on many specific topics allocated across eight sections – Theories and Methods in the Sociology of Aging; Social Diversity and Inequalities of Aging; Social Relationships and Aging; Social Institutions and Aging; Economies, Government, and Aging; Social Vulnerabilities and Aging; Public Health and Aging; and Care Arrangements and Aging.

We asked the authors of each chapter to keep in mind the 30-year metric and consider the following questions as they treated their topics:

- Where has the field been and where is it now? What specific ideas have generated excitement and transformed thinking? What important ideas have been lost along the way and might now be reclaimed in light of contemporary conditions?
- What new intellectual frontiers should be pursued to ensure a vibrant decade ahead? What opportunities exist or might be made to propel the field in these directions? What barriers might be anticipated and how might they be overcome?

- What are the central social sources and consequences of the topic under study? How might greater attention to "the social" revolutionize theories and empirical research on this topic?
- What are the implications for social policy?

The section "Sociological Lives" contains intimate, and often playful, essays written by a group of senior statespeople who share their personal experiences in the field and their hopes for its future.

As we were getting the handbook launched, Janet Wilmoth and then-Chair Eliza Pavalko also began to organize a special session for the 2009 annual meeting to commemorate the 30th anniversary of SALC. We worked with Janet and Eliza to feature in that session a handful of papers that were being also planned for the handbook. We are grateful for their willingness to collaborate in this way, and we are pleased that they both contributed chapters here in their areas of expertise.

We chose Duane Alwin to write the scholarly foreword, as he was Chair of SALC when we designed the handbook and began commissioning chapters. Duane has quick wit, shrewd observation, and a long and broad view of both the substance and methods of our field. We asked Ken Apfel to write the policy foreword, as he had served as commissioner of the Social Security Administration during the Clinton years and was a colleague of Jacqui's at the Lyndon B. Johnson School of Public Affairs at the University of Texas. Ken has unwavering commitment to interdisciplinary scholarship and respect for the important and unique contributions that sociological perspectives bring to policy-making related to aging. We are honored to have Duane and Ken's insights open the volume.

We would like to express our gratitude to the nearly 80 authors who contributed to the project. Each one has inspired us. Each was also patient as we rigorously reviewed their chapters and asked for revisions. We are especially indebted to our senior colleagues who, in the final section of the book, permit us a glimpse into their personal and intellectual lives as they look back on their many years in the field. What a treat it is to read their essays.

At Springer Science, we also wish to thank our editor, Teresa Krauss, and assistant editor, Katie Chabalko, for their steadfast support of the project from the inception of the idea to its completion. Teresa is a champion of the sociology of aging in the publishing world, and she has the special ability to see the momentum in a field and seize it. Katie did the yeomen's work in house to ensure that the project stayed on course. We also wish to thank Morgan Ryan for her editorial assistance in the final phase.

One person deserves a very special acknowledgment: Liz Bayler Levaro, who served as project manager and is a doctoral student in human development and family sciences at Oregon State University. Words cannot express how much we appreciated Liz, especially as she was called to assume caregiving responsibilities alongside the handbook and her doctoral dissertation. We would not have completed the project were it not for Liz's generous spirit, contagious enthusiasm, editorial acumen, technical wizardry, and unfailing patience.

It is our hope that the *Handbook of Sociology of Aging* will be of great use to researchers, emergent scholars, and policy-makers whose work focuses on aging and the life course. We also hope it will be of use to those who study other periods of life (e.g., infancy, childhood, adolescence, early adulthood, or midlife) – especially in being more sensitized to how experiences earlier in the life course might be affected by older people or an aging society or have a legacy for individuals or families decades later. The subject matter will, of course, speak directly to sociologists working on the many topics covered here, but it will also be of interest to members of other disciplines who also work on issues related to aging.

Most of all, we hope that the chapters of the handbook not only showcase the extraordinary advances in our field and how vibrant it now is, but also how much excitement we have as we imagine the decades ahead. Thanks to all who have contributed to our rich history, and to those who will make its future, in ways big and small.

Corvallis, OR — Richard A. Settersten, Jr.
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Part I
Historical Trends in the Sociology of Aging

Chapter 1
Trends in the Sociology of Aging: Thirty Year Observations

Richard A. Settersten, Jr. and Jacqueline L. Angel

This chapter takes a broad view of scholarship on the sociology of aging, highlighting how the contours and content of the field have changed over the last 30 years. The chapters of the *Handbook of Sociology of Aging* provide fertile grounds for these observations. Each chapter traces the evolution of important ideas, synthesizes knowledge, and offers compelling new directions for future inquiry on specific topics. This handbook illustrates the fact that one of the greatest strengths of the sociology of aging is the wide range of topics and methods that characterizes the field. To generate additional observations on the field, we examined a wide range of books and articles on behavioral and social aspects of aging, including three decades of the *Journal of Gerontology: Social Sciences*, *The Gerontologist,* and *Research on Aging*.

In taking 30 years as the lens for our observations here and in the handbook – 1979–2009 – we became quickly aware of the extraordinary growth that has occurred in our field during this time. Our most senior colleagues will, of course, immediately recognize this. But many readers may not appreciate just how significant these advances have been. To begin, we therefore ask readers to simply imagine a field:

- Where scholarship on aging is relegated a marginal status in most disciplines, including sociology, and struggles for its legitimacy as an area of inquiry
- Without *Research on Aging, Journal of Aging Studies, Ageing and Society* and other aging-related journals that emerged at the start of this period or well into it
- Without all but the first of seven editions of the *Handbook of Aging and the Social Sciences* (e.g., Binstock and Shanas 1976), and without the two editions of the *Handbook of Theories of Aging* (Bengtson and Schaie 1999; Bengtson et al. 2009) and their predecessor, *Emergent Theories of Aging* (Birren and Bengtson 1988)
- Without major secondary datasets, including longitudinal ones, we now take for granted – the Health and Retirement Study, the National Survey of Families and Households, the Longitudinal Studies of Aging, Midlife in the United States, and many waves of the Panel Study of Income Dynamics, Current Population Surveys, Integrated Public Use Microdata Series, and other data sets and supplements sponsored by federal agencies
- Without so many of the advanced research methods, statistical techniques, and widely used and well validated measures we know today, including multi-level modeling, structural equation modeling, event history analysis, and advanced methods for measuring and analyzing change

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- Without the infrastructure of the National Institute on Aging (NIA) and other public and private agencies and foundations, including initiatives of the MacArthur Foundation and the Retirement Research Foundation, which have provided extensive funding for behavioral and social research on aging
- Without many of the training programs and research centers that have educated generations of graduate students, both within sociology proper or with core contributions from sociologists – including NIA-sponsored predoctoral and postdoctoral training programs, Centers on the Demography and Economics of Aging, Centers on Minority Aging Research, and the Roybal Centers for Translation Research in the Behavioral and Social Sciences of Aging
- Without so many other ground-breaking articles, books and special issues of journals, especially edited projects or commissioned papers, too many to name, in which authors were playful with ideas that nourished the field. Indeed, many of the readings we consider to be "classic" today were written not long before the start of this period and even into it
- Without many textbooks for teaching undergraduate students about the sociology of aging – or, for that matter, undergraduate courses on the sociology of aging
- Without the later works of so many of the pioneers of our field, some of whom are still with us, and without the contributions of so many scholars since
- Without the controversy over the name change of the American Sociological Association's Section on the Sociology of Aging to the Sociology of Aging and the Life Course, which was ultimately resolved after seven years in 1997. One proposal, to add "and the life course" to the name, was adopted, while another proposal, to change "aging" to "age," ultimately was not

Space will not permit us to discuss the many important works that have punctuated these three very rich decades of scholarship. However, the chapters of this handbook will do so, as each takes an in-depth view into the history and future of sociological theories and research on particular topics. We begin by describing larger historical trends in theories, methods, and topics.

Historical Trends in Theories, Methods, and Topics

Broad Trends in Theories

As sociologists arrived at the study of aging, they naturally relied on their toolbox of classical and contemporary theories. Besides the classical writings of Emile Durkheim, Karl Marx, and Max Weber, who were acknowledged as the "holy trinity" of founding fathers, sociologists of aging also drew upon theories of structural functionalism (e.g., Talcott Parsons, Robert Merton), social conflict (e.g., Gerhard Lenski, Ralph Dahrendorf), social interaction and exchange (e.g., Georg Simmel, George Homans, Peter Blau), symbolic interactionism (e.g., George Herbert Mead, Charles Cooley, Irving Goffman), and phenomenology and social constructivism (e.g., Alfred Schütz, Peter Berger and Thomas Luckmann).

Central starting points for developing theories were also found in social gerontology, especially disengagement and modernization theories of aging in the 1960s and 1970s (e.g., Cumming and Henry 1961, Cowgill and Holmes 1972, respectively). The former postulated that physical decline in old age, and the social withdrawal of old people, is inevitable and functional for both individuals and society. In generating spirited debates ever since, disengagement theory would become crucial in the evolution of alternative views (e.g., activity theory, Havighurst 1963; continuity theory, Atchley 1971; functional equilibrium theory, Rosow 1963). These theories focused on individual behavior, but with an eye to social expectations and the greater social good. In contrast, modernization theory

was crucial in taking a purer societal view on aging. It examined the status of the aged across cultures and identified how the social changes associated with modernization contribute to the disadvantaged position of older people (e.g., changes in the economy, medicine, technology, education, and urbanization).

Within sociology, the age stratification framework was also conceived not long thereafter and would become a dominant heuristic device for advancing inquiry into the social, and especially structural, aspects of aging. Although the age stratification framework is associated with Riley et al. (1972), the often overlooked work of Leonard Cain (1964) was an important precursor of both the age stratification framework and the life course perspective, as were much earlier works by sociologists and anthropologists of age status, including Shmuel Eisenstadt (1956), Ralph Linton (1942), Arnold van Gennep (1908/1960), and Anselm Strauss (1959).

Each in their own way, these theorists emphasized that aging and the life course are social processes and that age is a structural feature of societies, with both people and roles allocated on the basis of it. These theorists also pointed to the dynamic aspects of aging at both individual and societal levels. That is, new cohorts of people are born, grow up and older together, and move through the age structure of the population. These ideas also heightened the awareness of the need to not only understand the unique characteristics of particular cohorts as they aged, but also to understand the differential effects of social change on adjacent cohorts. This brought new thinking about how to better conceptualize cohorts and measure cohort effects (Rosow 1978; Riley 1973; Ryder 1965), building especially on Karl Mannheim's (1928/1952) classic essay on "The Problem of Generations." The emphasis on understanding the legacy of historical events and social change on individual and collective life histories would also become central to Glen Elder's *Children of the Great Depression* at about this time (1974) and, later, a hallmark of the life course perspective.

As the life course perspective evolved, it explicitly built on two paradigms – the *personological* and *institutional* paradigms (see Dannefer and Settersten 2010). The personological paradigm, of which Elder's body of work is a good example (and that of John Clausen too, e.g., 1972), attempts to use key features of early life experience to predict and account for outcomes later in life. Although this paradigm is often focused on individuals, it can address the life experiences of whole cohorts or populations (recent theories of cumulative advantage and disadvantage are good examples; Dannefer 2003). The *institutional* paradigm, in contrast, needs not focus on individuals at all, but instead analyzes the life course as a social and political construct, often consisting of more or less explicitly defined age-graded stages that are created or reinforced in institutions and social policy (e.g., Kohli and Meyer 1986; Mayer and Müller 1986). It therefore refers to a part of the social and cultural definition of reality that broadly organizes both people's lives and their "knowledge" about age and aging. In the field of aging, the institutional paradigm has strong roots in the writings on formal and informal age norms and the rise of age consciousness in modern societies (e.g., Neugarten et al. 1965; Kohli 1986).

Over these years, other major theoretical traditions in the sociology of aging would also emerge, especially theories informed by the political economy of aging (e.g., Kail et al. 2009), theories of cumulative advantage and disadvantage (e.g., Ferraro et al. 2009), feminist theories (e.g., Calasanti 2009), and critical theories of gerontology (e.g., Baars et al. 2006).

Social theories of aging can be characterized as having experienced a pendulum swing away from (1) at one extreme, "grand" theories in an early era of research that was "theory rich but data poor," to use James Birren and Vern Bengtson's (1988) phrase, to (2) a subsequent era that was, at the other extreme, "data rich but theory poor" – what C. Wright Mills (1959) might also have called "abstracted empiricism," in which too much attention is given to data over theory, to (3) the era of research today, which has perhaps swung back toward theories of the "middle range," to use Robert Merton's (1968) term, built around narrow topics and a good dose of data. The presence of

middle-range theories in the field is evident across the chapters of this handbook. A larger window into theories of aging, including *social* theories of aging, can be found in the recent *Handbook of Theories of Aging* (Bengtson et al. 2009).

Social theories of aging can also be characterized as having experienced a pendulum swing moved through eras with differential attention to micro issues, macro issues, or the connections between them (micro-macro linkages): from (1) an early era of theories that were focused on individual issues, especially activity and life satisfaction, to (2) a subsequent era that was focused on larger contextual issues, especially how structural conditions determine the parameters of aging and the life situations of older people, to (3) an era of theorizing today that has attempted to synthesize micro and macro perspectives, especially in explaining differences in aging experiences by larger social forces or through intermediate contexts (see also Bengtson et al. 1997).

Broad Trends in Methods

Over these decades, several important methodological shifts have occurred in the field:

- From studies that emphasize basic description, to explanation, and to causality
- From studies that emphasize qualitative methods or relatively simple quantitative ones, to advanced quantitative methods, and to multi-method studies (at least in principle, though this ideal, at least in doing right by *all* of the methods brought to bear in a single study, has proven to be difficult to accomplish in practice)
- From a reliance on cross-sectional studies to the eventual building of panel and longitudinal data sets
- From studies based on small, original data sets to a preponderance of publications based on the analyses of large secondary data sets\designed for the scientific community

The field has also shifted from a reliance on crude measures to the development of measures that are more refined, more reliable, and better validated – even though there is much distance to go in creating truly meaningful measures that capture the complexities and realities of social aspects of aging. In fact, the most frequently read and cited articles across these decades pertain to scales meant to measure aspects of health or quality of life – specifically, life satisfaction, psychological well being, caregiver strain, caregiver burden, and cognitive performance, self-reported physical health, the use of services, and loneliness (see also Ferraro and Schafer 2008).

The investments in gathering longitudinal data are particularly important to note, as these investments have been made alongside the growing interest in the life course and recognition of the need to understand aging as a long-term process. Although longitudinal data permit new kinds of analyses, they also demand new kinds of methods, and this time period has brought much attention to methods for doing so.

Consistent with shifts in theories, the field has also moved beyond the use of age as a causal variable and instead toward understanding age in ways that are mediating or contextual. With this, the field has also turned greater attention to the possible *processes* and *mechanisms* that drive change, rather than simply demonstrating the empirical connection across the variables that are arrayed in a model.

However, some of these shifts have also fractured whole people and phenomena in favor of a narrow "peephole" perspective on small sets of variables, though the growing recognition and respect for interpretive and qualitative approaches has helped to counter these limitations. Sociological research has become more specialized over these decades, which also results in what seem like small windows into narrow phenomena of interest – though it has simultaneously become more interdisciplinary, which has similarly helped to counter these limitations.

Trends in Topics and Associated Terms

In conducting our review, we were immediately struck by how much language structures and reflects our realities. The language of our field becomes powerful in signaling our intellectual preoccupations and some of the assumptions that we make about our subject matter. Some of the topics and terminology that were present in the earlier years have vanished, some have persisted, but most have emerged and taken shape in the last three decades.

First, we no longer use some of the terms that were a prevalent part of our lexicon in the beginning of this period – terms we immediately recognize as outdated today. Many of these terms shock the contemporary inclination in the academy to deny or defy age: terms such as "the aged," "the elderly," "old people," and "old age" were very present in early articles and have now faded away, though they continue to be used by policymakers and in the media. Their disappearance is also surely linked to the fact that statements about "*the* old" or "*the* elderly" homogenize large groups of people who may be more different from one another than they are similar – a theme that gerontologists have sounded strongly in recent years, along with the reminder that chronological age is itself a poor proxy for the biological, psychological, or social statuses of individuals. The increasingly taboo nature of these terms in scholarship today serves as a powerful reminder that the meanings of age, and in this case *old* age and the things associated with it, are *socially* constructed.

Some topics that were very salient at the start of our review period have now largely vanished as major points of inquiry – including "interstate migration," "snowbirds," "NORCs" (naturally occurring retirement communities), "SROs" (single room occupancy hotels), "elder abuse," "elderly drivers," "senior suicide," "homes for the aged," "senior centers," "institutionalized aged," "fear of victimization," and "aging group consciousness." Several of these terms reflect the strong early emphasis of sociologists on the social problems of aging, problems that now receive much less attention in the face of a strong countertrend toward positive aging.

Second, many topics have been persistent or grown in significance, especially those that relate to health, family, and retirement. The strongest specific example is the explosion of interest in successful aging over this time period. However, it will surprise some readers to know that the term "successful aging" was, to our knowledge, first used by Robert Havighurst in a 1963 article that preceded our period, and again at the start of our period by Erdman Palmore in a 1979 article. These articles appeared well before Jack Rowe and Robert Kahn's first landmark article (1987) and later works (1997, 1998). Since Havighurst's and Palmore's times, many other variants of successful aging have emerged, even before or around the same time that Rowe and Kahn came onto the scene with their oft-cited articles and book. These include references to "optimal," "productive," "vital," "proactive," "robust," and "healthful" aging, among others.

Third, there are terms that are very much a part of scholarship now, but were largely absent in the early years of our review period. This language signals significant trends in the intellectual preoccupations and commitments of our field in the past 30 years. These include the following:

Anti-aging speak: Terms such as "old people," "old age," and "elderly" have been replaced by neutral language intentionally meant to avoid the sense of "old." In the face of concerns about ageism, the field of gerontology has, ironically, become rather ageless. We now speak of "older people" and "later life." This reflects a growing sense that age is something that can be defied or transcended, and the accompanying emphasis among gerontologists and in our society on successful aging and positive images of aging. Yet in lauding the potentials of age and aging, the field has deemphasized the social problems of aging and old age that captured the attention of the field in the early years, problems that we, as sociologists, are uniquely positioned to help solve.

These trends also make apparent another striking fact: aging and anti-aging industries have become big business. Aging (and anxiety about aging) has demanded that new institutions be designed (e.g., residential settings to meet the full spectrum of needed care; educational settings to meet the

need for "lifelong learning") and that services and products be brought to market (e.g., aesthetic services, hormone treatments, vitamins and supplements, legal services). The marketing and consumption of these institutions, services, and products has also brought a wave of new legal and regulatory concerns.

Care speak: With the long era of caregiving research from the late 1980s through the 1990s, an extensive language of "social support" grew with it, especially to reflect the more negative aspects of giving care – including "caregiver strain" and "caregiver burden."

Generational relations speak: Longstanding interests in intergenerational relationships, especially between older people and middle aged children, and between older people and grandchildren, grew alongside the long era of caregiving research. With it grew attention to the dimensions to characterize family relationships – for example, many types of "solidarity" and "conflict" and, more recently, "ambivalence."

Health and disability speak: Health also becomes a dominant point of focus over these years. Here, we see the emergence of notions of "health span," "healthful aging," and "healthy life expectancy"; attention to "activities of daily living," "functional status," and the "disability cascade"; concern about a wide variety of specific disability or illness conditions, some of which also mark the times (including HIV/AIDS, Alzheimer's disease, cancer, osteoporosis, arthritis, and obesity); and language related to health care and institutions (including "independent living," "assisted living," "long-term care," "home health care," "rationing," and "person-environment fit"). Alongside major attention to health grew significant attention to the connections between health, religiosity, and spirituality (and their measurement).

Technology speak: With advances in technology came new hopes for the "built environment" and the use of new technologies to help people "age in place" and monitor their health, as well as terms associated with advances in computing, the internet, and digital social networking.

Life course speak: With the growing significance of the life course perspective came much attention to "pathways," "trajectories," "antecedents," "consequences," "event histories," "linked lives," "timing," "dynamics," and "human agency." Attention to human agency is also captured in a variety of related social-psychological concepts that also became salient over these decades – such as "self-efficacy," "self-determination," "locus of control," "effort," "mindfulness," "resourcefulness," "mastery," and "autonomy."

Methods speak: With major methodological advances came new language to reflect the strategies of the day that would become endorsed in journals: "multi-level modeling," "structural equation modeling," "longitudinal" methods, "growth curves," "latent classes," "life history" and "event history" analyses, and the like. The emergence of the life course perspective, apart from aging, also reinforced the need for advanced temporal and contextual methods, including strategies for better disentangling "age," "period," and "cohort" effects.

Diversity speak: As diversity became part of our scientific lenses in the late 1980s and through the 1990s, many new terms appeared to reflect those commitments – "aged heterogeneity," and regular references to Blacks, Hispanics, and other special populations (e.g., the "differently abled," "rural elderly," and "gays and lesbians"). With this came sensitivity as well to the combined risks of being in multiple vulnerable statuses or positions – for example, the "double jeopardy" or "triple jeopardy" hypotheses.

Gender speak: With greater attention to diversity also came a stronger focus on women – the "feminization" of later life, the "sandwich generation" of "women in the middle" who are caregivers to both parents and children, and women as "kin-keepers" of family relationships and traditions.

Inequality speak: Explanations of the differences among older people prompted a closer look at social inequalities. These were signaled especially by attention to the "Matthew effect" and theories of "cumulative advantage and disadvantage" over the life course, and to the "poor," "near poor," and "underserved" aged; widespread concern about "health disparities" across different groups of older people; and heated controversies about "generational equity" between the young and the old.

Taken together, the commitments to diversity, gender, and inequality in the intervening years have brought significant breakthroughs in understanding inter-individual variability in aging. In having made great strides to include women, minorities, and, to a lesser degree, children in our research, the field has gone far beyond the white, middle class, male perspective that was both the norm and the source of much complaint in our early science.

The Institutionalization of the Sociology of Aging

This handbook takes as its starting point the birth date of the Section on Aging and the Life Course (SALC) of the American Sociological Association (ASA) in 1979. The establishment of the Section marks the formal recognition and institutionalization of the sociology of aging in our discipline's primary professional organization. But the forces that led to its installation were underway before then, and its history since has been punctuated by some tensions that mirror waves of intellectual tension in the field. (For further information on the history of the Section, see Ferraro et al. 2005.)

The organization of sociologists with interests in aging grew out of activities of Harold (Hal) Orbach and Leonard Breen in the fall of 1961. They both explored the idea of launching a section on aging in the ASA. But it was not until nearly 20 years later that a petition, signed by eighty charter members, many of whom are past and present luminaries, to create a Section on the Sociology of Aging was officially approved by the ASA.

Yet as George Maddox, one of the field's pioneers, observed: "In the early days of the Section, [sociologists of aging] sometimes had concerns about their identity. Were they mainly sociologists and incidentally gerontologists? Could one be both? How one answered the identity query was usually based on who was asking. An accommodation was achieved in which sociologists and gerontologists largely ignored each other. In "Sociology of Later Life," Maddox (1979) documented that articles on aging rarely appeared in the principal journals of sociology and, when they did, citations to gerontological journals were rare. Unfortunately, gerontological journals and authors largely returned the disregard" (as cited in Ferraro et al. 2005:13–14).

Today, of course, sociologists of aging can find homes in vibrant sections of professional organizations that allow us to nurture both the "sociology" and the "aging" facets of our identity – in the SALC of the ASA, and in the Behavioral and Social Sciences Section of the Gerontological Society of America. Relative to the time of Maddox's observations, citations to gerontology journals today have also seen extraordinary leaps as the significance of gerontology and the quality and range of journals has expanded. But it is still the case that sociologists of aging do not have a journal to formally institutionalize the intersection between sociology and aging. Instead, we have the option of publishing either in sociology journals, with our papers emphasizing aging and life course issues, or in gerontology journals, with our papers emphasizing social issues. Two of a handful of gerontology journals have traditionally had strong sociological content – the *Journal of Gerontology: Social Sciences,* which in 1995 officially became its own section in "Series B" (though the *Journal of Gerontology* was launched five decades earlier in 1946), and *Research on Aging,* which began in 1979, and even for a while carried the subtitle "A Quarterly Journal of Aging and the Life Course."

As the field grew and diversified, many scholars felt that aging, and especially the term "gerontology," signaled interests that were too cohort-centric. That is, "aging" is a long-term process and

need not – and, indeed, should not – be restricted to the study of the population of older people at any given time. The emergence of the life course perspective, as we will later discuss, both heightened that concern and strengthened that intellectual thread in the sociology of age and aging. Thus, Matilda White Riley (who had fashioned the "age stratification" framework and founded the Behavioral and Social Research Program at the National Institute on Aging), along with other leaders and members of the Section, began in 1990 to advocate a name change to what was then the Section on Aging.

Their proposal was to change "Aging" to "Age" and add "and the Life Course." The reason for the change from "aging" to "age" was at least twofold. One reason was that the inclusion of the "life course" would repeat the attention to processes already captured by the term "aging." But a second and more important reason was that "age" would keep attention focused on age as a property of social life and social systems – and therefore topics of inquiry that had been central to the field and its evolution (e.g., how social roles and activities are allocated on the basis of age, how age underlies the organization of social institutions, how age determines legal rights and responsibilities or eligibility for social programs, how age is used to determine expectations eligibility for social programs of the self and others).

Seven years later, after much controversy, the "life course" part was eventually adopted, but the "age" part ultimately rejected. However, the emphases on the sociology of age were nonetheless very present in the revised mission of the Section, which holds to this day:

> Sociology of Aging and the Life Course provides an analytical framework for understanding the interplay between human lives and changing social structures. Its mission is to examine the interdependence between (a) aging over the life course as a social process and (b) societies and groups as stratified by age, with succession of cohorts as the link connecting the two. This special field of age draws on sociology as a whole and contributes to it through reformulation of traditional emphases on process and change, on the multiple interdependent levels of the system, and on the multidimensionality of sociological concerns as they touch on related aspects of other disciplines. The field is concerned with both basic sociological research on age and its implications for public policy and professional practice.

The Life Course as Both Friend and Foe to the Sociology of Aging

The renaming of the Section to include "the life course" foreshadowed what would perhaps become the most significant development in our field in the years that followed to today. And it is a development around which we sense some new tensions growing.

The life course has gained tremendous momentum in our field. This is evidenced in a search we conducted using Sociological Abstracts from 1975 through 2008. The number of articles indexed with the term "life course" was essentially nonexistent in the 1970s; grew very slowly in the 1980s, reaching an annual peak of 88 publications by the late 1980s; and stayed fairly steady over the early 1990s, growing to no more than 148 annual articles by the late 1990s. It was in the 2000s that the presence of the life course surged: with annual numbers between 200 and 300 in the early 2000s, the numbers nearly tripled between 2003 and 2004 (to almost 800) and have remained relatively steady since, with a shift upward in 2008 and no doubt jumping further today.

From our perspective, the life course is both a friend and a foe to the sociology of aging. On the one hand, the life course perspective, at its most basic level, reminds us that the biological, social, and psychological aspects of aging outcomes are often not determined by chronological age itself but by the constellation of social factors that accumulate over a lifetime. It has therefore been central to the task of reclaiming the "social" in social gerontology, particularly in emphasizing how experiences in late life are shaped by those in earlier periods, and how aging experiences are shaped by a range of social institutions and forces (for further discussion, see Dannefer and Settersten 2010).

It has emphasized the great degree and types of diversity among older people, and that dynamics of aging are a collective process characterized by the accumulation of inequality over the life course. It has also emphasized that although age is important in every society, societies vary dramatically in how they use age and the meanings they attach to it. These are all very crucial lessons for sociologists of aging.

On the other hand, so much attention to the life course could also threaten the sociology of aging. As attention to the life course seems certain to grow exponentially in the years ahead, it is our hope that this attention will not ultimately compromise the scope and clarity of the sociology of *aging*. There are questions about aging that do not entail the life course, and many more questions about the life course that do not entail aging. They are not one and the same. Both are naturally treated in our work, but how we put the two together has tremendous implications for future scholarship. The life course perspective has offered valuable insights and transformed scholarship in our field. It is important for researchers to consider what is gained and what is lost or put at risk in our understanding of the sociology of aging if too great an emphasis is placed on the life course. In pursuing an understanding of "aging and the life course," the field seems to become ever bigger and broader, and therefore difficult to draw boundaries around. Are we becoming a field of every possible age, and every possible transition, in every possible domain of life? As the life course perspective gains momentum in other areas of sociology (e.g., family, education, work, health, and criminology), the overlap between these fields and ours also grows. What is it, then, that leaves our own subject matter distinct?

To explore the status of publications on "aging," we conducted a parallel search of Sociological Abstracts for the same period. It tracks in exactly the same way. But more important, the number of annual publications on "aging" are surprisingly higher by hundreds more articles (as many as 500 more at the peak). The fact that sociological articles on "aging" far outnumber those on the life course is, in some ways, reassuring. Nonetheless, we sense growing concern that the life course might also compromise the sociology of aging. And it is our prediction that the tensions that sociologists of aging feel around these difficult and critical questions will become increasingly strong in the near future.

The Social Organization of the Field

Finally, in reviewing 30 years of scholarship on the sociology of aging, we were often aware of the social organization of our science and the power of social relationships in producing knowledge. We were aware of the strong roles that leaders in the sociology of aging expectably play in shaping the intellectual agenda of the field and the theories and methods used to advance it. These dynamics were especially apparent in the early years of the field, before there was an infrastructure to support it. Keep in mind the conditions we noted at the beginning of this chapter. The actions of individuals and small groups in education, government, or practice were instrumental in forming the infrastructure we take for granted today. The history of the Section on the Sociology of Aging and the Life Course of the American Sociological Association is a good example of that.

We could trace generational lineages in the sociology of aging and see how the intellectual preoccupations of particular times are rooted in those relationships and exert their influence over time. We could see the influence of mentors at work, and how their capital and visibility played roles not only in promoting their success but also ultimately in forwarding the field. A "sociometrics" of our field becomes visible – the emergence of stars, networks of in-groups and out-groups, old guards and new ones; the control and circulation of the elite; and the statuses of the universities where members train or work in shaping their mobility or the allocation of resources.

We wondered about the infamous file drawer problem: the sociological research on aging that we will never know because it does not make it into the published scientific record, especially if it does not reinforce or if it critically challenges the ideas and methods that are in fashion at any given moment. We were also aware of the bias to publish findings of difference rather than findings of no-difference, though the latter may be just as important as the former to developing theory and our knowledge base on the sociology of aging.

We wondered about the things that are also not revealed in the record of published papers: how nonlinear the research process is; the complex and nuanced decisions that are made on the spot as research is being conducted; the leaps of faith in interpreting data; findings that are downplayed or dismissed, even unconsciously, because they run counter to theoretical lenses, prior findings, or personal convictions; admissions of what went wrong or was not done well.

We wondered, too, about the ambivalence so many scholars seem to have about writing, and about writing in ways that often seem artificial and distanced – as if we are in the world but not of it, as if we are bystanders to our work, wholly detached from the people and topics we study. At the same time, sociologists of aging are not fully insiders to the people and topics we are seeking to understand: That is, while we are all aging, most of us are not yet old. And yet we play roles in creating expectations, conducting research, making policies, and designing practice related to both aging and old age – and we carry assumptions and values with us as we do.

We have much to gain in more often turning a critical sociological lens on the social forces that promote or inhibit the advancement of knowledge, careers, and professional organizations. With greater consciousness of the social organization of our field comes the possibility to change that which is questionable or problematic.

Concluding Comment

In this chapter, we have outlined some of the broad trends in the sociology of aging over the past 30 years. In the final chapter, we will highlight some of the most provocative and pressing prospects for the decade ahead. In between, readers will find 36 chapters devoted to 30 years of inquiry on specific topics, and seven additional reflections from senior statespeople about their personal experiences in the field. The future holds great promise for the field of sociology, but there is much work to be done. With the new generations of scholars making their way into the field, we know that the next 30 years of the sociology of aging will be as exciting as the last thirty.

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Part II
Theories and Methods in the Sociology of Aging

Chapter 2
Theoretical Perspectives on the Sociology of Aging

Victor W. Marshall and Vern L. Bengtson

Throughout the relatively short history of the sociology of aging, many scholars have lamented the lack of theory and common conceptualization of issues (Orbach 1974; Maddox and Wiley 1976; Passuth and Bengtson 1988; Marshall and Mueller 2003; Bengtson et al. 1997). This reflects the growing opportunity for theorizing about age and age structure, but at the same time points to the continuing lack of agreement in theoretical paradigms or perspective – a problem that has persisted throughout the years. Our approach in this chapter is to provide a brief history of theoretical perspectives in the sociology of aging, and to indicate some areas where promising theoretical developments are emerging. First, we review theory development up to the late 1970s, when the field began to turn to the life course perspective. Second, we explore some of the more significant developments in theory over the past 30 years. Lastly, we preview a few challenges in theorizing for the future.

This chapter is about theoretical *perspectives*, which we define as systematic "ways of looking" at complex and interrelated processes, such as social aspects of aging. Theories are *explanations* or systematic statements that provide generalizations about causal relations. Perspectives frame, and consequently guide, theorizing; and theorizing, developing an understanding of the *how* and the *why* behind the social manifestations of aging we observe, is the ultimate goal. We cannot possibly do full justice to this topic in one chapter, so we recommend several more detailed overviews and discussions of the development of theory in aging. For general overviews see Marshall (1999); for the life course perspective, see Marshall and Mueller (2003), Macmillan (2005), Mayer (2009), and Bengtson et al. (2005). For demography and the life course see Hogan and Goldscheider (2003); for families and aging see Bengtson and Allen (1993); for reviews of the latest theory in nine substantive areas in the sociology of aging, see chapters in Bengtson et al. (2009). For a description of 12 classic theories in social gerontology see Bengtson et al. (1997), and for an examination of trends in the use of theories in our field since 1990 see Alley et al. (2010).

Early Developments in the Sociology of Aging

Theoretical perspectives in the sociology of aging can be categorized as macro-level (structural) or micro-level (social psychological), and further classified as to whether the individual-society assumptions are normative (individual behavior is seen as following norms) or interpretive (individuals construct norms but may not necessarily adhere to them) (Marshall 1996). The 1960s were a dazzling period of theoretical developments in the sociology of aging at both the macro and micro

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levels, largely within the normative tradition. Burgess (1960) described an historical shift to a "role-less role" for the aged since the nineteenth century, and laid the foundation for the theory of aging and modernization, later developed more systematically by Cowgill and Holmes (1972). Cumming and Henry (1961) advanced the first truly multidisciplinary theory of aging in proposing that disengagement of older individuals from society was a normal part of the aging process. The theory posited that biological, psychological, and social withdrawals were universal, inevitable, and adaptive in preparing both the individual and the society for eventual death. But disengagement theory clashed with "activity theory," which implicitly treated aging as a decrement to be "adjusted to" by attempting to maintain as much as possible the activity levels of mid-life. This "keep active!" theory of successful aging was much more consistent with American values of individualism and autonomy than the disengagement perspective and was in keeping with concrete applications, such as the development of senior citizens centers and Leisure World housing developments.

The two competing theories stirred up debate in the previously uncontroversial sociology of aging; and this in turn led to healthy progress in the explicit development and testing of concepts and theories over the next two decades (Maddox 1965; Lemon et al. 1972; Longino and Cart 1982; Palmore 1968). Activity theory is still visible in current advice about "successful aging." In the best-seller of that name, Rowe and Kahn (1998) argue that the key to aging successfully lies in "keeping active" in four ways: active social engagement, active exercise, proactive diet, and avoiding disease. Critics note three difficulties with their prescription: (1) It is based on the old activity theory model (unfortunately never acknowledged or referenced), which had received little empirical support over the previous three decades of research; (2) It assumes that successful aging is under the control of an individual's own efforts and initiative; (3) It ignores social constraints and inequalities – race, poverty, gender, isolation – that could make it structurally impossible to follow these prescriptions (Schmeeckle and Bengtson 1999).

In the early 1960s, Bernice Neugarten and her students began conducting systematic research on age norms, concluding that in America there exists a prescriptive timetable for the ordering of major life events, such as the appropriate age to finish education, get married, have children, and retire (Neugarten et al. 1965). Moreover, the age expectations and the actual age at which these events occurred were highly related. They concluded that age norms operate as accelerators and brakes on individuals' behavior, sometimes hastening an event and sometimes delaying it. Regarding old age, however, Neugarten (1974) subsequently argued that normative roles for later life were changing, and that "old age" needed to be differentiated into "young old" and "old old" categories, based largely on a good health-frail health transition that, she suggested, typically happened around the age of 75. Neugarten later expressed regret at having set age 75 or any particular age for the young old-old old division, since this could lead to stereotyping, but the terminology was widely adopted, creating two reified groupings that failed to capture diversity within and across these groups.

A few years later, Suzman and Riley (1985) proposed that a third group be recognized, the "oldest old" at age 85. This led Leonard Cain Jr., the pioneering sociologist of aging, to playfully dub the three categories "the frisky, the frail, and the fragile." Perhaps having second thoughts about their tripartite division of the aged, Suzman and Riley (1985:180) tried to have it both ways: "Also widely unrecognized is the pronounced diversity of the population aged 85 and over. At this age many people still function effectively, while others have outlived their social and financial supports and have become dependent upon society for their daily living."

Rosow (1974) presented the most nuanced theorizing to date in this normative tradition in social psychology of aging. He argued that for various reasons socialization for old age was not highly successful. Riley introduced the age stratification perspective in 1971 (elaborated in Riley et al. 1972). Her model included both structural and social-psychological levels of analysis, with links between the society and the individual through role allocation processes (structural) and socialization. The main contribution of this perspective was to conceptualize age stratification as a component of the social structure, a succession of age statuses through which cohorts or individuals flowed

as they aged. The model depicted two sources of change over time – the aging of individuals and the differentiation of cohorts. The way this conceptualized social structure as groupings of role positions followed the predominant perspective of general sociology at that time. Parsons's (1951) structural–functional "general theory of action" downplayed more materialistic aspects of social structure that constrain or create life chances for individuals or for cohorts (Marshall and Clarke 2010; Sewell 1992) and presented the aging individual as a somewhat passive receptor of socialization (Dowd 1987, Marshall and Tindale 1978–1979; Settersten and Gannon 2005).

Through the 1960s and 1970s, most research in social gerontology focused on "the aged" and a narrow range of such later-life transitions as retirement, and widowhood was considered at the social psychological or social structural levels. The unit of analysis was primarily the individual, and the processes investigated usually focused on the short term. The dependent variable most frequently investigated was "life satisfaction" (including "morale," "happiness," and "adjustment"), examined principally in relation to short-term causal mechanisms, such as current economic well-being, health status, and social integration (Marshall and Tindale 1978–1979). The temporal scope of investigation largely was confined to single events in these domains – retirement, health decrements, and widowhood – leading to role loss that affected life satisfaction.

At the same time, at the structural level of social institutions, aging and modernization theorists saw macro-level social forces acting on individuals through highly deterministic processes. In this theory (Cowgill 1974), forces of modernization (the rise of scientific technology, urbanization, literacy and mass education, and health technology) created population-level changes in life expectancy, the emergence of new occupations, geographical and occupational mobility, and changing marital status. These, in turn, fostered residential and social distancing between the generations, including the shift to a primarily nuclear family form, leading to cultural changes and to the emergence of the social institution of retirement. Finally, the theory maintained, development of the institution of retirement and accompanying cultural changes led to a lower status for the aged. Burgess (1960) had laid systematic foundations for this view in coining the phrase, the "role-less role of the aged." The processes postulated by Cowgill involved long periods of historical and family time. However, theories are made for testing, and the modernization theory did not stand up well to subsequent empirical investigation.

At the micro or social psychological level, *several* investigators began research in the interpretive theoretical tradition. Matthews (1979) drew on symbolic interactionism to understand *The Social World of Older Women*, and Kuypers and Bengtson (1973) used labeling theory principles to develop their "Social Breakdown Theory of Aging." Gubrium (1975) drew on phenomenological sociology for his study of life in a nursing home. Explicit recommendations for the application of Mead's perspective to the study of aging were given by Chappel and Orbach (1986) and Spence (1986). Marshall (1978) analyzed socialization for impending death in a retirement community from the perspective of Schutz and the symbolic interactionists. Atchley (1971) proposed a continuity theory of aging to explain why older adults were able to maintain a strong and consistent sense of self, emphasizing the active role individuals take in developing personal constructs.

Developments from the 1980s

Reviewing the "sociology of later life" as the decade of the 1970s drew to a close, Maddox (1979:113) suggested it was "…at the edges of mainstream sociology." However, the foundation for change had been laid, and the decades to come would see significant changes to the definition of the field and decreasing marginalization. Much of this progress would be shaped by three developments: increased adherence of sociologists to the political economy perspective, theoretical formalization of the life course perspective, and the maturation of interpretive sociology applied to aging.

Establishment of the Political Economy Perspective

As the 1970s ended, the framework of political economy became widely accepted in sociology and scholars in the sociology of aging soon found it a useful corrective to previous macro-social perspectives in the field. Townsend (1981:5) suggested that the dependency of the elderly in the twentieth century was "socially manufactured," calling it "structured dependency." Walker (1981:74) noted that poverty had wrongly been accepted as an inevitable consequence of old age and therefore something to which elderly people must simply "adjust." Estes (1979) linked the social construction of reality with a political economy perspective that focuses on the function of social policies and programs in bolstering existing power arrangements. Gerontological theories, she felt, support the status quo by locating the "problem" within the older individual rather than in the socio-political production of the problem. Guillemard (1983) brought together social scientists from Europe, America, and Canada to examine old age and the welfare state, stimulating much new work: Guillemard and Rein (1993) on the welfare state and retirement; Kohli et al. (1991) on state policies and the retirement transition; Myles (1984) on the political economy of pension policies; Myles and Quadagno (1991) on aging and labor markets; and Leisering and Leibfried (1999) on welfare state policies and their impact across the life course in a comparative context (see Mayer 2009).

Quadagno (1982) suggested that the aging and modernization theory as developed by Burgess (1960) and Cowgill and Holmes (1972) was ahistorical and idealized the past. In a historical analysis of nineteenth-century England, she showed that the aged were not generally venerated; rather, their status was highly conditioned by structured power relations. She also provided evidence that negated the timing of some events in the causal chain hypothesized by Cowgill.

Aboderin (2007) applied a political economy perspective to refine the earlier theorizing of aging and modernization. She suggested two central mechanisms leading to a decline in the status of the aged with modernization: increasing individualism, which weakens traditional norms of filial obligation by emphasizing the value of independence in old age, and "modernization," which erodes conformity with filial obligation norms by eroding older people's powers to wield sanctions that traditionally enforced the norms, and the resources they can offer in exchange for support. She criticized the aging and modernization theory for ignoring family exchanges other than filial support from children to parents, and for ignoring the impact of constraints such as poverty or economic crisis on the provision of support.

A variant of the political economy perspective, the "moral economy" of aging, suggests that social movements, political and economic processes are shaped not only by material interests in a Marxian sense but also by cultural conceptions of legitimacy, equity, citizens' rights, and moral contracts across generations (Hendricks 2005; Marshall and Clarke 2007; Minkler and Estes 1999). In its many variants, the political economy perspective has had a great impact on aging research since 1980. Moreover, because it addresses the ways in which individual lives are affected by changing social structures, the perspective is frequently merged with the life course perspective.

Development and Formalization of the Life Course Perspective

The first formal statement of the life course perspective was provided by Cain (1964), who drew on other sociologists (Strauss for a dynamic view of negotiating age structure and Eisenstadt for the importance of generations), anthropologists (van Gennep for the concept of structured age statuses), and other disciplines (Marshall and Mueller 2003). A decade later, Abeles and Riley (1977) outlined three central premises that still form the core of the life course perspective: (1) developmental change and aging represent a continuous process; (2) change occurs in interrelated social, psychological, and biological domains, and (3) life-course development is multidetermined.

They urged a cross-disciplinary research agenda covering domains such as the sense of self and self-esteem; health, physical functioning and stress; social networks and relationships; and work and retirement. Riley's approach to the life course built directly on her prior work on age stratification but with greater emphasis on social processes of individuals and cohorts passing through the age structure (Riley 1987).

Elder (1985) described the life course perspective as emanating from Chicago-school sociologists who made prominent use of case studies of individual lives and advocated a longitudinal approach to research methods. Incorporating aspects of Bronfenbrenner's ecological perspective, Elder (1995) pointed to five principles of the life course perspective; expanding those originally suggested by Abeles and Riley to emphasize the importance of historical time and place, how linked lives influence behavior, and human agency. Placing the individual and structural life course in historical time is perhaps Elder's major contribution to theorizing the life course, as exemplified by his classic, *Children of the Great Depression* (Elder 1974).

Although the concept of "linked lives" refers to any social linkage, which creates contingencies in life decisions and actions, the principle has most frequently been employed in the intersection of life course sociology and family sociology, with issues such as family caregiving or grandparent–grandchild relationships. Building on earlier work by Shanas et al. (1968), Bengtson developed, refined, and measured a typology of dimensions of intergenerational solidarity and conflict (Mangan et al. 1988) for use in the Longitudinal Study of Generations, which began in 1971. The typology was widely used by others (notably Rossi and Rossi 1990). Although Shanas's work was in effect a test of the modernization theory of aging as applied to the family domain, Bengtson linked his work to social change through his conceptualization of generational succession, employing the concept of generation in both its kinship and cohort usages to examine stability and change in kinship generation relations as successive cohorts age.

The term "generation" is much debated because it can refer to both kinship generations and generational cohorts (Bengtson et al. 1985; Alwin 1995). As Uhlenberg and Miner (1995) observe, "cohort" has been a critical concept in the life course perspective. Ryder's (1965) influential paper, The Cohort as a Concept in The Study of Social Change, recommends confining the term generation to the kinship realm, a recommendation seconded by Kertzer (1983). However, European social scientists, paying attention to Mannheim's conceptualization of generations, mostly disagree. Maddox and Wiley (1976) and Marshall (1983) recommend restricting "cohort" to a methodological device to array data by year of birth or some other date. Bengtson et al. (1985) suggest the term "generational cohort" to distinguish a Mannheimian usage from the methodological or kinship usages. Being able to distinguish between cohorts and generational cohorts has profound implications for aging and life course theorizing because it allows generations to be treated structurally.

Interpretive Sociology and Social Construction of Aging and the Life Course

In a third major contribution shaping aging research since 1980, symbolic interactionist, phenomenological, and related "interpretive" sociologies come together in what is often now called the social constructionist perspective; these emphasize that individuals exercise agency over their life courses.

Handel (2000) recently revived the "Chicago School" tradition of life narratives with his study of a working class man in New York, situating him in time and place and recognizing that the life course is a social institution and that the individual exercises choice while navigating it. Handel states life course principles in the language of symbolic interactionism (using "career" rather than "trajectory") and situates the "story" in historical time and place, illuminating the extensive life-story data that provide the empirical base for the book. Newman's (2003) life-course study of

minority women's journeys from adulthood into old age, struggling for economic security and family stability in poverty areas of New York, used a set of narrative case studies.

In Europe, the University of Bremen's "Status Passages and Risks in the Life Course" Research Center has promoted this approach for almost 15 years, theorizing and pursuing life course studies that integrated individual lives with social structure in the context of the risk society, distinguishing its approach from the early life course theorizing in North America (Heinz et al. 2009; Marshall and Mueller 2003).

Phenomenological sociology represents an important variant of the interpretive perspective in aging and life course studies (Holstein and Gubrium 2007). Common to various approaches in phenomenological sociology is the notion of meaning-making through what Berger and Luckmann (1966) had called the "social construction of reality," drawing heavily on the phenomenological sociology of Alfred Schutz (1967). In its various guises, the interpretive perspective has influenced aging and life course theorists to emphasize the active part played by individuals as they struggle to make their lives.

Current Theoretical Development in the Sociology of Aging

We feel that a number of perspectives are currently emerging that appear promising for significant theory development in the sociology of aging. These will provide an agenda for theory-relevant research in the next decade, including – and this will be particularly important – efforts to make links among these topics. We confine ourselves here to a selected number of these developments.

Stress Theory, Aging, and the Life Course

The largest and most rapidly growing substantive area in aging research recently has been in aspects of social health and aging, often theorized in terms of social models of stress. Pearlin (Pearlin and Skaff 1996) contributed to theoretical development in this area by his own research as well as by providing a publication vehicle as editor for many years of the *Journal of Health and Social Behavior*. Departing from previous perspectives in stress research, especially in the critical life events tradition (Holmes and Rahe 1967), he emphasized that life changes are not necessarily negative, that it is a normal part of aging to experience them, and that life course transitions are not necessarily associated with decreased psychological well-being (Pearlin 1982). Instead, he theorized that life course transitions do lead to changes in social and economic conditions, and these conditions can pose "life strains." Furthermore, he issued a sociologist's challenge to the prevailing wisdom at the time: "Given the variety of ways in which different people respond to being at the same stage (of life), any research that is worth its salt has to attend to the parts played by social and economic factors in creating and channeling the effects of life-cycle transitions" (Pearlin 1980:359).

As Wheaton and Clarke (2003) note, recognizing that the impact of stressors can spin out over long periods of time led to a "natural alliance" of the life course and stress process perspectives. Structurally, even early-life neighborhood contexts continue to be operative throughout transitions over many stages of the life course, with the strongest effects in relation to gains and losses of status and roles (Clarke and Wheaton 2005). A major way of theorizing how earlier life course conditions and events can have outcomes later in life is through the concept of "cumulative advantage" or "cumulative inequality," a concept applied to stress but to many other outcomes in later life.

Cumulative Inequality

Possibly the most active theorizing within the sociology of aging recently has been in the areas of cumulative advantage, disadvantage, and inequality (Dannefer 2003; DiPrete and Eirich 2006; Ferraro et al. 1999; O'Rand 2003). Theory development in this area was initiated by Merton's (1968) description of the "Matthew Effect" in shaping scientific careers ("To he who hath much, much will be given") and applied to the problem of accounting for differential aging trajectories by Dannefer (1987), O'Rand (1996), and O'Rand and Henretta (1999). Building on this work, Ferraro and his colleagues have engaged in formal theory development, formulating specific hypotheses linking life course principles, through cumulative inequality processes, to later-life outcomes such as variability in self-efficacy or mental and physical health (Ferraro et al. 2009). O'Rand and Hamil-Luker (2005) traced a "sequentially contingent" process of cumulative disadvantage in terms of heart attack risk, while Hayward and Gorman (2004) examined the influence of early-life social conditions on men's mortality. Willson and Shuey (2007) muster cautious support for both path dependent and duration dependent processes of cumulative disadvantage affecting self-rated health in later life.

Cumulative inequality outcomes are seen in later life, making this an important theoretical development for the sociology of aging. However Mayer (2009:417) notes that few studies demonstrate linkages between early initial conditions to late life outcomes. Thus, in their enthusiasm for the plausibility of the cumulative advantage hypothesis – and it must still be considered a hypothesis, given the absence of data demonstrating long-term causal linkages – theorists in aging should not forget the importance of history, including the effects of changing social institutions and policies.

The Standardized Life Course

Cain (1964) had suggested that the life course experienced by an individual included a preparation for work stage, a "breadwinner" stage, and a retirement stage. Decades later, Kohli described the life course as "periods of preparation," "activity," and "retirement" (Kohli 1986:72). O'Rand (2003:693) observed that "The life course – when defined as interdependent sequences of age-related social roles across life domains (family, education, work, health, leisure) – is a product of the linkages among state (welfare), market and familial (gender) institutions, and demographic behaviors across the life span." She notes that "… when these linkages are tightly coupled and universally salient in a population, their coherence and normative strength lead to a more highly institutionalized, age-graded life course. Alternatively, when these linkages are loosely coupled, variability (de-institutionalization) in the life course increases: The relationship of age to role transitions weakens, and the synchronization of roles across life domains becomes less standardized."

Since 1978, empirical and theoretical studies have questioned the extent to which the social institution of the life course is now or was ever highly standardized (Bruckner and Mayer 2005; Hogan 1978; Rindfuss et al. 1987). Wilensky (1960) debated the consequences of not following a standardized life course for individuals and suggested that a focus on the time or the order of entry to states is insufficient to understand standardization of life course issues and their impact on later life (see Settersten et al. 2005).

Some industrial or occupational sectors offer stable and predictable opportunities for a career more than others. In labor market segmentation theory, the primary distinction has been that between firms with internal labor markets and firms that employ unstructured, open labor markets (Sorensen 1986). Blossfeld and Mayer (1988) showed that even a more complex typology of types of labor market structures is not highly effective to characterize the occupational life course.

There have been major changes in the past century in the age patterning of labor force participation and in the timing of retirement (Cahill et al. 2006; Carr 1966; Hardy 2006). Age-related labor force participation and retirement timing have been much in flux since 1995 in response to changing economic conditions and public and corporate policy responses (Marshall 2009a), but these have not been well theorized.

A similar three-part view of the life course is assumed in welfare state provisions for income security, education, and family supports (Marshall 2009a; Moen et al. 2005, Myles and Street 1995), yet the life course can be destandardized through the reinforcing effects of industrial change, weakening of the welfare state, and globalization, which devolve risk from social institutions to individuals (O'Rand 2006).

Risk Society

The concept of the risk society has been seldom applied in theorizing of aging (Phillipson and Powell 2004), despite important areas of cross-fertilization between aging and life course and risk society theorizing. Giddens (1991) argued the need for greater life course reflexivity in late modern risk societies. The risk society is one in which social institutions provide less "insurance" against the vicissitudes of life, such as job loss or loss of one's health, and individuals are expected to assume responsibility to navigate these risks. Risks such as income loss with retirement cannot be anticipated with certainty (e.g., unexpected "early retirement" because of job loss or the need to provide family care). DiPrete addresses "unanticipated events" in the context of stratification and life course mobility under different welfare regimes, which provide various degrees of protection for such instability. He argues that highly educated people orient their lifestyle to the long-term expected living conditions corresponding to the wealth associated with their human capital. But to do so requires long-range estimates, while the future cannot be anticipated accurately. As DiPrete argues, "unpredictable …. changes that have large and potentially durable effects offer a challenge to the behavioral theory implied in the concept of permanent income" (DiPrete 2002:272).

Chance Events and the Life Course

The concept of a structured and predictable (institutionalized) life course has been an important element in the life course perspective and assumed by social gerontologists to be the key to a good old age. However, Pearlin (1982:57) noted the distinction between the "relatively durable strains" of daily life; scheduled and transitional life events, and the less-expected, unscheduled events. Notable are "…the more eruptive and less predictable events of life, which stand in sharp contrast to the normative events that can be forecast far in advance of their actual occurrence." To understand both anticipated and unplanned life course events, we need to appreciate them as events organized through time and space. We need to consider not only the stimulus of the event, but also the ways in which people experience, adapt, and find social support to cope with them (Pearlin 1982).

However, Pearlin's call for attention to unanticipated life course events has been infrequently heeded. Shanahan and Porfeli (2007) observe that "chance" is a tricky concept that, when applied to the course of human lives, goes well beyond probability or statistical odds. Our understanding of how people experience aging and cope with it changes will be enhanced if we can better theorize the role that unanticipated events and chance play. This is particularly true in the context of a risk society, which provides few institutional supports.

Structure and Agency in the Life Course

Understanding the relationship of agency (individual choice) and social structure (societal constraints) has been the goal of much sociological theorizing. This has recently surfaced as an important focus for life course and aging researchers (Dannefer 1989, Settersten and Gannon 2005). In the normative perspective that characterized much early sociology, sets of roles organized into social institutions constituted the social structure, defined in terms of norms, or expectations for behavior. The individual appeared mostly as a role player. The metaphor was that of the theatre, in which actors learned their scripts through what were presumed to be highly efficient socialization mechanisms and then acted them out. Those employing the interpretive perspective took as metaphor free theatre or "theatre improv," in which individuals worked jointly and collectively to produce a play, simultaneously writing and enacting the scripts (Marshall 1986). The human agency principle was Elder's conceptual device to argue against extremes of normative determination in the shaping of individual's biographies.

How to define, measure, and use a concept such as "agency" (or "social action," as it has been otherwise termed) has been a matter of considerable debate in the social sciences and the aging and the life course literature (Marshall 2005, Marshall and Clarke 2010). We will not be able to cover the complexity of this issue; see Dannefer (1989), Marshall and Clarke (2010) for applications of agency to aging and the life course and Sewell (1992) for a general overview of the problem. Settersten and Gannon (2005:36) call for models of "agency within structure, which explicitly seek to understand how individuals set goals, take action, and create meanings within – and often despite – the parameters of social settings, and even how individuals may change those parameters through their own actions."

The Family and the Life Course

Some of the clearest theoretical applications of life course concepts can be seen in research on families (Bengtson and Allen 1993). Although many aspects of the life course perspective are useful in theorizing family processes, the concept of "linked lives" has proven the most useful tool in understanding the actions and interactions of family members over time. For example, research on grandparents and their influence has expanded the concept of linked lives beyond the boundaries of the nuclear family (Bengtson 2001; Roberto et al. 2001). Grandparents are increasingly important for the survival and well-being of growing numbers of children worldwide. As grandparents go on to live longer and in better health, they are called upon for longer years of both caregiving and mentoring (Mueller et al. 2002) and they serve as core conveyers of values and moral teachings, as well as personal and family identity (King 2003). Religion is an area where grandparents appear to be particularly influential (Bengtson et al. 2008). We suggest that grandparenthood be theorized much as parent–child socialization has been, that is, with a focus on processes or mechanisms reflected in socialization theories: role modeling, status inheritance, reflected appraisal such as attachment or solidarity (Bengtson et al. 2002a).

A second example concerns caregiving for dependent elders, also a growing concern in nations both East and West. Despite variations between nations in state welfare provisions, the primary responsibility for providing care and support remains with the family (Bengtson and Lowenstein 2006). Elder-caregiving can be theorized as a career. It epitomizes the long-term linkage between lives, with consequences that continue up to dying and beyond death to widowhood and bereavement. Its demands begin slowly but may progress to the highest levels of stress and burden experienced during the life course, resulting in exhaustion, depression, and declining physical health

(Pinquart and Sorensen 2006). Agency also can be seen in "caregiver growth." Positive consequences of caregiving mentioned by many respondents include increased self-understanding and a sense of pride (Roberto and Jarrott 2008).

The linked lives in caregiving careers often extend well beyond the marital dyad, and then inequities can surface and conflict may result. Siblings will negotiate who will provide care, what kind of care, and with what exchanges or rewards – negotiations that are often marked with perceptions of inequalities (Connidis and Kemp 2008). There are marked gender inequalities in caregiving. Its stresses are more evident in women than in men, a reflection of disadvantage in balancing demands of work and family (Heinz 2003). Thus we suggest caregiving be theorized as a career in itself, a story of linked lives involving earlier family antecedents, cyclical engagement, negotiations of roles, short- and long-term impacts, structural constraints and agency.

Beyond Theory? Critical Gerontology and the Critical Feminist Perspective

Achenbaum describes "critical gerontology" as having "entered the gerontological mainstream without losing its edge" (Achenbaum 2009:35). This probably exaggerates the extent to which critical gerontology has been accepted by sociologists of aging today. It is not adhered to by the vast majority of researchers producing empirical studies that characterize almost all of the aging research published in major sociology or social gerontology journals, whose work, incidentally, would be criticized by the critical theorists.

Marshall (2009b) has asked, "What is new about critical gerontology?" Except for the self-labeling as a critique of the status quo in society and their claim to be struggling for social justice and a better world, an observer may have difficulty identifying perspectives or concepts that are unique to critical theory. All self-labeled critical gerontology incorporates earlier traditions, especially the political economy tradition in the sociology of aging, and employs narrative approaches that relate closely to symbolic interactionism and related interpretive sociologies. The same may be said of the varieties of "feminist theory" (Marshall and Clarke 2007). An emphasis on social justice and efforts to usefully apply research-based knowledge is common to both of these. However, many other sociologists in aging could argue that their scholarship is supporting social justice and human betterment. In the tradition of Dewey's pragmatism, many interpretive sociologists see practice as the test of knowledge. It is not always necessary to proclaim humanitarian goals as a unique contribution of one's own perspective.

Estes (2006) links critical theory and feminist theory in articulating four premises of the "critical feminist perspective": (1) the experiences and situations of women across the life span are socially constructed; (2) the lived experiences and problems of older women are not solely, or even largely, the product of individual behavior and decisions; (3) the disadvantages of women are cumulative across the life course; and (4) the feminization of poverty is inextricably linked to the interlocking oppressions of race, ethnicity, class, sexuality and nation that produce the marginalization of women. What apparently makes all this different from the existing political economy of aging perspective is a "critical feminist epistemology" that requires that the world must be understood from the standpoint of women (and not men). The reader can judge whether men could ever be able to take a similar standpoint, or whether men and women could possibly be able to see things the same way. Moreover, one need not be a feminist to recognize that gender and the other interlocking sources of inequality mentioned by Estes, as well as age stratification, are the proper subject matter of all good sociology (McMullin 1995).

Notably absent from our discussion here is postmodernism, which might be considered a perspective in the sense that it represents something like a "way of looking." But as postmodernism

eschews development of explicit theory, in fact is anti-theory in many formulations, it is not considered here. See Baars (2006) for a stimulating discussion from the perspective of critical theory, and Marshall and Clarke (2007) for a less sympathetic discussion.

Globalization, Aging, and the Life Course

Attention to globalization in aging research can enrich perspectives guiding theory by directing attention to neglected phenomena. Attending to globalization requires going beyond a comparative perspective to address how social institutions and the movement of people, products, and ideas across nations influence the life course and aging (Marshall 2011; Phillipson and Vincent 2007).

A political economy of aging and the life course in this era must extend beyond national boundaries or comparative analysis to develop theory that addresses complex linkages of people and social institutions globally (Walker 2005; Walker and Deacon 2003; Vincent 2006). The concept of globalization and its effects have been addressed over the working life course in an international study of information technology firms (McMullin and Marshall 2010). Estes (2006) describes the emergence of "global families," with generations separated and moving back and forth between the developed and less developed nations, accompanied by the economic marginalization of women and the emergence of international caregiving networks.

Where Does Theory Need to Go?

In the past decade, there has been considerable progress in the development of theory to help understand social processes related to aging. This is reflected in the increased use of theory in journal publications recently. For example, in the *Journal of Gerontology: Social Sciences*, the rate of theory-related articles grew from 20% of the papers published between 1990 and 1994 to 47% published from 2000 to 2004 (Alley et al. 2010). In light of the theoretical progress summarized in this chapter, we suggest five issues worth addressing in future theory development.

First, we need more explanatory theory. We have much research that is descriptive and much less that is confirmative or theory-supportive. Theories are explanations, descriptions of general causal relationships among phenomena of interest to us. The rigor and maturity of a scholarly or scientific field can be judged by the strength of its theories. Mayer (2009:423) suggests that "In contrast to other disciplines dealing with human lives, life course sociology lacks a coherent body of theory." This has been a consistent criticism of our field since the 1960s. By contrast, Mayer notes the fields of economics, life span psychology, and biology integrate coherent theory with the life course and aging perspectives (e.g., the life cycle theory of consumption and savings; Baltes's Selection, Optimization and Compensation psychological theory of aging; biological theories of cellular maturation and senescence). Mayer (2009:423) states the dilemma: "Indeed, because there is not just one mechanism underlying the social structuring of human lives but rather manifold mechanisms, one might contend that a simple, unified sociological theory of the life course is not possible at all. Nonetheless, I claim that the lack of explanatory theory(ies) accounts for much of the mostly descriptive or illustrative rather than confirmative nature of life course research."

Second, researchers should pay more attention to previous theorizing lest they repeat the mistakes of the past or attempt to reinvent the wheel. As sociologists, we and our students are trained to be highly critical, but we would benefit from not rejecting out of hand insights from earlier theoretical approaches, as it often seems fashionable to do (structural–functionalism being an example).

A genuinely dialectical approach will distill the best and most productive insights from both the thesis and the antithesis into a synthesis. To remain ignorant of past theorizing may waste precious scientific resources. In Rowe and Kahn's (1998) earlier-mentioned widely-cited prescription for "successful aging," – that keeping active is what propels individuals into a trajectory of a satisfying old age – the authors seemed unaware of the research tradition three decades earlier questioning the linkage between such activity and a "good old age," or of evidence supporting the competing theory, disengagement, as one of several "styles" of aging, nor did they benefit from insights of political economy theorists concerning the social constraints that block some elders from engaging in the activities they prescribed. Talent and energy would better be spent refining and redeveloping, rather than ignoring or rejecting, theoretical perspectives that can help us understand the current social and technological climate of aging.

Third, we will need to foster more interdisciplinary research and theory. The conclusion of the recent decade review of theory development in the biology, psychology, sociology, social policy, and practice of aging is that the most striking theoretical trend since the publication of the previous edition of the *Handbook of Theories of Aging* is the development of interdisciplinary theories of aging: " Despite the difficulties in bridging traditional disciplinary boundaries and despite the challenges of working with different research paradigms, there have been significant breakthroughs in explanations of aging that take approaches from several disciplinary perspectives and blend them together into a unified theory" (Bengtson et al. 2009:6). Unfortunately, too much current theorizing in the sociology of aging is still insular, with sociologists reluctant to venture beyond their comfort zone. Disciplinary boundaries have increasingly become barriers to aging and life course theorizing. This is ironic, since from its earliest beginnings both gerontologists and life course scholars drew not only on sociological concepts but also on anthropological constructs of age grading, psychological perspectives on developmental stages, and biological theories of epigenetic development throughout the life cycle. Aging and life course scholars are well positioned to cross over disciplinary boundaries and profit from the proliferating knowledge about aging mechanisms from other disciplines.

Fourth, as theorizing in the sociology of aging progresses, we should take care that the predominance of the life course perspective does not obscure our vision, preventing us seeing the value of different perspectives – for example, continuing research on the social institutions that create opportunities and constraints for people's lives. These social institutions need to be understood in terms of their own dynamics, and trying to squeeze theorizing into the life course perspective might actually limit our vision (Marshall 1995).

Fifth, we should continue awareness of diversity in social aspects of aging. Early contributions toward this goal were to highlight diversity on the basis of age, cohort, and generation, which in turn emphasized the diversity of history and of place, and then to recognize diversity across age strata. Feminist theorists prodded researchers to take not only gender differences but also gender relations seriously, and this mission has expanded to a recognition that we need to simultaneously consider class, age, gender, race and ethnicity, place, and other social factors as they shape individual life courses (McMullin 1995; 2000).

Finally, we should keep ourselves and our students conscious of the fact that there *has* been important theory development in the relatively few years since the beginning of the sociology of aging; moreover, the pace of theory development has increased in the past decade. Sociological perspectives and theories of aging – many of them insightful, many of them generative, and a few of them not – have considerably helped our understanding of social processes related to age and aging at a time when aging societies across the world are in great need of such knowledge. We need more efforts directed at understanding the how and the why underlying social aspects of aging.

In this chapter, we have noted some promising first steps in developing theory concerning a number of emerging issues: the accumulation of advantage and disadvantage; theorizing the life course in terms of risk and chance events; the social psychological balancing act between social constraints and individual initiative; globalization; generational and family negotiations with aging

and the succession of cohorts. This is a rich agenda for future research; but the collection of information – data – about these important issues will not add much to our deeper knowledge unless we pay attention to the development of *theory* about social processes and the course of life to help us understand the data we accumulate.

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Chapter 3
Aging Individuals, Families, and Societies: Micro–Meso–Macro Linkages in the Life Course

Merril Silverstein and Roseann Giarrusso

As a conceptual lens with which to view and understand changes over the human life span, the life course perspective has achieved a dominant, some might say near hegemonic, status in social gerontology over the last several decades. It is difficult to overstate the importance of life course concepts to the sociology of aging and the science of human development. In simple terms, the life course framework considers the process of human growth and senescence within historical context, producing unique life experiences and trajectories for different birth cohorts (Elder 1994; Riley and Riley 1994). For its sweeping scope and focus on biographical and historical dynamics, the life course perspective is a powerful tool in the social scientific investigation of aging, but it is not without conceptual and empirical challenges.

The purpose of this chapter is to bring institutional contexts more fully into the purview of the life course framework by developing a dynamic *biographical–institutional–societal* model of the life course that hierarchically links micro, meso, and macro levels of analyses. In our conceptualization, these three temporal metrics simultaneously and interdependently exert a dynamic force on aging individuals. By presenting an empirical example of this model, we hope to increase the likelihood that researchers will consider human development as guided simultaneously by individual, institutional, and societal forces.

We begin the chapter with an overview of the life course perspective in its twin guises as the interplay of individual development with changing historical conditions and institutional structures. Next, we present a model with three levels of analysis that formally incorporates social institutions as pivotal links between individual development and historical conditions. Finally, we discuss a unique methodological design that allows us to test the three-level model by treating the *aging family* as a set of micro-level experiences, a meso-level social institution, and a macro-level societal construct, each fully dynamic with respect to its respective time metric.

Dynamic and Structured Aspects of the Life Course

Underlying the life course perspective is the notion that individuals advance through time in two ways: (1) ontologically through chronological aging and the structured dynamics of development and decline and (2) historically by passing through epochal periods that shape value orientations and give rise to unique opportunities and constraints. When aging and historical time meet in particular configurations – that is, when particular historical periods are experienced

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at key junctions in life – individuals may bear the indelible imprint of the conditions of those periods in their dispositions and value orientations as well as in their stock of social, health, and economic resources. A fundamental principle of the life course perspective is that exposure of birth cohorts to unique events and social conditions variously constrains or expands opportunities that structure life circumstances and pathways. Ryder's (1965) treatise on inter-cohort change as the engine of societal transformation formalized in earlier discussions by Mannheim (1952) about how "fresh contact" with the world by newly minted cohorts brought about social change through questioning the implicit arrangements and taken-for-granted conventions forged by their predecessors.

Treatment of the role of history in shaping human lives has several traditions in life course scholarship that we divide into three general approaches: those focusing on *great-events*, *cultural Zeitgeists,* and *institutional change*. We discuss each approach in turn below.

Great Events

The life course perspective has gathered some of its most compelling support through evidence showing how human lives are abruptly influenced by great events such as wars and economic depressions. Consideration of cataclysmic historical events of World War II, the Great Depression, and the farm crisis of the 1980s has shed light on how life choices and life chances are structured by far-reaching events (Elder and Conger 2002; Clausen 1993; Conger and Elder 1994). Elder's epic research into the children of the Great Depression (Elder 1974) is a transformative piece in life course scholarship for demonstrating the ripple effect of an economic catastrophe on the life paths of a whole generation in terms of subsequent timing of marriage, family formation, schooling, and careers. The macro-policy environment has been an object of study as well in life course research, such as in investigations of how military service and the periodicity of benefits affect career development and long-term quality of life among veterans (London and Wilmoth 2006; Settersten 2006).

Political transformations provide the opportunity to conduct natural experiments that test how sudden macro-societal change alters the social institutions that govern the metabolism of human lives. Notable in this regard is the fall of the Berlin Wall in 1989 and the reunification of Germany, a seminal historical event that obliterated the social order of the former East Germany, shifting schedules of educational achievement, career advancement, family formation, and fertility in subpopulations at risk (Diewald et al. 2006). As a result of reunification, retired East Germans also saw increases to their state pensions that in conjunction with a strong sense of family duty resulted in increased economic transfers from older to younger generations (Kohli 2005).

Cultural Zeitgeist

A second stream of life course scholarship that we label the *cultural Zeitgeist* approach most often focuses on the social climate to which birth cohorts are exposed at critical junctions in their lives. For instance, shifting gender norms and lifestyle preferences may be incorporated by individuals differently depending on when in the lifespan those shifts were encountered. Formally, a cohort-based model focuses on how cohort turnover – the process by which new birth cohorts replace older ones – changes attitudes and behaviors in the population. Key to this logic is that birth cohorts are indelibly shaped in their world views by the historical conditions into which they emerge as newly

formed adults. Such a mechanism is suggested in the *impressionable youth hypothesis* positing that fundamental values are absorbed from the wider culture during the early adult years (when world views and preferences are beginning to coalesce) and then remain fairly stable over the remainder of the life span (Alwin et al. 1991). The concept of cohort turnover has become a staple in the study of how social change results from cohort differentiation, and has been related to such diverse outcomes as socio-political orientations (Alwin and Krosnick 1991), gender role attitudes (Brooks and Bolzendahl 2004), crime rates (O'Brien et al. 1999), and perceived age discrimination (Gee et al. 2007).

Another application of the *Zeitgeist* approach traces evolutionary change in society and its influence on the entire population (a "period" effect). In this version, the force of history and aging may be seen as simultaneously and independently influencing individuals as they age across the lifespan. One multi-generational longitudinal study of competing values of individualism and collectivism from the 1970s through the 1990s found that both values strengthened over time. Collectivism strengthened due to chronological aging (family and social ties gaining salience in middle and old age) and individualism strengthened due to advancing historical time (presumably a post-1970s shift in the socio-political climate toward favoring self-interest over altruism) (Roberts and Bengtson 1999). What is clear from the overall evidence is that several time clocks operating at personal and historical levels of analysis guide the pace and junctions of human development.

Institutional Change

An *institutional* approach to the life course stresses how the major institutions of society – social organizations such as the workplace, the educational system, and the family – guide orderly transitions in role and status positions across the lifespan by fostering collective expectations for an orderly life path, and by providing incentives and disincentives for particular actions. When institutional arrangements change or their rules are in flux, new social conventions may emerge as older ones are discarded. For instance, institutional age markers for appropriate role transitions in families are malleable based on the changing normative basis of family life guiding if and when to marry and have children (Bengtson and Allen 1993). Much contemporary commentary has focused on the *deinstitutionalization* of the life course, by which it is generally meant that the coercive power of social institutions to standardize life transitions by age has ebbed, in favor of greater individual discretion and flexibility in the timing of important life transition decisions of marriage, fertility, schooling, work, and retirement (Settersten 2003).

Age constraints on role transitions have weakened leading to a variegated set of lifestyle options available to individuals (Bruckner and Mayer 2005; MacMillan and Copher 2005). A study of family and non-family role configurations in two cohorts of British young adults separated by 12 years found a distinct move away from traditional social arrangements, related to marriage and children, to a diversified set of arrangements that were more focused on career and less on family (Ross et al. 2009). Some social theorists suggest that de-standardization of the life course is the result of economic turbulence and globalization which rendered the normal life course and its institutionalized pathways less certain. In late modern society, labor markets are increasingly fluid and contingent, while individuals have greater freedom but also less certainty (Phillipson 2003). Because of greater difficulty in building a work career with continuity and security, family life and human capital acquisition are also less certain. The timing of individual life course transitions has been affected, as reflected in the increasingly later ages of marriage and childbearing, delayed completion of education, and later ages of retirement (Heinz 2003). That the de-evolution of a single dominant cultural script is predicated on interdependent structural social changes – such as increased

economic inequality, entry of women into the labor force, diversity in family structure – lies at the heart of the idea that life courses are institutionally embedded and multi-level in form.

While institutional approaches include cohort-turnover and historical change in their formulations, they tend to focus on social institutions as mediating bridges between macro-historical conditions and individual outcomes, providing explicit middle-range explanations for *how* social change occurs. Institutional approaches are also consistent with ecological orientations toward the life course that conceptualize human lives as hierarchically embedded within families, communities, political regimes, and, the most distal of all, global systems (Bronfenbrenner 1995; Dannefer 2003).

The life course perspective has roots in the institutionally focused conceptual framework developed by Riley and Riley (1994) known as the age and society paradigm. Their model specifies that lifespan development could be understood as the process by which human lives are shaped by the social institutions – family, education, work, and leisure – through which they passed on their developmental journey (Riley et al. 1972). This approach provided a sharp analytic lens to describe how key life transitions are organized by the expectations and opportunities structured into the institutions of society at the particular historical time they are encountered. A key tenet of this perspective is that social institutions, while not static, change at a considerably slower pace than emergent needs and preferences rising out of cohort replacement. In other words, lifestyles transform faster than the institutions meant to accommodate them, a phenomenon known as structural lag (Riley et al. 1994). Such different rates of change between cohort flows and institutional transformation may lead to dilemmas such as workplace polices incapable of accommodating older workers who prefer to remain in the labor force, and family support systems unable to serve elders in divorced and remarried families.

A Dynamic Biographical–Institutional–Societal Model of the Life Course

Using the life course perspective as a sensitizing concept, we propose a *biographical–institutional–societal* model of life span development that hierarchically links three levels of analysis: micro, meso, and macro. Our model resembles Bronfenbrenner's ecological theory (1995) positing that human development unfolds within multiple social spaces and embedded contextual systems that spiral outward from micro to macro-realms. In our conceptualization, three temporal metrics simultaneously and interdependently exert dynamic force on aging individuals through time (see Fig. 3.1).

At the micro-biographical level, we note that physical, mental, social, and financial forms of well-being evolve over biographical time as individuals grow up and grow old through the life-span. At the meso-institutional level, family, education, work, and leisure institutions guide expectations and provide incentive (and disincentive) structures for making (or delaying) life transitions and taking (or not taking) certain pathways. Finally at the macro-societal level, the wider social environment exerts influence over the population by virtue of society-wide norms, economic conditions, public policies, and demographic structures (cataclysmic events such as depressions and wars fit into this category). Three important contributions of the model are that (1) social institutions are considered to be dynamic, evolving with individuals and societies through time and most likely at different rates, (2) each of the three levels is considered mutually interdependent with the other two (for example, changes at the micro-biographical level when aggregated can produce institutional and societal change), and (3) substantive areas within each level interact to produce unique outcomes (for example, at the meso-institutional level, incompatibility between work and family institutions may result in individual manifestations of stress).

As with many conceptual schemes with a multiplicity of inputs, the three-level model presented in Fig. 3.1 requires quite elaborate data to empirically articulate. Few, if any, studies are

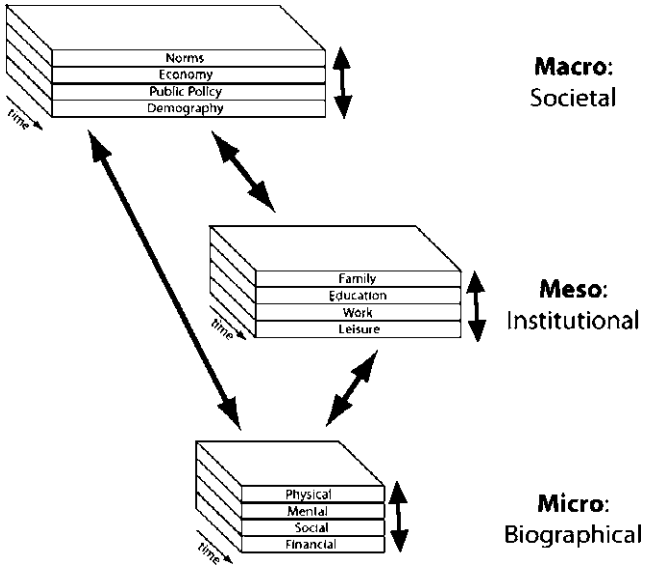

Fig. 3.1 Dynamic biographical–institutional–societal model of the life course

capable of providing a test of such a model; most studies only examine two levels of the model. Therefore, before describing a unique research design and data set capable of investigating this three-level model, we briefly review an example of recent empirical work that assesses one of the two levels of the model: macro–micro, macro–meso, and meso–micro.

Multi-Level Life Course Approaches

Macro-Level Effects

The widest distance across levels is that between national state policies and the manner in which intimate social relationships are maintained. The case has been made that cultural styles of interaction, national in character, map onto the social welfare gradient (Turner 1988). Using a more structural orientation, Mayer (2009) writes that "progress may be achieved by…moving away from developmental origins towards a specific understanding of life courses as institutionally embedded purposive action," which, he adds in the European tradition, has focused on how welfare state policies have shaped the organization of social life.

At the macro-level the demands placed on families are structured by the generosity of welfare state provisions variably releasing or obligating filial duties of adult children toward older parents and affecting the emotional tenor of their relationships. Micro-interactions in the family may be shaped by the political economies and cultures within which those interactions are embedded, specifically the way in which welfare production is allocated among state, market, and family. A commonly used gradient of nation-states puts *social democratic* nations at one end of the spectrum (citizens are incorporated under a single universal benefits system) and *residualist* nations at the other end (benefits provided by the state only when personal resources are exhausted), with the middle ground occupied by *liberal-market* nations (benefits are means-tested and modest social insurance plans exist) (Esping-Anderson 1999). Welfare production influences helping behavior,

interaction, and coresidence between adult generations with generally weaker filial behavior in the social democratic states of northern Europe than in the residualist states of southern Europe (e.g., Brandt et al. 2009; Broese van Groenou et al. 2006; Hank 2007).

Policy changes within a welfare regime may motivate behavioral change at the micro-level. For instance, a study in Sweden found that an increase in the proportion of elders supported by family members followed the restriction of eligibility rules for home-help services (Sundstrom et al. 2002). In another example – but from a less-developed country – Yi (1996) found that fertility rates declined in an area of rural China where an experimental pension program was initiated, concluding that pension availability weakened the belief that having children was necessary to ensure old age security.

In a study of the influence of national membership on intimacy in close personal relationships (arguably representing the largest gap between macro- and micro-environments), Silverstein et al. (2010) examined how state structures influence the emotional quality of older parent–child relations in England, Germany, Israel, Norway, Spain, and the United States. The authors found four relational styles across the six nations: (1) *detached* – low affection and low conflict, (2) *amicable* – high affection and low conflict as, (3) *disharmonious* – low affection and high conflict, and (4) *ambivalent* – high affection and high conflict. Further, the styles were distributed differently across the six nations studied. What macro-level characteristics might explain these national differences? Relationships measured in the United States were more than twice as likely as those in the other national samples to be characterized as *disharmonious* and *detached* – the two relational styles with higher levels of conflict. Compared to its national counterparts, the United States embraces a stronger individualistic ideology with respect to kinship ties and a relatively weak public sector that may serve to obligate children to a degree not seen in the other countries (Hollinger and Haller 1990). The fact that relationships in Israel were more likely than average-to-be *ambivalent* reflects a culture that emphasizes interpersonal engagement and legitimates mild forms of conflict in intimate relationships. The greater prevalence of emotional *detachment* among parent–child relationships in Germany possibly reflects an intergenerational schism rooted in the association of older parents with the National Socialist regime, a hypothesis suggested by Szydlik (1996). The finding that intergenerational relationships in England are more likely than those in other nations to be emotionally close and free of conflict could result from a cultural tendency to inhibit the expression of strong negative emotion (Peabody 1985).

Meso-Level Effects

The family represents an institution that has been in flux over the last several decades with profound implications for how individuals live their daily lives and the resources that are available to them. A large amount of attention has been devoted to tracing the micro-level consequences of divorce and remarriage, and non-marital childbearing, forcing a reconsideration of how families and kinship relations are to be defined. No longer is there a single culturally dominant family pattern, but rather a multiplicity of family and household arrangements whose forms are fluid. Indeed, the very definition of "family" has become ambiguous (Stacey 1991). Schmeeckle et al. (2006), for instance, found substantial cohort variation in the extent to which adult children perceived their parents, stepparents, and former step-parents as full family members. These findings have implications for the caregiving of aging stepparents by adult stepchildren in cohorts where family structures have increasingly diversified and become more complex.

As we discussed earlier, institutional domains are rarely independent and it is often unrealistic to partition an institution as if it were isolated from the others in society. The institutions of family and work, for instance, mutually interact but also compete with each other for the time and energy of

their constituent members. Within a multi-level perspective the protections and benefits afforded workers (e.g., equal opportunity laws, family-leave policies), and macro-economic conditions can be seen to influence interfaces between the institutions of work and family life.

One of the greatest social changes of the last half-century has been the increase of women and mothers in the paid labor force (Sayer et al. 2005). While this trend is undeniably favorable for women and the financial well-being of families, it also means that there are fewer family members available for care of family dependents such as the very young and the very old. Changes to the economy – particularly stagnation in real wages since the 1970s and relative growth of the service economy – have increased economic uncertainty in many families, consequently increasing the amount of time devoted to labor market activities. These changes have made it increasingly more difficult for families to simultaneously meet the demands of work and the obligations of family life (Moen 2003).

Empirical Test of a Biographical–Institutional–Societal Model of the Life Course

Our multi-level approach to human development presented in Fig. 3.1 takes its cue from versions of the life course that speak to historical events and epochs, as well as social institutions in structuring individual outcomes. In this section, we use intergenerational family relations as our social realm of interest and present an empirical example to explore the linkage between meso- and macro-realms on emotional cohesion between older parents and their adult children. We examine long-term change in the strength of emotional cohesion between generations as a function of changing family structures at the institutional level, and weakening strength of filial obligation at the societal level.

We rely on the dialectic between individual and contextual characteristics to examine how intergenerational relationships are shaped by the historical epochs within which they are embedded. In our empirical example we focus on two fundamental changes in families over the last few decades: (1) change at the meso-level in family structure as a result of increases in divorce, remarriage, and step-family formation and (2) change at the macro-level in norms of filial responsibility that reflect a societal drift from values of collectivism to those of individualism. We review these trends briefly below.

Change in Family Structures (Meso-Level)

Increases in marital disruption and remarriage since the 1970s have introduced uncertainties about the quality of intergenerational relations and have cast doubt on whether adult children will continue to serve as resources to their aging parents. The structure of the family within which a child is raised defines a host of social, economic, and psychological factors that set a standard for how intergenerational relations are maintained through the life span. Non-traditional family structures may adversely affect the quality of intergenerational relationships by engendering interpersonal strains with divorced parents and step parents (Amato 1994; Cherlin 1978) that may put children at risk of having distant relations with them into adulthood (Aquilino 1994; Furstenberg and Cherlin 1991). Evidence is accumulating that the legacy of divorce and remarriage extends to later life, suppressing the economic and instrumental support exchanged between adult children and their divorced parents, stepparents, and remarried biological parents (Aquilino 2005; Ganong and Coleman 1999; Pezzin and Schone 1999). Yet cross-generational studies capable of examining the historical effects of the divorce-revolution are rare, as almost all studies to date have relied on inferences about divorce and remarriage that have occurred in a single generation.

Weakening Norms of Filial Responsibility (Macro-Level)

Filial responsibility as a social norm reflects the generalized expectation that family members should be central in each other's lives and perform particular functions with respect to each other. Much has been written about the declining importance of the family in American society over recent decades. Social scientists, historians, and cultural critics have noted that values of collectivism – including those of familism – have been overtaken by values of individualism (Bellah et al. 1985; Popenoe 1993; Putnam 1995). Gans and Silverstein (2006), for instance, found that the strength of parent-care norms weakened between the 1980s and 1990s, a trend that is not disconnected from marital instability. Some research suggests that children of divorcees feel less filial obligation to their aging parents than those who have not experienced a marital disruption (Ganong and Coleman 1999).

The Generational–Sequential Design

The superficial simplicity of the model in Fig. 3.1 belies the complexity of its underlying assumption that individuals may age differently depending on *the historical time and personal age when the institutions are experienced.* Timing of exposure to history is a key feature of our rendering of the life course paradigm, but cross-generational comparisons are difficult because generations pass asynchronously through historical time such that earlier and later generations experience the same historical periods at different life stages, or age through the same life stages in different historical periods. To remedy this difficulty, we advance a *generational–sequential design* that examines parents and their adult children at the same chronological age but in different historical periods, essentially standardizing age of exposure to different macro-institutional conditions. An example of this design is presented in Fig. 3.2 where parents and their adult children are represented as arrows being

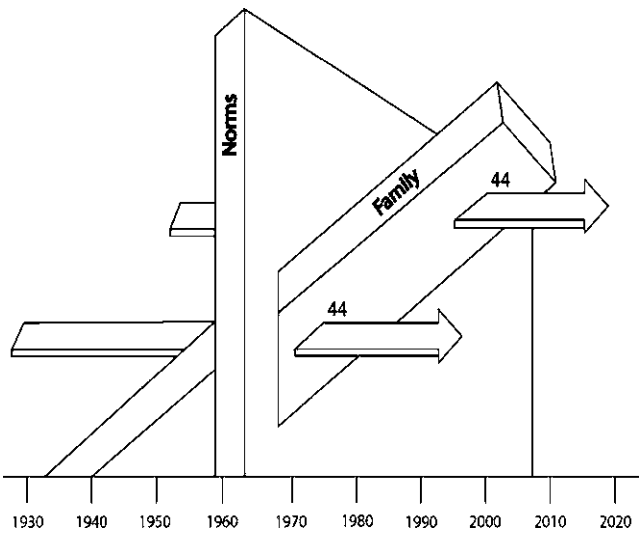

Fig. 3.2 Generation-sequential design: examines parents and adult children at the same chronological age (44 years) but in different historical periods (1970 vs. 1997)

exposed to different macro-institutional conditions (the intersection of changing norms of filial responsibility and changing family structures) at the same chronological age (44 years) but in different historical periods (1970 and 1997, respectively).

Data Set

To examine cross-cohort variation in intergenerational relations we use data from the Longitudinal Study of Generations (LSOG) (see Bengtson 1975). The LSOG began in 1971 with a survey of 2044 respondents from 328 three-generation families living in southern California and including grandparents (G1s), parents (G2), and adult children (G3). Beginning in 1985, follow-up surveys were administered every 3–5 years until 2005.

The LSOG is unique in that it follows individuals over biographical time, includes family members in linked generations, and follows them over a period of history when many of the social changes affecting families occurred. Combining these special design features leads to an important feature of the LSOG: the capacity to compare human development of adjacent generations within the same family lineages and at the same ages but under different socio-historical conditions. With data collected over three decades we provide an empirical example that examines age-standardized historical differences between generations in the strength of emotional cohesion with aging parents, as well as potential explanations for observed differences based on several social trends over the period of study.

The LSOG due to its unique multi-generational design and long time horizon allows such cross-generational comparisons. Unlike typical cohort models, the generational–sequential design is capable of accounting for the fact that individuals are intimately tied to members of other cohorts through common family membership. Approaches that use repeated cross-sectional data are highly useful for separating aging and cohort effects in *aggregates* of individuals, but are not fully able to investigate human development as an intra-familial process. A core principle of the life course paradigm is that human lives are interdependent with each other particularly as they are linked by family bonds.

Methodological Considerations

There are not insignificant practical difficulties when life course propositions are tested empirically. Attributing individual phenomena to the character of historical periods is a well-known challenge in contextual analyses given the myriad number of ways that contexts differ from one another and the often large amount of heterogeneity within them; data demands may be quite substantial.

In approaching our topic, we rely on the principle of *methodological individualism* – the idea that contexts may be represented by the aggregation of their constituent elements (Weber 1968). Extending (or reversing) this logic, we argue that if the size of contextual variation or change in a social phenomenon is reduced after statistically controlling for individual characteristics, then those characteristics hold the promise of being explanatory factors or causal agents at the contextual level (even though they are measured at the unit level). This logic is implicit in Schooler's (1996) argument that the influence of national context on a seemingly individualized psychological process is identifiable if variables representing alternative theoretical explanations are controlled *at the individual level*. Such an approach also can be used to make cross-cohort comparisons where historical location can be considered a context.

Our empirical model includes 554 G2 parents and their G3 children measured between 1971 and 1997 when the large majority of children reached the age their parents were at baseline. The mean age of generational convergence is 44 years. The outcome variable of interest is emotional closeness with mothers and fathers. To test for historical effects, we match each generational pair so they are aligned at a common age. In this approach, "generation" becomes a dummy variable to assess G3–G2 differences in the strength of intergenerational ties when the generations are approximately at the same life stage: a negative value indicates weaker intergenerational cohesion of G3 children compared to their G2 parents. Estimates are generated using Hierarchical Linear Models that consider age, historical time, and family membership.

Results

We describe the most important results of our analysis in Fig. 3.3. The first set of bars (for relations with mothers and fathers) shows a statistically significant historical difference, with G3s feeling less close to their parents than G2s felt toward *their* parents several decades earlier. In other words, using age-matched controls we found that intergenerational cohesion has weakened over historical time. We then assessed whether this generational difference was mediated by marital disruption in either of the two generations as a manifestation of institutional change in the family. The second set of bars in Fig. 3.3 shows that with marital disruption controlled there is a discernable and significant reduction in the historical loss of intergenerational cohesion, though the decline is still statistically significant. Next we examine the contribution of weakened norms of familism as an element of societal change in the salience of family life measured as the importance of discussing important life decisions with family members, and degree to which personal life-styles choices should conform to family wishes. The third set of bars shows that when norms of familism are controlled, the historical differences between generations shrinks toward zero and loses their statistical significance. Thus, we attribute historical weakening in the strength of emotional bonds between generations primarily to a secular decline in the centrality of family life. Beyond the particulars of our analysis, we demonstrate the potential of a generational–sequential design to isolate historical effects in micro-level data by using age-standardized differences and then attribute these effects to specific institutional and societal forces to which adjacent generations have differential exposure. In doing so, we also intend to alleviate anxiety over the sometimes daunting complexity and theoretical abstractness of the life course perspective – in terms of representing multiple dynamic and hierarchically embedded systems – by connecting it to the more practical realm of operational definitions, empirical modeling, and statistical method.

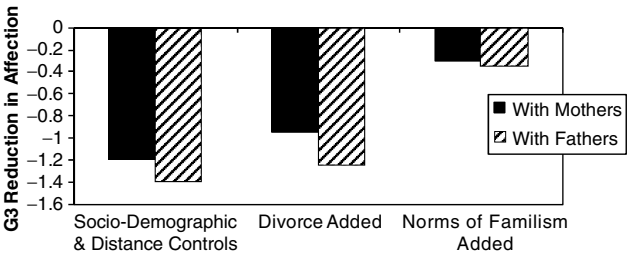

Fig. 3.3 Average G3–G2 difference in affection for parents when generations are age-matched ($M = 44$ years)

Conclusion: The Life Course as a Sensitizing Concept in Multi-Level Studies

In this chapter we considered the life course paradigm in aging research as a system of conditions that includes micro-biographical, meso-institutional, and macro-societal dimensions all moving dynamically through time and subject to change. The study of human development has deep roots in the biographical–historical framework, relying on age-period-cohort models to study the extent to which cohort replacement is responsible for social change and cohort constancy is responsible for social stability. Less considered are the institutional forces that directly influence micro-conditions and that mediate or explain the influence of macro-conditions on human lives. In synthesizing these perspectives – what might be summarized crudely as dynamic and structural perspectives – we developed a fully dynamic model of nested social processes based on the aging of individuals, the reconfiguring of social institutions, and the transformation of societies.

To bridge the division between the theoretical and empirical, we presented an example of research that showed how historically comparative research can gain explanatory leverage by selectively including theoretically relevant variables into predictive models. We employed a generational–sequential model showing that contemporary adult children maintain lower-quality intergenerational relationships when compared to those maintained by *their* parents up to one-quarter century earlier. Mapping marital disruption and norms of familism onto our multi-level model of the life course suggests the importance of institutional-level and societal-level factors as potent historical explanations for the decline in the emotional tone of intergenerational relationships within families.

The term *life course* has been applied in numerous ways to important questions in sociology, social psychology, and gerontology. While many life-course studies employ longitudinal data, a longitudinal design – even if long-term – is not sufficient, but neither is it necessary for research to gain the life course appellation. For the *life course* to have utility as an operational concept – beyond being a general heuristic to describe long-term change – it needs to be distinguished from the many other terms used to describe dynamic systems in the social and behavioral sciences (the most common being life-span development). Here the multi-level distinction may be of use. In our opinion, any formulation of a research question in the life course tradition must at minimum consider how a social context (macro and/or meso) exerts a force on more micro-level outcomes, and at its best treat social contexts as evolving through time.

We also note that the method of data collection is of lesser concern as studies invoking the life course need not be longitudinal. Retrospectively reported data may invoke the life course paradigm when accounting for the influence of divergent social contexts experienced in youth on contemporary adult behaviors (see Axinn and Yabiku 2001 for an excellent example using retrospective reports to examine how dynamic community contexts affect fertility in Nepal; see also Mayer 2007 for an application using retrospective data). A comparison of groups that experienced the same historical conditions but with different types of exposure – such as the disadvantages experienced by aging WW II combat veterans (Elder et al. 1997) – provides purchase on the specific aspects of historical contexts that matter for life trajectories.

In reviewing the literature and looking ahead, we make three general suggestions by which life course research will benefit from considering aging as a multi-level, hierarchical phenomenon and move the "field" of life course studies closer to achieving its promise.

Multi-National Studies

Our impression from reviewing the empirical literature in life course studies is that publications making use of multi-level designs have proliferated, offering insights into how variation in state

(or lower level) structures influence life choices and life chances throughout the life span. Multi-national studies, in particular, are essential for documenting the importance of the macro-level environments for micro-level processes and are to be celebrated. However, as a general rule, the larger and more heterogeneous the contexts of interest, the more difficult it is to make valid causal inferences about their influence on life choices and life chances over the life-span. Contextual level variables such as gross domestic product or public spending on dependent populations are certainly useful in documenting how nations differ on dimensions of theoretical interest, but remain essentially proxies for what remains a complex set of pathways leading from welfare regimes to individual outcomes. In addition, the attribution of causal agency to macro-level characteristics is best avoided. Consider the following counter-factual thought experiment: were the United States to instantly possess a Scandinavian-type welfare system, would outcomes (defined in terms of less inequality, improved life expectancy, and increased women's labor participation) be the same, or of the same magnitude, as that achieved by Sweden, Norway, and Denmark over the second half of the 20th century? Our guess is probably not, given the isomorphism between politics, economics, culture, and historical timing that determine how a national program of this type comes into being and is maintained over time. Nevertheless, increasing diversity in represented contexts and better targeting macro-measures to suit the object of study will better insure that multi-level studies will converge on fundamental truths about how social environments influence individuals – whether those environments are nations, regions, or birth cohorts.

Institutional Change

Consideration of dynamic institutions represents one of the most promising areas in hierarchical representations of life course studies. As we discussed, naturally occurring historical change presents opportunities to explore natural experiments at the population level. Yet few societal level factors fluctuate sufficiently to have demonstrable impacts over time (with the possible exception of the impact of German reunification and more generally the breakup of the Soviet empire) and those that do produce a myriad of changes, the effects of which are difficult to isolate. Specific changes in public policy present opportunities to more precisely link the macro to the meso and then to the micro. For instance, demographic change in the aging of populations may engender policy changes such as reduced and/or delayed retirement benefits (or in the case of less-developed Asian countries the initiation of such benefits) that ultimately alter work and family decisions. Japan's universal long-term care insurance, instituted in part because of dramatic population aging and alarming fertility reductions, may have the unintended consequence of further reducing fertility and shifting the responsibility of caregiving farther away from family members (see Takagi and Silverstein 2006 for a similar discussion with regard to older parent–child coresidence in Japan).

Cross-Generational Correspondence

Finally we note that much of the literature on social change and societal transformation is rooted in the idea that each birth cohort that arrives into adulthood (re)invents its social milieu. Although many studies have shown cohort replacement to be the engine of social change in a given population over time, they tend to ignore the main societal institution that promotes continuity from one generation to another – namely, the multi-generational family. The life course principle of *linked lives* provides a useful metaphor for describing how family members are interdependent with each other, particularly as they are linked across generations by bonds of kinship. The family as the primary

meso-social institution charged with maintaining societal stability serves as the conduit through which values and resources are reproduced in subsequent generations through time. The paradox that continuity is maintained in society even during times of great transformation has yet to be theoretically or empirically integrated into life course scholarship on social change and represents a promising direction for future development.

At its core, the life course perspective is a conceptualization of life span development as guided by the twin axes of biographical and historical time. In this chapter we strived to bring social institutions more fully under the life course umbrella and present an empirical strategy that teases out institutional explanations underlying descriptive differences in life pathways between social aggregates – in our example generations rooted in historical time. We hope that by laying out the issues in this way researchers will be more likely to consider human development as guided by micro-individual, meso-institutional, and macro-societal forces, and, where the data exist, to render as complete a depiction of the embedded life span as possible.

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Chapter 4
Widening the View: Capturing "Unobserved" Heterogeneity in Studies of Age and the Life Course

Jessica A. Kelley-Moore and Jielu Lin

In the first volume of their three-volume work entitled *Aging and Society* (1968), Matilda White Riley and Anne Foner produced the first comprehensive inventory of empirical studies on aging. Demonstrating the growing interest in age and aging processes, the scope of this work spanned many disciplines and included a wide array of topics including adjustment to retirement (Thompson et al. 1960), response to institutional care (Beyer and Woods 1963), and age composition of the labor force (Bancroft 1958). The varied approaches to questions of the nature and process of aging had resulted in a significant body of empirical information but, to date, as Riley and Foner accounted, as yet there was "…no unified body of knowledge, no general theory of aging, that can be transmitted to students, applied in professional practice, or tested and amplified through further research" (Riley and Foner 1968:1).

In the 40 years since, great advances have been made in research on age and the life course, largely due to significant improvement in research designs, particularly the explosion of high-quality longitudinal studies – panel, rotating panel, and repeated cross-sections – that have allowed investigators to separate the effects of age, chronological time, and historical placement of cohorts on a range of observable outcomes. The composition of samples have become more representative of the population, because of concerted efforts to draw more diverse samples of older adults (and oversamples of under-represented groups), and to include multiple birth cohorts in the same study design. Further, administrative data sources (e.g., Social Security records; Medicare claims), geographic indicators (e.g., Census tracts), and vital statistics data have been put to use in myriad new ways to address questions related to the age distribution of society and the social distribution of resources based on age. International collaborations have sought to standardize study designs and measurement, such as the Health and Retirement Survey (HRS), Survey of Health, Ageing, and Retirement in Europe (SHARE), English Longitudinal Study of Aging (ELSA), and the China Health and Retirement Longitudinal Survey (CHARLS), opening a new vista of cross-national research to further understand the social experience of aging.

Over the past several decades, sociologists have been instrumental in shifting the logic of inquiry away from chronological age as *explananda* and toward the socially-constructed meaning and consequences of age and the life course in which lives are embedded. The significance of age as a critically important organizing tool for society, justifying allocation of resources, rights, and responsibilities – has been recognized. At the same time, chronological age itself is a weak predictor of human development and behavior. By identifying elements of social context with increasing precision (e.g., the social distribution of opportunity structures), and then locating individuals and

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groups within that structure based on their age, birth cohort, and stage in the life course, sociologists have systematically reduced the scope of phenomena that can be attributed to organismic aging. The increasing sophistication in study designs and an ever-growing bank of social indicators have allowed researchers to identify processes that may correlate with chronological age, the onset of chronic disease for example, but are not in fact caused by age.

Through this advancement in methodological tools, social research has made a significant contribution toward the "unified body of knowledge and general theory of aging" that Riley and Foner noted was lacking nearly a half a century ago. Indeed, critical inquiry about the socially-constructed meaning of age and the life course – and the decreasing utility of chronological age as an explanatory factor – has begun to pervade other disciplines, including developmental biology (Gluckman and Hanson 2006), economics (Heckman 2006), and health services research (Halfon and Hochstein 2002). Sociologists are in a unique position to document, characterize, and explain the patterns associated with age in a population and continue to make substantial contributions across the many subfields and lines of inquiry.

Across a range of domains and specific outcomes related to human lives, we observe a robust association with chronological age. We observe substantial age patterning in the distribution of social roles, socioeconomic resources, disease risk, and movement into and out of social institutions. This occurs at the individual level, such as age at labor force exit (Warner et al. 2010) and at higher levels of aggregation, such as within-cohort rates of disablement by age (Hoffman 2009). The significant improvement in study designs, measurement, and statistical modeling that have advanced the study of age and the life course in the past few decades means that social scientists have access to information in a wide array of domains that are sensitive enough to decompose causal factors that are sociogenic or organismic in origin. Yet, this focus on normative, or "average," trends in age-associated phenomena should be coupled with empirical attention to patterns of *variability* that may also be associated with chronological age.

Sociologists have for some time now emphasized the importance of characterizing and acknowledging variability in the aging experience (Maddox 1987; Riley 1983), exemplified in discussions of heterogeneity (Nelson and Dannefer 1992), diversity (Bass et al. 1990), differential gerontology (Dannefer 1988) or inter-individual differences in intra-individual change (Baltes and Nesselroade 1979). It is important to note that these discussions cut across different levels of aggregation, making it critically important in empirical studies to specify which type of variability pattern one is testing and at what level (individual, cohort, etc.). At the individual-level, for example, one may examine an average rate of change in a phenomenon with age, but such an analysis could be enhanced by further asking: do the between-person differences in within-person variability diminish or increase with advancing age? At the level of a birth cohort, age-based patterns of variability can include increasing differentiation with age (e.g., health or income), decreasing differentiation with age (e.g., cognitive functioning due to selective mortality), and constant variability with age (e.g., personality).

In this chapter, we refer to "unobserved" heterogeneity as the systematic patterns of variability in observational studies that has been largely under-recognized or under-specified in social science, and our special concern is with unobserved heterogeneity within cohorts or age categories. At least in the context of age, this neglect has been largely due to limitations in (1) standard statistical practices, (2) current prospective study designs, and (3) single-methodological approaches. This is not to say that we should focus on age-based heterogeneity to the exclusion of "average" trends in aging. Rather, a rigorous accounting of phenomena that is arrayed across the life span must necessarily examine the "main effect" of age, as well as potential age-based patterns in variability. The precise characterization of patterns of age-based heterogeneity, within or between individuals or cohorts, opens the range of explanatory frameworks for phenomena arrayed and organized over the life course to the "sociological imagination" ranging from the social context in utero to continued development and growth in adulthood (Dannefer 2011).

Drawing our focus to age-based variability in empirical research will allow for finer identification of social and individual characteristics or patterns that may influence well being over the entire life course. Refocusing social inquiry to include sociogenic origins of age-based heterogeneity can yield significant benefits for the field of aging. First, characterizing and understanding how social context may lead to differential outcomes for individuals within and across cohorts over the life course reduces the phenomena that may be mistakenly attributed to organismically-based age-related change or other individual-level factors (e.g., genetics; Freese 2008). Second, systematic attention in empirical studies to variability in life paths reduces the tendency to over-emphasize "normal" aging explanations. For the remainder of the chapter, we explain how three current streams of methodological inquiry (standard statistical practice, current prospective study designs, single methodological approaches) have limited our ability to examine age-based patterns of variability, then we present potential solutions to these limitations and note exemplary research that has already "widened the view" of social inquiry to include unobserved heterogeneity.

Unobserved Heterogeneity Due to Standard Statistical Practice

With the recent explosion of high-quality longitudinal data sources that follow both individuals and cohorts over time, social scientists now have significant potential to identify and characterize patterns of variability that we observe as a population ages. Despite the availability of both the data and statistical tools for documenting patterns of age-based heterogeneity, standard statistical practice continues to rely heavily on measures of central tendency to the neglect of the distribution around these estimates. In the current statistical paradigm, indicators of range (e.g., confidence intervals) have been used solely to document statistical significance, rather than precision of the estimate (Cohen 1994; Ziliak and McCloskey 2008). Interpretations of the findings in observational studies that tend to focus exclusively on the central tendency neglect the opportunity to integrate these indicators of variability into the causal interpretations regarding the phenomenon under study.

Although this exclusion of range and variability is a general problem when interpreting statistics in scientific inquiry across disciplines, it is particularly consequential for sociology of age and the life course. The degree of heterogeneity in the population, particularly patterns that may be associated with age, has received scant attention in empirical studies rather emphasizing comparison of "average" levels across age groups, estimation of a global age-based trajectory without accounting for birth cohort, or estimation of average rate of change over time. If there is a high degree of variability in the population, one risks a weak characterization of that particular phenomenon when using a central tendency estimate or age-based trajectory. Further, emphasis on the "average" in observational studies (without acknowledging variability) implies the existence of a "normal" aging pathway that may be driven by physiologic or organismic processes. Characterizing the extent of variability in a population in conjunction with measures of central tendency opens the opportunity to examine social processes arrayed over the life course that may lead to both the global pattern observed with age and age-based patterns of variability.

Although sociologists are generally cautious about attributing observed individual or collective patterns of change solely to organismic aging processes, there is a tendency to relax this caution where the subject matter has an inherently organismic dimension such as age-related physiological decline (e.g., frailty; Hoffman 2009). Standard statistical practices that focus on increasingly more precise central tendency estimates – and neglect age-associated patterns of variability – falsely imply that there is, indeed, a normative "aging" effect. In recent years, significant advancement in statistical modeling, specifically mixed models, multi-level models, and growth curves, have allowed investigators to estimate unexplained variance in observational studies. Yet these robust

patterns of variability around the average trajectory, many of which have some age patterning, continue to be relegated statistically and conceptually to *deviations* from supposed the global estimated trajectory by age.

Recently, sociologists have begun to address questions of heterogeneity and to make creative use of the statistical modeling techniques available to do so. Indeed, there is a growing practice to estimate age-based trajectories by social subgroup using either a group-based trajectory modeling technique (Sampson and Laub 2003) or stratified modeling (Kim and Durden 2007; Willson 2003). There are statistical techniques that explicitly model heteroskedasticity and complex patterns of variation, accounting for differing levels of variance across subgroups (Browne et al. 2002; Goldstein 2005). Some notable work has decomposed the unexplained variance around a global age trajectory by gender, race, and socioeconomic status to help account for the social patterning of variability (Yang and Lee 2009). This work is at the frontier of understanding social patterns of differentiation and variability, but the statistical tools exist to push this line of inquiry further. A largely-presumed but unchecked assumption is that the degree of variability in inter-individual differences and intra-individual change does not vary across social groups such as gender or race. Systematic examination of subgroup differences in age-based heterogeneity could contribute to our understanding of the complex social patterning over the life course that influences individual level and cohort level patterns with age.

Among the numerous types of heterogeneity in the population that are associated with time-based and age-based processes, we illustrate three specific types in this chapter that could be characterized using existing longitudinal studies but have to date been neglected due to standard statistical practice that emphasizes central tendencies or "average" trends. The first source is *intra-individual variability over time*, which refers to the patterns of change (or stability) within a particular individual over time. In panel data with only two observation points, analytic strategies generally center on whether change occurred for the individual and the amount of change. Yet, with an increasing number of observation points, analytic techniques typically *smooth* an individual's trajectory of change, estimating the average rate of change over the period. This estimated trajectory of change for an individual obscures the variability within individuals over time, and this dynamic pattern of change is relegated to individual-level residual error or the disturbance term in statistical modeling.

As an empirical example, Fig. 4.1 illustrates the high degree of variability that may exist in repeated measurements of the CES-D scale in a 12-year period. Drawn from the Health and Retirement Study (HRS), the figure shows the raw scores for a single respondent at each observation point, overlaid with the estimated trajectory over time. Although the trajectory for this individual is

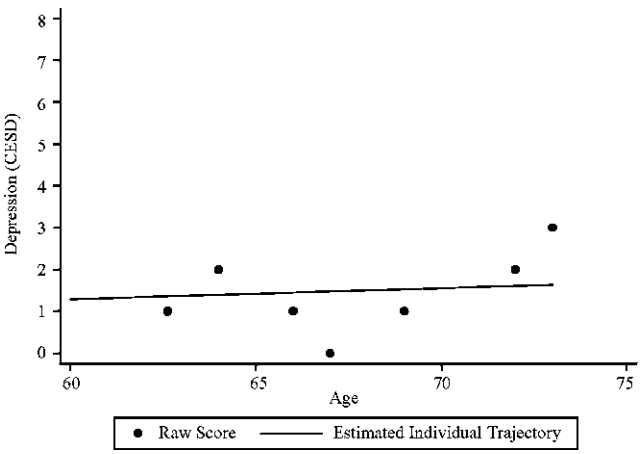

Fig. 4.1 Intra-individual variability over time

nearly flat, it is clear that she/he did, indeed, fluctuate over time in response to the same questions. In standard statistical practice, this intra-individual variability is relegated to the residual error term, and given that total fluctuation was between 0 and 2, this can seem inconsequential. However, when considered in aggregation across many respondents with varying levels of fluctuation over time, it amounts to a significant amount of unaccounted variability in individual life paths. Some portion of the observed within-person variability may reflect measurement error. Yet, if there is, indeed, an age-based pattern to the intra-individual variability, such as greater within-person variability at older ages relative to younger ages, systematic attention to the individual-level error term could yield important information about age-related processes.

Intra-individual variability over time is an area of inquiry that has long been considered (see Baltes and Nesselroade 1979 for a discussion) but with the improvement of panel designs, namely expansion of observational windows and increase in number of observation points, it is worthy to reemphasize the importance of analyzing within-person variability. Understanding what may fluctuate, remain steady, or decline for individuals over a period of time – and if there are associated age patterns – could provide a richer understanding of well being over the entire life course. As Hooker (1991) has demonstrated, there is significant theoretical and empirical value in understanding variability within a single individual over time. A number of statistical models have been refined for the exact purpose of characterizing variability in individual life paths (Halaby 2003; Macmillan and Eliason 2003).

The second source of heterogeneity is *age-based patterns of intra-cohort variability*, which are patterns of heterogeneity over the collective life course of a single birth cohort that are correlated with chronological age. There are a number of age-based patterns of heterogeneity depending on what phenomenon is under study. This could include increasing heterogeneity or other systematic fluctuations in variability over the collective life course of a cohort (Dannefer and Sell 1988). For example, social opportunity structures may cause a cohort to increase in heterogeneity with age (e.g., income and wealth in Wolff 2002) or selective mortality may cause the heterogeneity among survivors to decrease (e.g., chronic conditions in Dupre 2007). Further, age-graded policy interventions may restrict or otherwise alter patterns of heterogeneity as well (e.g., Medicare age eligibility). This is especially important because presumptions that such age-based patterns do not exist, or failing to characterize them, risks the over-reliance on normative aging as the primary explanatory framework.

To illustrate an age-based pattern in variability, Fig. 4.2 shows an estimated age-based trajectory of physical function for adults ages 65 and older, adjusting for selection bias due to mortality. Data for this figure were drawn from four waves of the North Carolina *Established Populations of*

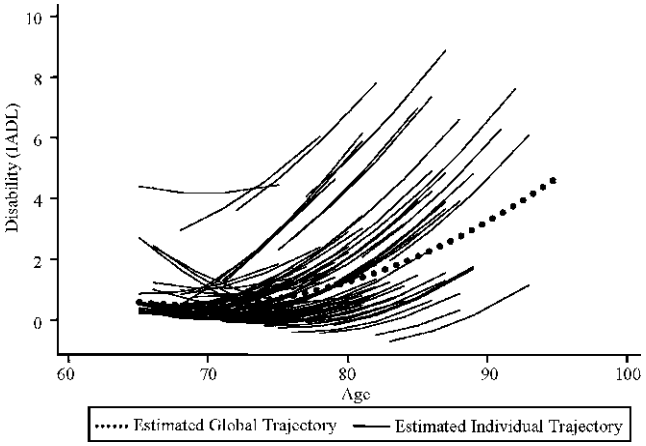

Fig. 4.2 Age-based pattern of intra-cohort variability

Epidemiologic Study of the Elderly, a community-based sample of more than 4,000 black and white older adults. For illustrative purposes, arrayed around the global age-based trajectory of IADL disability is a random sample of individual trajectories. In this example, the estimated variance of total residuals increases over time, as evident by individuals becoming more heterogeneous at upper ages. In very old age, the mean estimation poorly characterizes the "average" or "typical" individual's physical function. This example demonstrates the danger of relying on a global or average age effect because of its decreasing utility for characterizing physical function. On the contrary, it imposes a "created" trajectory associated with age and largely neglects the existing heterogeneity caused by other social processes, thereby reifying age as an ontogentic process.

In sum, assuming homoskedastistic variance around age-based trajectories (constant variance across age) results in significant loss in both empirical and theoretical contributions to our understanding of aging processes, particularly associated with age-based patterns of intra-cohort differentiation. Much of this empirical neglect of variability in growth curve or trajectory models may stem from the early application of this technique, which focused on early-life phenomena such as verbal acquisition, where a developmental or "age" effect is presumed. It is tenuous to presume commensurate "normative aging" effects for outcomes in later points in the life span, such as disability, income, and depression.

The third source is *inter-cohort differences in patterns of intra-cohort variability*. As Dannefer and Kelley-Moore (2009) noted, a rarely-addressed question in research on age and the life course is the extent to which patterns of change or stability with age that are observed in one birth cohort can be generalized across cohorts. The historical placement of a birth cohort, which represents a specific set of social influences on opportunity structures over the life course, may produce an age-based pattern of heterogeneity unique only to that cohort or to a narrow band of adjacent ones. For example, did the unprecedented governmental assistance in education and home-buying for World War II veterans *narrow* or *delay* age-based patterns of heterogeneity of health or wealth among Baby Boomers, relative to subsequent or previous birth cohorts?

Considerable conceptual attention has been paid to the problem of inter-cohort differences in intra-cohort variability (Alwin et al. 2008; Riley 1973; Riley et al. 1972) but, until recently, it has not been matched with empirical attention, largely due to the lack of panel studies designed sufficiently to examine potential inter-cohort differences in age-based patterns of intra-cohort variability. Such an examination requires data that measures (1) *distinct* cohorts, (2) on *multiple* occasions (3), at the *same* ages. It is the only way to determine whether there is systematic change in variability with age and whether the patterns of that systematic change differ by cohort. These data requirements are extensive and to date, there have been few available sources for study. There are now several high-quality panel studies with which this can be accomplished.

The HRS is perhaps the most recognized choice for research questions about inter-cohort differences in intra-cohort patterns of variability. The HRS is the largest on-going longitudinal study of older persons' health and labor force activity in the United States (HRS 2008). With its transition in 1998 to a steady-state cohort design, there is sufficient data to study inter-cohort differences in age-based patterns of change for persons in their 50s and 60s from at least three different cohorts with at least five (for the Early Baby Boom cohort) and up to ten (for the original HRS cohort) measurement occasions. The potential for studying inter-cohort differences with the HRS continues to increase with biennial interviews. Moreover, the steady-state panel design means that new birth cohorts are added to the panel every 6 years, with Early Baby Boomers (b. 1948–1953) sampled in 2004 and the Mid Baby Boomers (b. 1954–1959) sampled in 2010 (HRS 2008).

A second data source, much less utilized by sociologists studying aging but that meets the standards for inter-cohort comparisons of intra-cohort variability, is the *National Longitudinal Surveys of Youth* (NLSY 2009). The original NLSY cohort came under observation in 1979 and has followed the experiences of the Late Baby Boomers (b. 1957–1964; ages 14–22 in 1979). A new NLSY cohort of persons born between 1980 and 1984 (roughly corresponding to the Echo Boom Cohort)

came under observation in 1997 when they were in the ages 12–16. Both NLSY cohorts have been observed for more than eleven waves of data collection, which allows for cohort comparison of patterns of change or stability *plus* the potential age-based patterns in variability in emerging adulthood, i.e., persons in their mid-teens to late 20s. As with the HRS, data collection for these NLSY cohorts is continuing and the potential usefulness of these data sources for understanding inter-cohort differences in intra-cohort variability has yet to be fully tapped.

Despite the availability of *data sources* that can be used to make cohort comparisons in age-based patterns of variability, *standard statistical practice* continues to utilize an accelerated longitudinal design, also called a synthetic cohort design. In these models, investigators estimate a global age-based trajectory of a particular phenomenon that *assumes* that there are no differences in these age-based patterns of variability across cohorts, yet Alwin and colleagues have noted that birth cohort itself is a potential source of heterogeneity (Alwin et al. 2006). Consistent with this, many studies now test whether the global age-based trajectory does, indeed vary by birth cohort (Yang 2007). The general conclusion is that if the trajectories (average rate of change for the same age range) are not significantly different, then birth cohort is not consequential. However, few studies press further and examine whether the *patterns of age-based heterogeneity* vary by birth cohort.

Figure 4.3 illustrates the differences in age-based variability across cohorts; specifically, this is the estimated trajectory of number of functional limitations for the birth cohorts HRS and CODA in the HRS for the age range of 65–74. It is important to note that the "average" trajectory is not greatly dissimilar across cohorts, indeed the estimated slope is not significantly different across cohorts. Yet there are notable differences in the age-based patterns of variability, compelling the question about the differential social experiences and opportunities across cohorts that led to these patterns of variability. Our illustration uses adjacent birth cohorts, which may not be that dissimilar given some shared social experiences. However, for one to consider birth cohorts that were further apart, it would be tenuous to presume similar patterns of age-based variability. The cost of such assumptions is a prime example of the neglect of unobserved heterogeneity due to standard statistical practice.

Careful examination of the patterns of variability around global trajectories has a number of implications for the study of stability and change in phenomena with age and over time. First, a dominant assumption, both statistically and conceptually, is that population variation around age-based or time-based trajectories is normally distributed but this is rarely confirmed (Lumley et al. 2002). The presence of a few outlier respondents with extremely high or low values on an outcome can skew the estimate of the "average" level. Indeed, returning to Fig. 4.2, a few respondents had

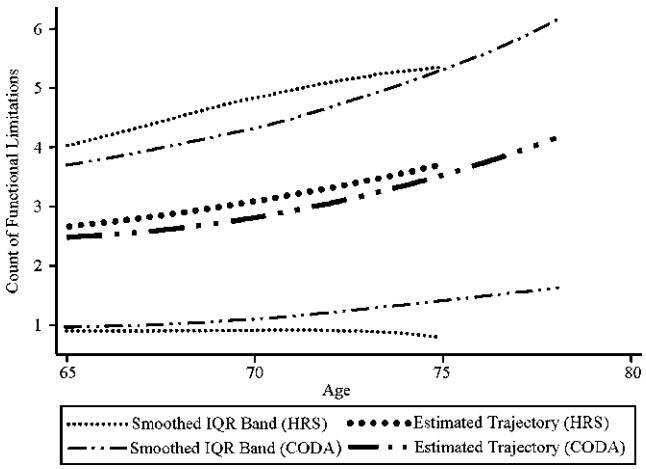

Fig. 4.3 Inter-cohort difference in age-based pattern of intra-cohort variability

extremely high levels of functional limitations, biasing the global estimate upward relative to the actual population. Neglect of the distribution of observations around measures of central tendency can directly affect findings of a range of empirical questions, including comparison of average differences between age groups, average rates of change over time, and average age-based trajectories within a cohort. Researchers risk over- or under-estimating the phenomenon under study when there is no systematic consideration of patterns of variability around the central tendency estimate.

Second, an empirically well-established pattern of an age-based trajectory of a certain characteristic perhaps even now considered axiomatic (e.g., frailty with age) may need revision when the patterns of variability around that trajectory are taken into account. However, in a study reporting the raw data along with the predicted value of verbal ability with age (Alwin and McCammon 2001), the great amount of variability, particularly in old age, suggests that cognitive functioning may actually decrease at a much slower rate than what we have assumed when the focus was on "average" rates of decline with age, which may be biased by a small number of persons with faster-than-average cognitive decline. Documenting variability in what is largely-presumed to be an "age effect" represents an opportunity to think critically about the role of the social environment and life course experiences that lead to differentiation, rather than focusing solely on the organismic aging processes that lead to homogeneity.

The foregoing discussion has been based on the premise that all observed variability in studies is "true" heterogeneity in the population. We want to caution that statistical models can capture the amount of unexplained variance remaining but cannot distinguish between actual heterogeneity in the population and variability due to measurement error (Alwin 2007), study design (Kelley-Moore 2006), or imputation procedures (Allison 2000). For the purpose of our arguments here, this means that a sociologist needs both theoretical frameworks and a solid understanding of the fallibility of data and measurement to aptly consider potential sources of variability in an observational sample. Our major task as social scientists is not to "correct for" or "explain away" the heterogeneity that exists in our studies. Rather, researchers need to consider critically the founding assumptions of the standard statistical practices – which rely heavily on measures of central tendency – and incorporate explicit tests for patterns of variability, whether within individuals over time, within a cohort with age, or across cohorts with age. Continued emphasis on just the "middle" or "average" effects, to the neglect of potential age-based patterns of variability, limits the contribution that social scientists can make in understanding phenomena arrayed over the life course.

Unobserved Heterogeneity Due to Study Design

There is a strong theoretical literature articulating the influence of life course processes on late-life outcomes (Ferraro and Shippee 2009; George 2005), particularly the potential ways that social structure and individual characteristics may interact in early and mid-life, yet there has not been much empirical research accounting for these social selection patterns in studies of older adults. This type of unobserved heterogeneity, which is the variability in individual life course paths that we do not observe due to limits in study design, can have substantial impact on phenomena under study in samples of older adults. One of the key contributors to this gap in our knowledge is the left-truncation or censoring of sampling frames, where studies of aging start at ages 50, 65, or even older. When an accelerated longitudinal design is employed, many respondents first come under observation at even higher ages amounting to further loss of information. To further exacerbate the problem, some study designs impose additional selectivity on their samples by restricting eligibility to those who, for example, have no functional limitations at baseline (e.g., Women's Health and Aging Study I).

The consequence of these limits in study design is that we know little about cohort-specific patterns in social selection over the collective life course. A bevy of empirical work has articulated complex social selection mechanisms in domains such as mortality (Hoffman 2009), disablement (Verbrugge and Jette 1994), and labor-force exits (Brown and Warner 2008). Although this work has had untold value in the study of aging, attention to selection has been almost exclusively limited to the prospective observation window of the panel study. This focus on "selection moving forward" virtually ignores the mechanisms of selection that occurred *prior* to the observation window.

The one social selection mechanism that has received systematic attention is premature mortality, the process whereby individuals are selected out by high mortality risk prior to old age, leaving a robust cohort with less overall variability and low subsequent mortality risk (Markides and Machalek 1984). Mortal attrition bias in studies of older adults is not only a problem of who may remain in the panel study, but also who would appear at the time of study origin. Men, persons of lower socioeconomic status, and race/ethnic minorities tend to have higher rates of premature mortality, so the survivors in these groups likely appear substantially more robust in older adulthood compared with their socially-advantaged counterparts (Markides and Machalek 1984; Willson et al. 2007). Additionally, the social distribution of premature mortality shapes not only *who* is available for observation at the oldest ages but also *when* these individuals may experience particular phenomena (e.g., end of life processes). This problem becomes more acute as the age-eligibility threshold for the sampling frame is set at higher ages. These patterns of mortality selection have received considerable conceptual attention (Geronimus 1992) and the empirical patterns of premature mortality are well-known (Hayward et al. 1997; Lantz et al. 1998; Mansfield et al. 1999). Given the substantial attention selective mortality has received, researchers who utilize prospective studies of older adults are generally quite informed about the social distribution of mortality risk over the entire life course and the differential effect on social subgroups within a particular cohort. Indeed, many studies acknowledge that the observed *homogeneity* in late-life outcomes may obscure the *heterogeneity* that existed much earlier in the life course.

Beyond selective mortality, however, there are myriad other social selection mechanisms that influence the well being and composition of a cohort, many of which remain largely unobserved in studies of older adults. These include health processes such as early onset of disability (Doblhammer 2003), socioeconomic circumstances such as lack of employer-based health insurance (Baker et al. 2001) or unsteady labor force participation (Moen and Chermack 2005); and social processes such as assortative mating (Lillard et al. 1995; Mare 1991) or residential moves (Sampson and Sharkey 2008). Some notable work has begun examining selection processes over the life course, demonstrating the complex social patterning of structural opportunity, individual circumstances, and social constructions of age. Wilmoth and Koso (2002) reconstructed individual marital histories and identified the pathways to late-life financial well being across life course marital status typologies. Elman and O'Rand (2002) demonstrated that mid-life educational attainment has a substantial impact on income trajectories. There has even been some consideration of inter-generational contributions to social and health inequality over the life course (Gluckman and Hanson 2006; Oliver and Shapiro 1995; Uhlenberg 2009). Characterizing patterns of social selection over the life course is both an empirical and conceptual frontier in need of systematic attention.

With the rising recognition of the "long reach" of early-life circumstances, a number of studies have incorporated survey questions or other data sources on childhood, including abuse (Irving and Ferraro 2006), neighborhood stability (Bures 2003), family socioeconomic circumstances (Hayward and Gorman 2004), and birth weight (Barker 2001). Although these studies that examine the potential influence of early- or mid-life social circumstances have been extremely valuable in identifying life-course selection pathways and their impact on later-life outcomes, the specification and measurement of these circumstances typically remains limited to major life circumstances that are easy for respondents to recall (e.g., date of marriage) or can be measured through administrative records (e.g., hospitalization; birth). Unfortunately, due to study design limitations, these earlier-life indicators are

often treated as "turning point" events comparing those who did and did not experience a selected early-life exposure. Such an approach does not allow for the consideration of the *cascade* of events or circumstances that follow, which likely shapes the outcomes seen in later life.

Figure 4.4 presents a conceptual representation of a selection of socially-constructed life course processes that can influence not only the composition of the cohort at a given age, but also within that cohort, when individuals may be at risk of adverse outcomes such as compromised health. Study designs that do not capture patterns of social selection across the life course may lead to three types of mis-specification in analyses and interpretations. First, there may be an over-emphasis of current social, health, and economic circumstances and perhaps even over-estimation of their impact, since these indicators may "absorb" the effect of these earlier-life selection processes. A prime example is the current explosion of research on the influence of neighborhood context on older adults' well being. Although current residential environment may influence physical and mental health among older adults through mechanisms such as frequency of recreational walking (Li et al. 2005), fear of crime (Chiricos et al. 1997) or distress (Hill et al. 2005), a fundamental cause of these environment-health correlates is chronic resource deprivation in disadvantaged neighborhoods over the entire life span, which suggests intersecting influences from race, poverty, and family structure of the residents. Over-emphasizing the current residential environment may obscure the interim social processes such as selective residential patterning and/or housing discrimination.

The second type of potential mis-specification is because temporally-proximate indicators of social disadvantage may show only marginal impact on late-life outcomes largely due to the neglect of their influence in early and mid-life, which shaped the composition of the cohort at advanced ages. For example, Hoffman (2009) demonstrated that mid-life socioeconomic status had a greater impact on patterns of old-age mortality than later-life socioeconomic circumstances because social disadvantage shapes the composition of the birth cohort at all ages, not just in older adulthood. Third, we may risk the "Time 1 Encapsulation" problem identified by Dannefer and colleagues (Dannefer and Kelley-Moore 2009; Dannefer and Uhlenberg 1999) whereby late-life outcomes are over-attributed to early-life social circumstances to the exclusion of interim social context. Neglect of the ongoing and interactive nature of social structure and individual characteristics that occur *throughout the life course* over-emphasizes starting berth (in tournament framework, c.f., Rosenbaum 1978) or early-life circumstances.

Despite the growing recognition that social structural circumstances provide and limit opportunities for individuals over the entire life course, scarce attention has been paid to the *mechanisms of selection*, particularly in mid-life, that influence later-life outcomes (George 2005). To date, solutions to the unobserved heterogeneity "problem" due to age-truncated (left-censored) study designs have been statistical in nature, even using simulated data to adjust estimates in an observed sample (Gutierrez 2002). Although study designs have greatly improved in recent decades, there are still many gaps in our knowledge about early and mid-life circumstances. Beyond selective mortality, there are myriad social selection processes that occur at all ages and influence what we are able to observe in older adulthood. Investigators should consider carefully appropriate study designs that may allow the identification of potential selection processes over the entire life course, articulate the mechanisms at work, and characterize the impact of this "left selection" on later-life outcomes.

Unobserved Heterogeneity Due to Single Methodologies

The growing availability of large-scale panel studies in the past decades has changed the scope of inquiry and the specificity of measurement available to scholars interested in age and the life course. Although this type of quantitative, survey-based methodology has been our primary focus up to this point in the chapter, it is important to note that the exclusive use of any single methodology has the

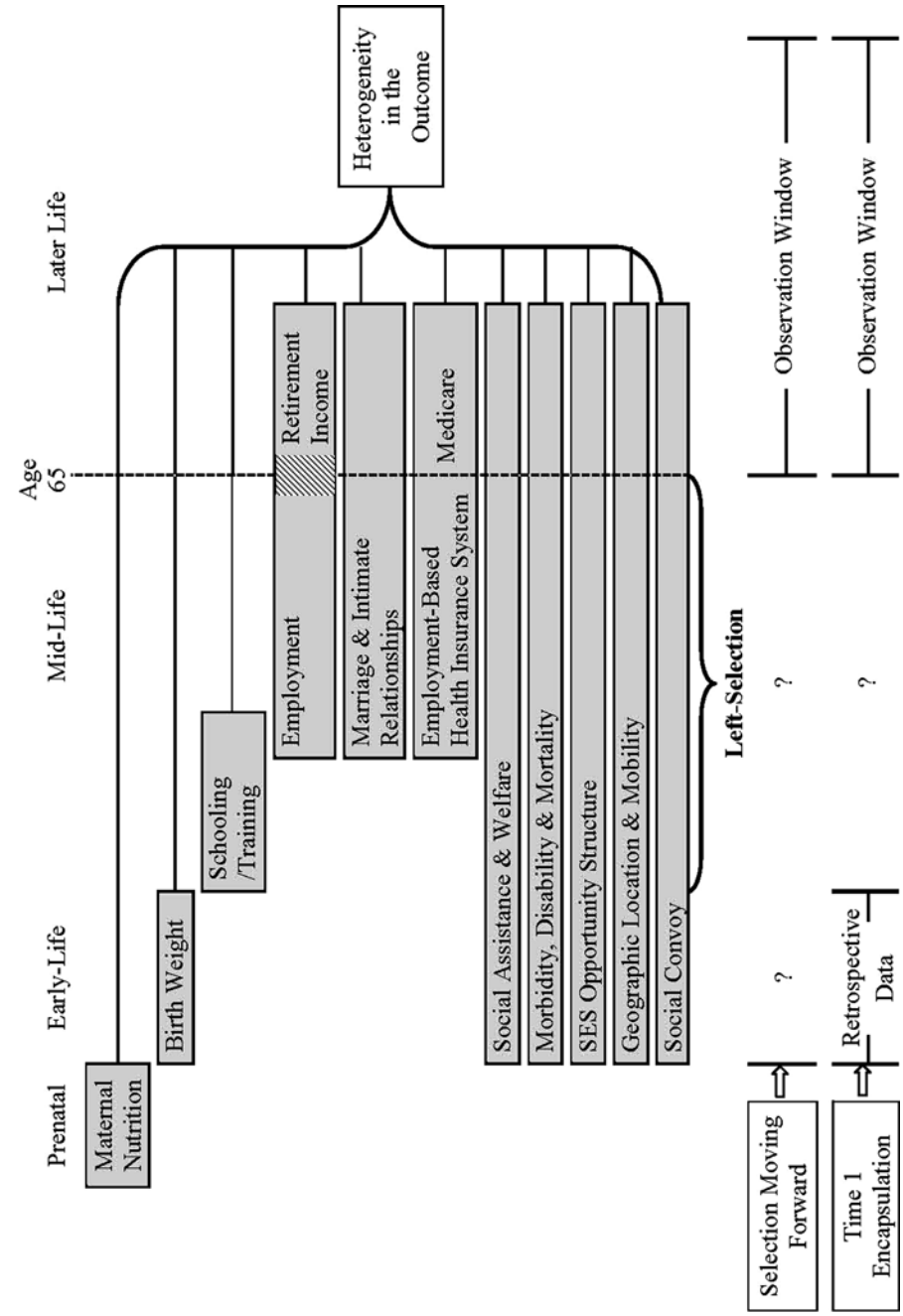

Fig. 4.4 Life course selection processes

risk of obscuring underlying social processes that may contribute to differentiation in life paths. The third type of "unobserved" heterogeneity discussed here is the variability in lived experiences that cannot be explained or confirmed due to reliance on a single methodological approach to the question under study. This type of unobserved heterogeneity, aptly addressed, represents a rich source of new theorizing about the influence of the social world on individual lives over the life course.

Scholars of age and the life course widely acknowledge that there are limitations in existing studies that do not allow for identification of underlying processes or finer characterizations of phenomena (Holstein and Gubrium 2000; Riley 1983; Sørensen 1986). This critique is commonly leveled on quantitative studies such as surveys and administrative databases since many important concepts are limited to only a handful of indicators (Dannefer 2011). Yet the utilization of any single methodology, including qualitative approaches, can leave sources and patterns of population variability over the life course largely unstudied – even undetected. The type and pattern of variability that remains obscured varies by the phenomenon under study and the methodology put to use. In this section, we discuss the scope of the problem stemming from the utilization of a single methodology in studies of age and the life course and then provide examples how a mixed-methods approach could either *explain observed variability* or *confirm hypothesized variability* in the population, opening the door for new and better-articulated social explanations.

Just as we noted in Section "Unobserved Heterogeneity Due to Standard Statistical Practice" about standard statistical practices, the challenges of relying on a single methodology are not unique to sociology, but do have significant consequences for the types of inquiry we make and the conclusions that we draw. Because of the complex social world in which individual lives are embedded, age-based patterns of variability may not be fully detected or explained with a single methodology. A multi-dimensional study could open the vista for inquiry into the sociogenic influences that lead to differentiation (or lack thereof) in the population at any point in the life course, allowing for a better articulation of social patterns or the discovery of new social paths that had been previously obscured due to the primary methodological lens applied to the problem.

Singer and Ryff (2001:44) were among the first to advocate for the blending of qualitative and quantitative methodologies in the study of age and the life course, specifically noting the " . . . dearth of analytic strategies for producing representations of whole lives and for aggregating them into meaningful taxonomies that facilitate the understanding of how given outcomes come about." More than simply an ad hoc approach where a supplemental qualitative component is added to a largely quantitative study (or vice versa), mixed methodological approaches are emerging as a paradigm of inquiry that triangulates evidence regarding the phenomenon under study. Mixed-methodology is accomplished through interacting elements of qualitative and quantitative approaches to inquiry and integrating methodologies that utilize a specific type of reasoning, including inductive, deductive, or abductive (Creswell 2009). Although there are a number of other important contributions that mixed-methods can make to scientific inquiry, we focus here on the potential gains in studies of age and the life course. Below, we present two examples where a mixed methodological design would help explicate the underlying processes and mechanisms that lead to age-related variability in the population – one that utilizes an explanatory approach and one that utilizes a confirmatory approach.

First, a mixed-methods design can be useful when a quantitative study documents substantial variability in a particular outcome and may even detect subgroup (e.g., gender, race) differences but cannot capture sufficiently the underlying forces that drive the pattern of variability. A secondary methodology can be used to *explain* the patterns of variability observed in the primary study. For example, surveys and administrative databases (e.g., MDS) that capture segments of the older adult population typically use the standardized assessment scales of Activities of Daily Living (Katz et al. 1963) and Instrumental Activities of Daily Living (Lawton and Brody 1969) to assess dependency or need for assistance on a limited set of tasks. These measures have been critiqued because

they poorly identify those with mild to moderate limitations (Guccione et al. 1990), those whose functional limitations fluctuate over time (Gill and Kurland 2003), or those who have developed successful adaptation strategies (Atchley 1998; Gignac et al. 2000). Empirical studies continually note that *despite equivalent levels of ADL or IADL dependency*, we observe significant variability in social engagement (Mendes de Leon et al. 2003), mental health (Albrecht and Devlieger 1999), and self-rated health (Cott et al. 1999). Integrating a qualitative component into the quantitative study could capture the narratives individuals construct about their functional limitations, which may *explain* the observed variability in well being and social engagement despite similar levels of functional dependency.

Second, a mixed-method approach can be used to *confirm hypothesized* patterns of age-based variability. This is particularly critical in cases where there is a strong conceptual foundation for hypothesizing variability in a particular outcome but the primary methodology cannot detect it. For example, both qualitative and quantitative studies have demonstrated that when one partner of a married couple becomes critically ill or develops severe functional limitations, there tends to be a decrease in mental health for both partners (Northhouse et al. 2007) and an increase in caregiver stress for the other partner (Sherwood et al. 2005). However, subsequent changes in marital satisfaction after a partner becomes ill or disabled yields mixed results (Suitor and Pillemer 1994; Wolff and Agree 2004; Wright and Aquilino 1995). Drawing from conceptual work on the socially-constructed life course, one could reasonably hypothesize that there is an *age-based pattern* in the degree of change in marital satisfaction when one partner becomes ill. Specifically, couples who consider disability or illness to be an "off time" event, perhaps even biographical disruption (Bury 1982), may experience greater marital strain or take longer to make adjustments in the dyad that are satisfactory to both. Degenerating health conditions and functional limitations are negotiated within a marital dyad daily, weekly, or monthly such that annual follow-up surveys may be too far apart temporally to capture variability in marital adjustment, obscuring an age-based pattern that unfolded between observation points. A complementary methodology that examines marital dynamics repeatedly in a shorter time window could *confirm* whether there are truly age differences in subsequent marital satisfaction and adaptation to an ill or limited partner.

This type of unobserved heterogeneity, which cannot be explained or confirmed without a complementary methodology, is a greater challenge to the field of age and the life course than the previous two types discussed. This is because it requires careful consideration of conceptual and theoretical frameworks in which we work to even develop a mixed-methodological approach to the empirical question. Mixed-methods research attempts to incorporate insights offered by both qualitative and quantitative methods into a single study design to provide the most accurate answer to the research question under study. These selected methodologies are part of a broader integrated research design, where the methodological components may be sequential, parallel, simultaneous, or even unbalanced (Creswell 2009; Creswell et al. 2003). With such powerful tools and flexibility in research design, social scientists are now able to identify, document, and address heterogeneity in the population, including age-based patterns of variability.

Conclusion

Social inquiry into phenomena associated with age has grown in the past decades, fueled by increased sophistication in statistical methodology and study designs. As a result, sociologists have had more voice in the broader inquiry about what it means to age in society by documenting the myriad ways that social structure influences the individual and collective life course. The success in generating a broader recognition of social influences in human lives is evident by the range of

disciplines that now acknowledge the social environment as a critically important causal factor for human development and later-life outcomes (Guo and Stearns 2001; Shanahan and Hofer 2005). Yet, as this chapter has set out to demonstrate, we are only at the frontier of recognizing and identifying the range of social influences that frame individual and collective experience over the life course. To date, the dominant paradigm of inquiry for sociologists of age and the life course has focused on the "average" experience using prospective data. As a discipline, we should work to integrate empirical and conceptual consideration of age-based patterns of variability around these presumably normative phenomena.

Our description of "unobserved" heterogeneity in standard statistical practice, study designs, and single-methodological approaches was designed to demonstrate the range and scope of social inquiry that has yet to be addressed systematically but has the potential to radically shift not just our understanding of individual or collective lives over the life course but the complete paradigm of inquiry about what it means to age in society. This age-based heterogeneity, which is undocumented and even undetected in some cases, is within the grasp of social inquiry through systematic empirical investigation. Yet it requires commensurate conceptual attention to the influence of the social environment on individual lives and potential age-based patterning in the variability that may or may not be directly captured in studies.

In section "Unobserved Heterogeneity Due to Standard Statistical Practice," we present unobserved heterogeneity due to the standard statistical practice of relying on measures of central tendency to the neglect of age-based patterns of variability around those central measures. In this case, we argue that the variability is already captured in observational studies, but has been neglected in empirical tests due to over-reliance on middle observations leading to a lack of conceptual attention to the social constructs within which individual lives are embedded. This type of unobserved heterogeneity can be addressed most readily because much of the variability is already captured in existing data sources and the statistical tools exist to conduct such systematic observation.

In section "Unobserved Heterogeneity Due to Study Design," we discuss unobserved heterogeneity due to limitations of study designs, specifically age-truncation of samples and few, if any, indicators of early-life, mid-life, or ongoing processes that may lead to age-based patterns in variability within a cohort. This type of heterogeneity is unobserved because it is not captured in current study designs but is ripe for conceptual and empirical attention – particularly to ongoing life course processes rather than encapsulating the effects into life stages or over-emphasizing a single early life event. In section "Unobserved Heterogeneity Due to Single Methodologies," we introduce a third type of unobserved heterogeneity, which is due to the utilization of a single methodology. Variability in process and outcomes may remain unexplained or unconfirmed in studies that utilize a single mode of inquiry. Creating an integrated design that would triangulate information around the phenomenon under study can strengthen our understanding about range of social influences over the life course – even those that are subtle or short-lasting. Although there is great value in large-scale omnibus panel surveys, sociologists must recognize that these cannot detect, confirm, or explain all patterns of age-based variability that exist.

In sum, the future challenges for sociology of age and the life course include the following: sufficiently characterizing the variability in phenomena that are already captured in observational studies; addressing potential life course (collective and individual) pathways and social selection processes that produce heterogeneity or homogeneity in late-life outcomes, but may be predominantly unobserved in studies currently; and designing multi-methodological studies to identify and characterize the myriad life course pathways. By widening the view of social inquiry to include these as-yet minvestigated sources and patterns of age-based heterogeneity, studies of age and the life course can reclaim the discourse about what it means to age "normally."

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Part III
Social Diversity and Inequalities of Aging

Chapter 5
Gender and Aging

Susan Venn, Kate Davidson, and Sara Arber

Over the last 30 years, the field of aging has been the site of an exceptional growth of research interest, yet it is only really within more recent social gerontology that the many varied experiences of older people are being acknowledged and explored through the intersection of race, ethnicity, sexuality, class, and, as many have argued, most importantly, gender. This chapter will show the importance of recognizing the gender dimension within the study of aging by exploring how using a "gendered eye," or adopting a "gender lens" (Calasanti and Slevin 2001) not only reveals neglected issues for older people, but is also fundamentally important in thinking about the study of old age at a time when the growth in the aging population is unprecedented.

The chapter commences by stepping back 30 years to reflect on theoretical approaches to the study of aging and approaches that initially neglected gender. We then move on to demonstrate how the contribution of feminist scholarship raised awareness of the need to identify and address the neglected area of older women's issues, and at the same time neglecting older men's issues (Thompson 1994). Next, we consider how this approach ultimately evolved to take account of the interlinkages between age and gender relations in recognition of the need to examine men's and women's experiences relationally.

Emerging issues within this new era of age and gender relations are introduced in the form of the changing nature of roles, relationships, and older people's identity. The following section focuses on the aging, gendered body through discussion of the tension between aging identities and narratives of bodily decline as experienced differently by men and women (Gullette 1997). Finally, the chapter concludes by highlighting challenges for the future of aging for men and women, such as the growing numbers of the oldest old, who are predominantly widowed women, implications for unmarried or childless older men and women, and the policy implications of such challenges.

Introducing the Gendered Dimension

Reflecting the dominant cultural views of the time, earlier theoretical approaches to aging focused on retirement as a marker for the commencement of old age (Midwinter 1997; Phillipson 1998), rather than as a physiological process (Townsend 1981; Gilleard and Higgs 1998). With old age thus categorized by retirement, and therefore socially constructed, approaches to the field of aging were

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primarily policy oriented. Subsequently, "old age," and the issues that accompany aging such as poverty and health problems became perceived as a "problem" or "burden" to society.

Having conceptualized that old age is "problematic," several different theoretical approaches to studying the "problem" of aging were posited, and disputed over the last half century. Disengagement Theory (Cumming and Henry 1961), for example, although conceived some 50 years ago, continues to resonate with lay perceptions of how and why older people come to terms with withdrawal from the labor force, society, and ultimately, life. Criticized widely as an outdated positivist approach, the theory was challenged by those proponents of the Activity (Havighurst 1963) and Continuity (Atchley 1971, 1987) theories. The Structured Dependency theory of the 1980s saw old age as socially rather than biologically or psychologically constructed, predicated on mandatory retirement with the ensuing loss of income, social status, and self-identity.

However, these theories, ground-breaking in their conceptualization of later life, were largely gender blind. Cumming and Henry's research was carried out in mid-western conservative Kansas in the 1950s, and the vast majority of their participants were (white, physically able) men who had experienced long-term employment. Women in mid-century post-World War II America were less likely to have been long-term employed, and thus did not experience the disengagement stimulated by retirement. Similarly, Havighurst (1963) and Atchley (1971) concentrated on older people who were mainly physically fit and could afford to continue active life after retirement, without recourse to the constraints that impact men and women differently in later life. There was little recognition of those people with disabilities and/or in poverty who are, in the main, women.

In the 1980s, writers such as Walker (1981), Phillipson (1982), and Estes (1979) moved away from traditional gerontological approaches toward a political economy perspective, which called attention to how an individual's position in the labor market is a determining factor for subsequent inequalities in life post-retirement. For example, Calasanti (1986) was among early feminists, who challenged the male paradigm of production in a formal economy by highlighting the vital, unpaid work carried out particularly by older women. This was later echoed by Estes (1991), who pointed out how the gendered nature of the division of labor is an extra causal factor in the post-retirement position of women. In essence, as Bury (1995) quoting Walker (1981), explains, "the effects of a weak position in the labor market, prior to retirement, meant restricted access to a 'wide range of resources' and resulted in 'the imposition of depressed social status in old age'" (Bury 1995:18; Walker 1981:88). However, Estes (1991) recognized that this perspective is rooted in the predominantly male experience of employment and economic security and does not adequately address issues of women and members of minority ethnic groups. Their different work pattern means that women and other minority groups are often excluded from the labor market long before the official age of retirement. Thus, the political economy perspective expanded in the 1990s to take into account other dimensions of inequality.

Earlier social structural approaches failed to address the varied and diverse nature of the aging experience for men and women, including diversity *within* the gender categories such as according to race, ethnicity, class, and sexual orientation. The political economy approach to aging expanded in the later 1980s and 1990s to take into account other dimensions of inequality by including race and ethnic inequalities as well as gender.

During the 1990s, feminist insights sought to further raise awareness of the diversity of the aging experience by examining these many cross-cutting influences on the aging experience for women (Arber and Ginn 1995). Although remaining within a broadly political economy focus, they demonstrated the extent of structured inequalities experienced by women in later life by highlighting how women do not merely "do gender," they also "do" race, ethnicity, class, and sexual orientation (Krekula 2007).

The numerical predominance of women in later life, and the particular "problems" faced by older women became identified as "the feminization" of later life. Such feminist emphasis was placed largely on the disadvantaged position of older women in relation to their pensions, health status, and access to care (Arber and Ginn 1991; Estes 1991). Thus, a feminist political economy approach sought to redress the earlier neglect of issues that are predominantly related to women in later life,

as, they observed, women are more likely to face greater constraints, and have access to fewer resources (Arber and Ginn 1991; Bernard and Phillips 1998; Bury 1995).

Yet, though feminists challenged the theoretical perspectives that omitted aging women, they have also themselves been subject to criticism for not only neglecting to recognize the diversity of the aging experience, but also for ignoring men (Katz 2005). As an attempt to counter these criticisms and to integrate age, with gender, and other dimensions of inequality, such as race and ethnicity, a fresh approach was adopted, whereby men's and women's experiences of aging are seen in relation to each other.

Emergence of Gender Relations Through a "Gender Lens"

The adoption of a "gender lens" arose out of a move to counter critics of a feminist approach to aging, where only women's issues were seen to be addressed, albeit in recognition of other, intersecting, social identities such as race, class, and ethnicity. This approach to gender and aging was introduced in recognition of how men's and women's experiences of aging are shaped in relation to one another, rather than as a separate and unique experience for each gender individually (Calasanti and Slevin 2001). Thus utilizing a "gender lens" leads to a more all-inclusive and wide-ranging understanding of old age and offers a framework within which to understand men and women's varied experiences of aging.

McMullin (1995) emphasized that it is important not just to "add" women into research where men are the reference group, with women seen as an "add-on" after the fact, and their experiences are only viewed in light of their difference from men's experiences. Calasanti and Slevin (2001:34) explain:

> Research conducted in this vein not only constructs women as "other," but also obscures the similarities between women and men. It also mystifies gender relations. For example, research on employed women often considers the impact of their family roles, but this is often neglected in research on employed men. Yet family plays an important role in the careers of both.

Emphasizing the need to understand gender relationally, Calasanti and Slevin (2001) also argued that gender should not be the remit of women solely, such as when asking only women about gendered roles within the family, as this would, in essence, imply that such matters do not influence men.

An example of research that adopted a "gender" lens is a recent study on older people's experiences of poor sleep (SomnIA, Sleep in Aging), where equal numbers of older men and women who were aged 65–95 years were interviewed in their own homes to gain an understanding of how their diverse lifecourse experiences shaped and influenced their experiences and management of poor sleep (Venn and Arber 2011). Additionally, varying health status, class, and age groups were incorporated in the study design, to ensure that other social dimensions were included. Caregiving for a partner was often given as a reason for disturbed sleep, and, echoing Calasanti's (2006) study on spousal caregiving (see later), both women and men were engaged in physical and emotional support for their partners during the night, as well as during the day.

Disadvantages and Advantages Facing Older Men and Women

Adopting the use of a "gender lens" by feminists has allowed for an exploration of both the disadvantages *and* advantages faced by men and women in later life. For example, examining employment and retirement has not only drawn attention to gender inequalities in pension provision, but also raised awareness of the neglected issue of unpaid work, largely undertaken by women. Access to pension provision has previously been male focused, which is largely designed with men in mind, assuming long term, continuous employment leading to access to an income in retirement. Women, on the contrary, were expected to receive income and benefits indirectly through their marital relationship (Ginn 2003).

Changes to existing pension schemes have attempted to address gender inequalities, but inherent disadvantages faced by women pre-retirement still lead to them tending to have lower retirement income than men. Several factors contribute to the disadvantaged status of women with regard to pensions:

- The influence of life events such as marriage, divorce, and childbirth affect women's participation in the labor market and therefore access to pension provisions (Ginn 2003; DWP 2005). Married women are more likely to be dependent on their husband or the state for their pension provision than men, and women are more likely to work part-time or withdraw from the labor market when they have children (Ginn 2003; Price and Ginn 2003).
- Women are also more likely to undertake unpaid labor, such as when caring for sick or elderly relatives and therefore are more reliant on state pensions (Ginn 2003).
- Women's pay does not increase over time at the same rate as men's, resulting in a gendered pay gap, which continues after retirement (McMullin 1995).
- Women live longer than men so that their pension will have to pay out for longer (DWP 2005).
- The majority of older women are widowed, and alongside divorced older women, widows are particularly financially disadvantaged in later life because of their reduced employment participation (Ginn 2003; Arber 2004).

However, not all pension provision disadvantages women. For example, in the UK, where employees have the right to swap some pension income for a lump sum on retirement, men face disadvantages, as the lump sum they may be entitled to withdraw could be less than women's, because of the expectation that women will live longer, based on actuarial calculations by insurance companies (Goldsmith 1993).

Furthermore, Arber et al. (2003) highlighted other *advantages* older women often face, in relation to some older men, such as in better social relationships with friends and family through their role as "kin-keepers" (Finch and Mason 1993). Older women living alone are also more likely to draw on their social networks and neighbors to sustain connections within their local communities (Walker and Hiller 2007). Following widowhood, on the one hand, many older women also report experiencing a greater sense of freedom and autonomy, and would choose not to give this up in order to re-marry. On the other hand, older men do not always have the same opportunities to access social networks as women, and may not experience the same positive perceptions of widowhood (Davidson et al. 2003).

Redressing Imbalances: Changing Partnership Status and Older Men

Building on their previous work in the 1990s of integrating gender into the analysis of aging, Arber et al. (2003) sought to redress two imbalances within earlier feminist scholarship. First, they acknowledged the importance of the changing nature of relationships in later life since the latter years of the twentieth century. Second, they highlighted the long-term neglect of the meanings of masculinity and identity to older men. Men and masculinities have been the subject of much sociological research in recent years, such as Kimmel et al. (2004), yet very little of this research has addressed older men (Meadows and Davidson 2006).

Partnership Status

Those entering later life in the early years of the twenty-first century differ from earlier cohorts, not only just in economic terms, but also in the nature of their relationships (Arber et al. 2003). Changes to family structure are increasing, such as a rise in the number of couples who divorce, more couples

cohabiting and subsequently separating, and more people in Living Apart Together relationships, resulting in an increase in multiple partnership experiences over the lifecourse (Price and Ginn 2003; Borell and Karlsson 2003). In Sweden those aged between 65 and 69 are more likely to be divorced than widowed. These changes in partnership and family status have many implications in later life, especially in terms of gender disparities (Borell and Karlsson 2003).

For example, in terms of pensions, as mentioned earlier, women over the age of 60 living on their own in the UK are at greater risk of poverty compared with other older people, especially if they are divorced, largely because of lower pension levels. Additionally, divorced older women do not have access to any proportion of their husbands' pension, unlike widows (Ginn 2003; Bardasi and Jenkins 2004). In the US, pension provision similarly reflects a gender bias with substantially fewer women receiving a pension than men, and unmarried women expecting a pension of about half that of unmarried men (Calasanti and Slevin 2001). However, being divorced or separated may also have a negative effect on men's pensions, as this group are more likely to have experienced unemployment and loss of wealth or capital to a former spouse (Price and Ginn 2003), whereas the income of widowers differs little from that of married men of equivalent age (Arber 2004).

Changes in later life relationships and living arrangements not only have financial implications. Davidson (2002) found that older widowed women often did not choose or desire to be married again. Rather they expressed a preference to maintain autonomy over their lives and not to return to looking after a man in their later years; whereas most men who had been widowed wanted to marry again out of a desire for companionship, although opportunities to remarry may decrease with age and frailty. The wish for autonomy in later life is also exemplified by "Living Apart Together" relationships, where couples can experience intimacy and companionship, yet have the freedom to undertake their own daily activities through maintaining their own living space. This emerging type of relationship is particularly favored by older women (Karlsson and Borell 2002; Borell and Karlsson 2003).

Finally, a growing body of research is attempting to redress the neglect of older gay and lesbian relationships in the field of gerontology. Although there has been an increasing recognition of the need to understand diversity and heterogeneity in the study of aging such as including race, ethnicity, and gender, it is only more recently that sexuality in later life has been discussed, and within discussions of sexuality, the experiences of older gay and lesbian adults have largely been ignored (Cronin 2004; Calasanti and Slevin 2001). Cronin (2004) and Heaphy (2007) have shown that although many of the experiences of heterosexual older people are the same for lesbian and gay older people, there are additional issues that pertain specifically to the latter. For example, lesbian or gay older adults are more likely to live on their own, are less likely to receive social support from family members, but are more likely to have stronger friendship networks that provide support (Cronin 2004).

Challenges for Men in Later Life

Although there has been a growth in research into issues that pertain specifically to men and masculinities in recent years, the focus has largely been on younger men (Kimmel and Messner 2001; Whitehead 2002), and challenges to masculinity in later life has, with a few exceptions, been ignored (see Thompson 1994; Meadows and Davidson 2006). It has been contended that aging for men is less problematic than for women, both in terms of financial implications and fewer expectations of men to maintain a youthful appearance in later life (Sontag 1978). More recently, however, there has been a suggestion that older men may have to face their own particular challenges arising from changes that occur through the loss of normative roles and relationship status, which usually emphasizes masculine autonomy and power.

Particular challenges face divorced older men who experience greater loneliness because of reduced contact with children and other family members following marital breakdown (Dykstra and

de Jong Gierveld 2004). Trends indicate that the percentage of divorced men aged 65–74 will increase from 9 to 17% between 2007 and 2031, and the proportion of divorced men over 75 will increase from 4% in 2007 to 12% in 2031, whereas the proportion of widowed women aged 65–74 will decrease from 21 to 10% and those aged 75+ will fall from 61 to 40% (ONS 2009). Therefore, more recent scholarship has emphasized the importance of recognizing those older men who are divorced or widowed and the implications for their social and physical health and wellbeing (Arber et al. 2003).

For example, Davidson et al. (2003) addressed the issue of the social participation of older divorced and never married men, who are more likely to be socially isolated and to have poorer health than those who remain married in later life. They found that men who lived on their own were reluctant to join local community groups such as day centers, largely because they were perceived as being aimed at older people, and at older working-class women in particular. Policy changes, which adapt such community groups to make them more attractive to older men, as well as older women, could potentially make a difference, as they suggest:

> In order to attract older men, attention should be paid by local authority and voluntary organizations to offering appropriate facilities and activities for older men so that they may be supported in leading socially integrated and independent lives within the community (Davidson et al. 2003:88).

Attention has also been drawn to the challenges that men face in later life as they struggle to remain within the dominant hegemonic ideals of masculine space, as exemplified by younger, fitter, and employed men (Connell 2000; Meadows and Davidson 2006). They may even come to occupy, to some extent, feminine space, as when undertaking domestic activities such as cooking (Calasanti and Slevin 2001). Both of these challenges may cause men to renegotiate their status in terms of "manliness," as they attempt to come to terms with decreasing physical strength and position within society, and the loss of power that accompanies such altered status (Meadows and Davidson 2006).

The potential challenge to notions of "manliness" and masculine identity is particularly salient when examining caregiving experiences by older men, an area that has largely been overlooked in gerontology because of its traditional dominance by women (Calasanti 2003, 2006). Comparisons have traditionally been made between women caregivers who not only provide physical care, but also emotional support, and men caregivers, who are more likely to provide practical instrumental support. However, Calasanti (2003) and Thompson (1997) have pointed out that it is important not only to study and judge men's caregiving solely in relation to women's caregiving, as this may lead to an overemphasis on what women do, to the detriment of what men do. Indeed, men are caregivers, but little has been done to understand what caregiving *means* to them and their masculine identity (Thompson 1994). Suggestions that men are less effective at caring for their spouse or partner because of the rational nature of their caregiving has been challenged by Davidson et al. (2000) and Russell (2001), who argue that men do not solely adopt a professional or managerial approach to caring, but rather they see caring as "logical" and "natural" (Russell 2001:306), in recognition of the bond of a long-term marital relationship, which engenders a sense of responsibility to care sensitively and appropriately.

Feminist scholarship has also contributed to raising awareness of the gendered dimension of the aging body. The next section discusses changes in our understanding of the differential ways in which aging bodies are experienced by men and women.

The Aging (Gendered) Body

Understanding the body has increasingly become an arena for study within contemporary societies, such as Elias's (1978) discussion of civilizing bodies, as in etiquette and manners, and Foucault's (1979) disciplined or "docile" bodies in institutions. However, it is only in recent years that the

aging body has received the same attention, which is surprising given that the physical changes to the body are some of the more overt markers of aging (Twigg 2000; Calasanti and Slevin 2001). Ageism and sexism are embedded within contemporary societies, with the media portraying the young as beautiful, and the old as ugly, with a strong emphasis on women maintaining youthfulness (Calasanti and Slevin 2001).

Building on Susan Sontag (1978), Arber and Ginn (1991) highlighted the "double standard" of aging, where the definition of old age shifts according to gender, that is, women are seen to physically age sooner than men. With the discourse negatively focusing on (aging) women's bodies, it is no surprise that women express greater dissatisfaction with their aging bodies than do men. Feminist analysis has argued that the pressure on women to look younger in the (literal) face of the negative aspects of aging means they are more likely to adopt various forms of anti-aging strategies, such as cosmetic surgery, hair transplants, and hair dyeing (Gilleard and Higgs 2000; Ballard et al. 2005). Notwithstanding the importance of the media in defining the presentation of appropriate body images, Hurd Clarke et al. (2007) have suggested that older women also learn how to manage the presentation of their bodies and the proper way to "do gender" through their mothers. Paradoxically, women also face additional pressure from feminists, with on the one hand, women being urged to reject age-resisting activities and to "grow old gracefully," and on the other, to take hold of the increasing opportunities available to them and reject an aging identity (Ballard et al. 2005).

But female bodies are not the only subjects of negative discourses in both academic literature and the media. Although women are more likely to be dissatisfied with their body weight and attractiveness, older men also experience bodily dissatisfaction through reduced physical strength and sexual potency, all of which are related to their masculine identity.

As mentioned previously, the body has, until relatively recently, been ignored within gerontology, possibly, as Twigg (2004) argues that there can be negative consequences from focusing on (aging) bodies: "From this perspective, attempting to emphasize the bodily can seem a retrogressive step, one that takes us back into the territory of biological determinism and the narrative of decline" (2004:59). But Twigg emphasizes the importance of including the body in the study of old age, especially for women, who are more subject to ageist attitudes in terms of the aging body.

Challenges for the Future

It is undoubtedly an achievement that more people are living longer and healthier lives, in virtually all parts of the world. However, the questions now to be raised are what are the likely changes and challenges to be faced over the next 30 years for an aging population, and how can gender relations be integrated into effective policy planning to address these issues. The following are three areas that present challenges for the future.

Gender Imbalances

Global projections for an aging population indicate an overall rise in men and women over the age of 60 (Gist and Velkoff 1997). For example, in 1997, 10% of the world's population was over 60; this will most likely increase to 15% in 2025. In nearly all countries of the world, women comprise the majority of the older population, accounting for over half of the 60–69 age group and 65% of those aged 80 and above (Gist and Velkoff 1997). However, the gender balance is set to change in different ways in developed and developing countries. At one time in developed countries, the life expectancy of women increased at a greater rate than that of men, whereas the trend currently

is that the life expectancy of men is increasing at a faster rate than for women. For example in the UK, the proportions of women at older ages will decrease. But within developing countries, the current trend is expected to echo the earlier trend of developed countries, so that there will be a widening gap between male and female life expectancies (Gist and Velkoff 1997). This means that developing countries are set to experience the "feminization of later life" and will undoubtedly face the same issues, such as increased poverty and poorer health of older women. This is compounded by a decrease in multigenerational households, smaller families, and rural-urban migration, leading to a reduction in the availability of caregivers for frail older people, the majority of whom will be women.

Within this globally projected gender imbalance, further complicating anomalies exist. For example, China is set to have a proportionately larger percentage of older people by 2040 than, for example, the United States. Further to this, the one-child policy in China has led to an "unnatural" gender imbalance, with a ratio of 120 boys to 100 girls being born in 2000 (Li et al. 2007). As these young men age and have expectations of marriage and partnership, this raises important concerns about the impact on the stability of the country. The implications are that there may not be enough younger men and women to support the increasing aging population.

The Oldest Old

The fastest growing age group in the majority of countries is the oldest old, that is those who are aged over 80 (Gist and Velkoff 1997), and this trend is likely to continue. In the UK, the proportion of those aged 85 and above has increased from the 0.1% in the early 1900s to 2% of the total population by the start of the twenty-first century (Dini and Goldring 2008). Globally, the number of those aged 80 years and above is expected to grow from 69 million in 2000 to 379 million in 2050 (UN Population Division 2001). The implications of this rapid increase in the "oldest old" are numerous and are likely to have a significant impact on policy planning, such as the need for increased pension provision and other retirement incomes to cover longer lives. The percentage of women over 80 is smaller in developing countries, but it is anticipated that their numbers will increase more rapidly than those in developed countries (Gist and Velkoff 1997). As mentioned previously, women are more likely to experience disability and poorer health in later life, so an increase in the numbers of women over the age of 80 will inevitably lead to growth in the need for access and utilization of health care services.

Unmarried and Childless Older People

Declining fertility rates, increased childlessness, and changing social norms surrounding divorce and marital separation are leading to an increasing number of women and men without some sort of family support in later life (Kneale and Joshi 2008). The number of childless men and women is rising, particularly in Europe and North America, but also in Latin America and South East Asia (Li et al. 2007). This has significant implications, particularly in terms of costs of health, social, and long-term care. If the numbers needing long-term care, both in the community and in assisted living or residential settings increase, there will also be a need to increase the numbers of paid caregivers, who if current trends continue, are likely to be female, migrant workers from lower income countries (Li et al. 2007). This will ultimately have follow-on effects for long-term care of older people in lower income countries.

There are gender differences in the implications of childlessness. Childless never-married men are more likely to be disadvantaged than comparable with older women because they are more

likely to have smaller social support networks than women, and more likely to experience isolation. However, childless never-married women are more liable to have been better educated, have stable employment, and therefore have greater access to income and pensions in old age than women who have had children. Childless married couples, though, are more likely to be financially better off in retirement because of dual earnings, and a larger income and pensions (Koropeckyj-Cox and Call 2007; Plotnick 2009).

Conclusions

This chapter has examined how the incorporation of gender as a social dimension within the field of gerontology has grown steadily over the last three decades. Feminist perspectives sought to develop early theoretical frameworks on aging to focus on women's issues, but ultimately received criticism for neglecting men (Katz 2005; Arber et al. 2003). Later feminist approaches raised awareness of the need to not only include men but also incorporate gender relations alongside other dimensions that intersect with age, such as ethnicity, race, class, and sexual orientation. The adoption of a "gender lens" to address later life issues has highlighted emerging areas that have previously been neglected, such as the changing nature of social relationships in later life, and the lack of research on older men and masculine identities. Extending existing sociological studies of the (younger) body into aging bodies opens up further ways to explore how gender and aging intersect in later life within such arenas as body control and embellishment, body maintenance, and how the "social" influences the body, as in responses to ageist behaviors (Tulle 2003; Hurd Clarke et al. 2007).

Although there are clearly challenges for the future study of aging, it is important not to overemphasize the problematic aspects of an increasingly larger global aging population. It would undoubtedly be a retrograde step in aging research, if the growing aging population was conceptualized as a "burden," especially as the vast majority of the "oldest old" are women. One way of avoiding this is to maintain the current focus on all dimensions of aging, which means keeping gender, along with ethnicity, race, sexuality and class, firmly in the spotlight when addressing issues that surround aging and later life. The pertinence of this approach is demonstrated in recent policy frameworks that emphasize "Active Aging" (World Health Organization 2002). It is argued that men and women should be targeted differently, as when addressing lung cancer, for example. Smoking was formerly predominant in men in developing countries, but is increasing amongst women as they are particularly targeted by cigarette advertisers following women's increasing status and emancipation. Deaths from lung cancer in men are declining in some developed countries, whereas those of women are increasing (WHO 2002).

The primacy of gender for aging issues is illustrated by the WHO's approach to the increasing global aging population, "A gender analysis should be applied no matter the issue being considered, for example, abuse, emergencies, health promotion, primary health care, supportive environments and income security" (WHO 2002). Therefore, policies aimed at addressing the issues that impact on older people should be informed by an understanding that men and women, both separately and relationally, may experience old age very differently.

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Chapter 6
Race, Ethnicity, and Aging

Jan E. Mutchler and Jeffrey A. Burr

Sociologists recognize age and race as key dimensions of social reality, especially in the American context, with its heterogeneous population, turbulent race relations history, and rapidly changing age structure. As so-called "master variables," age and race (along with sex) are regarded as statuses shaping and penetrating nearly every aspect of social life, including but not limited to economic opportunity and overall well-being (for reviews, see Leicht 2008; Mayer 2009; Riley and Riley 2000; Winant 2000). Sociologists who focus their research at the intersection of age and race sometimes struggle to define the "social" boundaries of these constructs, as independent from perspectives found in the biological, anthropological, and psychological sciences. Understanding how race and ethnic group status, along with the related issue of culture, shape the experience of aging itself remains an elusive but worthwhile goal.

A series of literature reviews dating from the 1980s laments the theoretical and research limitations in the field of race and ethnic aging (Angel and Angel 2006b; Markides and Black 1996; Markides et al. 1990; Williams and Wilson 2001). Among the earliest of these commentators, Jackson defines the scope of the field as "the study of the causes, processes, and consequences of race, national origin, and culture on individual and population aging" (Jackson 1985:265). Jackson notes that a substantial share of the scientific literature at the time focused on *describing differences* among socially defined groups rather than developing theories and garnering evidence to help explain diverse outcomes in the aging context. Not much has changed in this regard. In the mid-1980s as well as currently, a substantial share of the published studies explores *dimensions of disadvantage* associated with race or ethnic group membership, with far less attention directed toward identifying commonalities across groups or areas of strength derived from association with and membership in specific race and ethnic groups (intra-ethnic sources of social capital being one prominent example). As a result, we know quite a lot from descriptive studies about the disadvantages faced by older members of some racial and ethnic groups in later life, especially in terms of the social factors that correlate with health, economic security, and family life. In contrast, the potential benefits associated with ethnic group membership are poorly documented. Moreover, far less knowledge has been accumulated relating to the causal pathways linking race or ethnic group membership to these outcomes as people age.

The field of sociology offers uniquely valuable insights in two areas critical to understanding race and ethnic status as markers of diversity in aging. First, the foundational insights relating to the role of social context and social forces in shaping individual experience and behavior are central (e.g., Durkheim 1951; Mannheim 1952). We outline below a number of ways in which this is the

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case, and we emphasize the opportunities posed by a life course framework for expanding this understanding. Second, although we acknowledge the potential drawbacks associated with an *over*-emphasis on dimensions of disadvantage, we note that understanding the forces linking racial and ethnic group inequality and aging is, in fact, useful in further developing the sociology of aging, race, and ethnicity (Markides and Black 1996). Significant and growing inequality based on social class characterizes American society, with the result being that many individuals, regardless of race and ethnic status, reach old age with insufficient economic and health resources (Crystal and Shea 1990; Gerst and Mutchler 2009). Sociological insights can be effective in helping to understand the processes that yield disadvantage for racial and ethnic minorities, as well as in drawing our attention to strengths associated with positive outcomes in later life.

The purpose of this chapter is to review briefly the limited scholarly literature in the sociology of aging that identifies social processes linking race and ethnic status to the aging experience. Illustrations are drawn from the empirical literature, focusing primarily on income security and health-related outcomes. Due to space limitations, many other dimensions of race and ethnic group status and aging are not covered here (e.g., impact of cultural beliefs and spirituality on coping and health outcomes). Following a description of the demographic context, we introduce the reader to several conceptual frameworks: double jeopardy, age as leveler, and cumulative (dis)advantage. We also briefly outline life course sociology and recommend that this approach has the potential to emerge as a viable framework for organizing research in this area. Cultural distinctiveness and assimilation are posed as potentially useful intervening and modifying constructs in developing a life course perspective on the sociology of aging, race, and ethnicity. Opportunities posed by recent methodological developments are discussed as avenues for enriching our understanding of race and ethnic diversity in aging. We also offer some potential linkages with policy consistent with this approach.

The Demographic Context

For much of the twentieth century, sociological studies of race focused primarily on comparing the experiences of African Americans to whites (e.g., Park 1950), while investigations into ethnicity were based largely on the "old ethnic" populations such as Italians or the Irish (e.g., Alba 1990; Lieberson 1980; Thomas and Znaniecki 1974). The foci of these earlier explorations were motivated in part by the demographic characteristics of the U.S. at the time. Most of the population was non-Hispanic and white or African American, and as late as 1980 only 9% of the population of all ages reported Asian, Native American, or another race, or Hispanic ethnicity (Gibson and Jung 2002). During the last 30 years, the share of the U.S. population that is both white and non-Hispanic has dropped precipitously and now represents less than two-thirds of the population for all ages combined. These changes are largely due to patterns in fertility and recent immigration, including large migration flows from Latin America and Asia and relatively small flows from Europe and Africa. [The topic of immigration as it relates to the older population is taken up in a subsequent chapter in this volume (Markides), and readers are advised to consult this work for a more extensive discussion.]

The spatial settlement patterns of both U.S.-born and immigrant racial and ethnic populations have resulted in geographic clustering of ethnic groups, residential segregation by race and ethnicity, and the development of ethnic enclaves in many areas of the country. Although race and ethnic minority populations are becoming increasingly dispersed geographically (Frey 2006), distinctive spatial patterns continue to characterize most groups and this geographic patterning contributes to differential experiences and outcomes among ethnic groups.

The Hispanic population now exceeds the African American population in size; Hispanics represent 16% of the population, whereas African Americans represent 12% of the total U.S. population.

Looking ahead, it is expected that population growth in the coming 30 years will be even more heavily Hispanic as well as Asian. More than half of total population growth will be among Hispanics, a group that is expected to represent 30% of the U.S. population by 2050 according to projections from the U.S. Census Bureau (U.S. Bureau of the Census 2008). The Asian population is expected to double in size from 4% in 2000 to 8% in 2050, while the share of the population that is African American is projected to remain steady at about 12%. By the middle of this century, the share of the population that is white and non-Hispanic is expected to drop below 50%.

The growing diversity of the older population parallels that of the overall population, although for some groups the expansion is advancing at a somewhat slower pace. For the elderly population (age 65 years and over), the largest rate of growth is among Hispanics, a group that is expected to increase from its current level of 5% of the elderly population to almost 20% by 2050 (U.S. Bureau of the Census 2008). The Asian population is expected to quadruple in relative size, increasing from 2 to 8% by 2050. The older African American population will grow from 8 to 11%; and although the older Native American population will grow numerically, it will remain a relatively small share – about 1% – of the older population. Only relatively recently have sociologists of aging begun to consider the minority aging population in broader terms (e.g., Angel and Hogan 2004). Yet these compositional changes have implications for a diverse aging society and the manner in which sociologists frame their research.

As noted above, immigration plays a sizable role in the growth of both the older and the total populations. Within the Hispanic population, 40% of the year-to-year change in size is due to immigration (U.S. Bureau of the Census 2008). Higher still, 70% of the growth of the Asian population is directly due to immigration. Immigrants from Latin America or Asia who arrived as youths or young adults are aging in place within their new U.S. communities. Other immigrants arrive in the U.S. after they are already older, often following younger family members, and thus may be described as seeking a place to age. In 2008, an estimated 96,000 persons aged 60 years and over obtained legal permanent resident status; this age group accounted for nearly 9% of the admissions that year. Most of these individuals (82%) were admitted as immediate relatives of U.S. citizens, with another 7% admitted under more broadly defined family-sponsored preferences (Department of Homeland Security 2008). The bulk of the projected U.S. population growth depends on immigration, which will simultaneously yield steady increases in the size of the Hispanic and Asian populations. The growing race and ethnic diversity in the aging population is, therefore, inextricably linked with immigration processes; and many of the factors shaping incorporation of younger immigrants also shape the well-being of older immigrants, the vast majority of whom are non-white or Hispanic (Angel and Torres-Gil 2010; Markides and Mindel 1987; Treas and Mazumdar 2002).

Some Conceptual Issues

The development of sociological theory specifically addressing the intersection of race, ethnicity, *and* aging is nascent, at best. However, scholarship informing this topic draws on a rich set of general sociological perspectives and concepts that have the potential to lend insight to this combination of social statuses. Many of these ideas focus on socially structured sources of disadvantage in later life (e.g., cohort location; discrimination; policies that work against the maintenance of families), and some also provide insight into sources of cultural variability that have implications for aging (e.g., health beliefs; linguistic acculturation). The sociological concepts introduced below share a focus on several central themes, including a longitudinal view of the issues, the importance of social status to life outcomes, and implications of being embedded in a social structure (Lynch 2008).

Early Sociological Perspectives

Modernization Theory, outlined initially by Burgess (1960) and developed more extensively by Cowgill (1972), highlights structural sources of distinctiveness in the significance and implications of age prevalent among different societies. Most relevant for this discussion, this perspective proposes that in developing regions of the world, where economic well-being depends on mutual support, cultural values arise and are reinforced that emphasize familial solidarity and filial piety. Given that sizable segments of the fastest growing race and ethnic groups in the U.S. are composed of immigrants coming from less industrialized countries in which elderly family members are respected and held in high esteem, it is likely that these values are retained in one form or another, even after some level of incorporation into the majority culture occurs. The maintenance of family norms from country of origin may act as a buffer for the difficulties that arise during the incorporation process, including offsetting some of the resource limitations.

Social Demographic Contributions

Themes drawn from the social demographic research literature also offer conceptual guidance with respect to race, ethnicity, and aging. The cohort concept (especially birth cohorts; Ryder 1965), for example, highlights the experiences and circumstances to which people who share the time period of their birth are exposed; people who subsequently move through stages of life together, including transitioning into later life. Through the process of cohort succession – by which birth cohorts with unique life course experiences are, over time, replaced by subsequent birth cohorts having a different set of life course experiences – the understanding of what it means to be "old" shifts over time. A familiar example of cohort succession compares persons who grew up during the "Great Depression" to those who came of age during the Vietnam War era. In a similar way, we anticipate that increases in ethnic and race heterogeneity among the older population will potentially change norms and expectations about aging. Evidence shows that different minority groups face different levels of discrimination and blocked opportunities, and that these experiences have evolved over time and across cohorts – yielding different levels of well-being in later life, different expectations about retirement, and different expectations about family responsibilities, including care receipt and delivery.

Another important insight offered in the social demographic literature relates to the understanding that any comparison of groups in later life is necessarily a comparison of survivors. A well-developed picture of this process occurs in the research literature on mortality differences by race, as depicted by the so-called "crossover effect." Crossover effects have been documented most extensively for African American populations compared to non-Hispanic white populations, but have been identified for Native American and other groups as well (e.g., Hummer et al. 2004). Social demographers have described extensively the risks to mortality posed by social and economic disadvantage, disadvantages that frequently are more concentrated in minority populations. As a result of these risks, for example, African Americans are more likely than whites to die at virtually every age. Some evidence suggests that survivorship rates may reverse or "crossover" in later life, at which point the risk of dying for African Americans (and, in some studies, for other groups with a history of disadvantage) drops below the mortality risk for more privileged groups (Eberstein et al. 2008). The extent to which this "crossover" is the result of selective survival, or alternatively, reflective of poor data quality, has not been resolved entirely. Because of this selectivity effect, comparisons of some minority groups to the majority group may be biased because only the healthiest minority group members survive. This is one reason why data are needed that cover long periods of the life course.

The principle of selectivity is reflected also in populations that are heavily shaped by immigration, such as among the Hispanic and Asian populations. Unlike the African American population, immigrant populations appear to have lower morbidity (for some conditions) and mortality risk than their non-Hispanic and white counterparts across the life course. To some extent, characteristics of the immigrant segments of these populations are affected by positive selection, a process by which the more advantaged segments of a population are more likely to migrate to the U.S. – particularly, those with the most to gain by moving. Inasmuch as good health and other forms of highly valued capital may be a prerequisite to initiating and benefitting from an international move, Hispanics and Asians who migrate to the U.S. may be more healthy and less likely to die than their U.S.-born, white counterparts (the "healthy immigrant" effect; see discussion in Mutchler et al. 2007b). Moreover, immigrants who experience declines in health or the onset of disabilities may choose to engage in reverse migration (the "salmon effect"); leaving behind in the U.S. their counterparts who are in better health, and who have a lower risk of dying (see discussion in Markides and Eschbach 2005 and Turra and Elo 2008). The research literature indicates that in some cases, healthy lifestyles among immigrant populations that are influenced by cultural practices (e.g., healthy nutrition behaviors) may contribute to relatively high levels of health and survivorship; however, these lifestyle advantages may erode with time (e.g., Frisbie et al. 2001).

A central insight offered by social demographers is that when segments of the older population are compared with respect to their well-being only in later life, what is observed is behavior that may be related to differential survivorship rates across race and ethnic groups (Lynch 2003; Shuey and Willson 2008). Because so many older minority group members are also immigrants, the well-being of race and ethnic populations is conditioned by processes of mortality *and* immigration, both of which are selective with respect to who survives to a given age.

Double Jeopardy Perspective

Among the sociological perspectives focusing explicitly on the intersection of age and race, ideas relating to double jeopardy are perhaps the most often referenced in the research literature. The general concept of double jeopardy has been widely used throughout the social, behavioral, and medical sciences to describe how two factors interact to influence a wide range of outcomes. In the sociological treatment of age and race, double jeopardy suggests that these characteristics combine to create a "double disadvantage" for aging members of minority groups (Dowd and Bengtson 1978). Among the individual characteristics examined with respect to the double jeopardy thesis are income, social interaction and engagement, health status, life satisfaction, and mortality (e.g., Dilworth-Anderson et al. 2002; Lynch 2008; Markides and Mindel 1987). The hypothesis holds that the disadvantage associated with being a member of a race or ethnic minority group increases with age; as a result, longitudinal data are required to adequately test this hypothesis (Ferraro and Farmer 1996). The double jeopardy concept offers a convenient, but largely descriptive way of summarizing expectations for widening gaps between minority and majority groups in later life. Racism and ageism are implied as the causal mechanisms for these expanding inequalities. The possibility of a triple jeopardy effect, based on gender and undergirded by sexism, has also been forwarded (Ferraro and Farmer 1996).

The double jeopardy perspective, as applied by sociologists interested in aging, often does not acknowledge the considerable heterogeneity within specific race and ethnic groups. For example, the African American aging experience is different from the experience of black persons from the Caribbean (e.g., Taylor et al. 2007) and the experience of aging is different when comparing Korean and Chinese elders (the Chinese group is further differentiated by persons whose background may be from the People's Republic of China or from Taiwan; Mui and Shibusawa 2008). The predictive

power of the double jeopardy hypothesis, as well as any other perspective that does not account for this heterogeneity, is thus limited.

An alternative to the double jeopardy perspective is the age-as-leveler perspective (Dowd and Bengtson 1978). Mixed support in the research literature has been generated for this hypothesis, which proposes that race and ethnic group gaps in critical dimensions of well-being decline with age (e.g., Herd 2006; Kim and Miech 2009; Willson et al. 2007). Strong evidence has been offered in support of a "persistent inequality" thesis, at least with respect to health (Ferraro and Farmer 1996). However, it is likely that race and ethnic group differences in survival rates and income security would be even larger if not for selectivity in the mortality experiences of members of minority groups, return migration of less healthy immigrants, and the social insurance policies of the federal, state, and local governments aimed at older Americans (e.g., Social Security, Medicare, Supplemental Security Income, Medicaid).

Cumulative Advantage and Disadvantage

The underlying premises of the double jeopardy and age-as-leveler hypotheses are expanded within the more fully developed cumulative advantage–disadvantage perspective. This concept has also been applied to a wide variety of issues within sociology, as well as economics, psychology, epidemiology, and criminology. A central hypothesis derived from this framework holds that over the life course, *initial inequalities* – in financial resources, in health, in social status, in educational opportunity, and in other dimensions of well-being – are heightened. Disadvantages experienced in childhood or young adulthood are accentuated, while advantages experienced by members of privileged groups multiply. Scientific evidence suggests that accumulated advantages and disadvantages are carried into old age, resulting in a persistently high level of economic inequality among those 65 years old and over (e.g., Crystal et al. 1992; Dannefer 2003; Henretta and Campbell 1976; O'Rand 1996; Walesmann et al. 2008). The original idea for this perspective flows from Robert Merton's observations surrounding the trajectory of scientists' careers, also known as the "Matthew Effect" (DiPrete and Eirich 2006; Merton 1968). Researchers more often emphasize the intersection of aging and inequality as defined by economic class rather than by race or ethnic status (Dannefer 1987); yet this approach has recently been usefully applied to dimensions of structured inequality in later life as defined by race and ethnic group membership, especially in the area of health (e.g., see Lynch 2008 for an introduction to a special issue of *Research on Aging* on this topic).

On average, members of some race and ethnic groups (most notably, African Americans, Native Americans, and Hispanics) are more likely to be born into families with fewer advantages than are their white counterparts, and they accumulate fewer resources as they age due in part to blocked opportunities for the development of human, financial, and cultural capital, yielding less prosperous outcomes in early adulthood (see Duncan and Brooks-Dunn 1997; McClanahan and Percheski 2008). We know from early seminal research in sociology that the intergenerational transfer of inequality among Americans is jointly determined by class and race (Blau and Duncan 1967). Unequal access to education, employment options, high status and high paying occupations, health care, and enriching life experiences are based at least partly on overt and institutional discrimination and partially on unequal returns to human capital (Leicht 2008). Gaps in the accumulation of wealth and in homeownership levels are also evident across race and ethnic groups (Burr et al. 2010; Sykes 2003), having substantial impacts on income security in later life and placing limits on the intergenerational transfer of wealth.

One advantage of the cumulative advantage/disadvantage thesis, as compared to the double jeopardy hypothesis and the age-as-leveler hypothesis, may be that by explicitly directing attention to

broader stratification processes associated with accumulation of human and other forms of capital (Nee and Sanders 2001), work and career trajectories, and the intergenerational transmission of poverty, it offers opportunities to specify within-group differentiation, while still acknowledging differences between race and ethnic groups as related to important trajectories and outcomes (Leicht 2008). For example, race and ethnic group membership shapes the values attached to (or benefit received from) important cultural characteristics such as family ties and other culturally defined conditions such as gender roles (O'Rand 1996). Further, a systematic devaluation or discounting of the human capital held by some race and ethnic groups (including immigrants), coupled with inflated valuation of human capital held by dominant groups, may over time be reflected in diverging patterns of well-being in later life consistent with the cumulative advantage/disadvantage hypothesis. Notably, processes of cumulative advantage/disadvantage are expected to result in divergence within racial and ethnic groups as well. African Americans, Latinos, or others who achieve early accomplishments through obtaining access to higher education, building a business within an ethnic enclave or elsewhere, or embarking on a promising career ladder, would be expected to reap higher levels of asset accumulation throughout their lifetimes, with enhanced well-being in later life an expected result.

Our reading of the empirical literature identifies a common issue in findings from research on late-life social group diversity on a variety of dimensions (e.g., living arrangements, income, and health). It is often the case that these differences remain statistically significant even after controlling for the factors believed to underlie these differences (e.g., Shuey and Willson 2008). Researchers typically identify methodological limitations in their research designs as being responsible for this outcome, including poor measurement, small samples and limited time frames of observation. Another limitation that is both related to research design and conceptual development in the field is the impact of unobserved variables (e.g., cultural and community variables).

Cultural Distinctiveness and Assimilation

One way to address the issue posed above is to expand our theoretical models by including explicitly in research projects the concepts of cultural distinctiveness and assimilation. A large scientific literature dating back many decades highlights the *cultural distinctiveness* of ethnic and race groups (e.g., Cox 1948). Members of social groups share a cultural heritage, often reflected in religious practices and beliefs, language, value systems, and norms; these differences distinguish them from the majority group and should shape aging experiences and behavior in distinctive ways.

The assimilation perspective (Gordon 1964) holds that over time, and with increased involvement in the broader society and culture, this distinctiveness will disappear. Whether in fact cultural distinctiveness disappears or evolves in form and significance are topics of considerable debate (e.g., Alba and Nee 1999; Portes and Zhou 1993). Nonetheless, for older members of many ethnic groups, culturally based norms and values may be related to distinct behaviors and expectations that impact social support and social engagement, income security, health and disability, and life satisfaction. For example, researchers find that older African Americans and Hispanics report stronger attitudes about family values than their non-Hispanic white counterparts, and that group variability in intergenerational co-residence is accounted for by these attitudinal characteristics (Burr and Mutchler 1999). Evidence relating to the role of assimilative processes has also been reported showing that the influence of cultural markers (i.e., English language proficiency and duration of residence in the U.S.) on the likelihood of living alone among older Hispanic women diminishes with higher economic status, but does not completely disappear (e.g., Burr and Mutchler 1993).

Life Course Sociology

The life course perspective as applied by sociologists is a central thesis for understanding social aspects of the aging process (e.g., Mortimer and Shanahan 2003). Although falling short of a formalized body of theory (e.g., Mayer 2009; Settersten 2003, 2006), the rich concepts and logic of the life course perspective provide a well-developed foundation for a sociological understanding of the dynamics of the aging process. The life course perspective provides a way to conceptualize the "twists and turns" of an individual's life through a focus on the transitions and trajectories that mark taking on, playing out, and relinquishing roles and statuses (Hagestad 1990).

Changes in roles and statuses are a hallmark of moving into the later years of an individual's life brought on by the relinquishment of work and family roles, the adoption of roles of family patriarch and matriarch, and the eventual acceptance of the retiree status (Weiss 2005). Although each individual's path is somewhat unique and is modified by individual free will and choice (*human agency*), the life course perspective highlights the social forces that influence and lend significance to those individual choices. Each individual's life course is also shaped by those of family members and significant others with whom he or she is linked both inter- and intra-generationally (*interconnected lives*). Features of the broader social structure relating to educational and work organizations, labor markets, and public policies attach significance to the age at which transitions occur (*timing*), the occurrence of transitions relative to one another (*sequence*), and the length of time spent in given statuses (*duration*) (Elder 1985).

Settersten (2006:4) writes that the life course perspective invites attention to "differentiation in aging-related experiences across cohort, sex, *race*, and social class groups, generations within families, and nations" (emphasis added). Lifetime experiences generate life course capital that is shaped by membership in race or ethnic groups. This life course capital is carried into later life, where its significance influences resource, health-related, or social support-related vulnerabilities (O'Rand 2006). Yet attention to differentiation defined by race and ethnic group status has occurred in the late-life life course research literature in a piecemeal fashion rather than as an integrated approach. In fact, in a recent, otherwise comprehensive review of life course sociology, very little attention is paid to race and ethnic group issues (Mayer 2009). One example where these insights are usefully applied relates to the differential accumulation of human capital over the life course. Barriers to obtaining schooling or training associated with race or ethnic group membership filter into the diversity of life-long accumulation of occupational and economic benefits, which have implications for later-life resources in the form of wealth, pensions, Social Security credits, and health (see Walsemann et al. 2008). Thus, the life course approach is linked to some of the central tenets of the cumulative advantage/disadvantage thesis, which in turn is linked to the double jeopardy and age-as-leveler hypotheses.

A more refined appreciation of how race and ethnic group membership among older persons shapes other aspects of the life course is under-developed. For example, the life course perspective attaches significance to the timing and sequencing of events, suggesting that events that occur "off-time" or out of sequence relative to other life course events result in negative consequences (e.g., having children before completing one's education; or retiring from the labor force at an early age due to health or employment discrimination). Yet for some group, distinctive norms may support an alternative sequencing or timing of events. Gibson's (1987) introduction of the "unretired-retired" concept, describing a scenario in which middle-aged African Americans find neither the "retired" nor the "worker" statuses fully available, is an example. Several questions need to be addressed. Are the consequences of off-time transitions consistently negative for older members of specific groups? And, if so, to what extent are these negative consequences enforced by social policies or social institutions that may increasingly be out of step with the way that people live their lives? Continued research combined with conceptual development and theorizing regarding the life course as structured by race and ethnic group status is required, along with a fuller evaluation of the implications of those structures in later life.

Opportunities Ahead

Several emerging frontiers for increasing our understanding of race and ethnic social issues as they relate to aging are identified here. Some of these opportunities involve building on the strengths offered by unique characteristics of the sociological imagination, relating to the importance of social context and specifying dimensions of inequality that are identified with race and ethnic group status. Other opportunities are defined by the ways in which sociologists may advance their contributions to interdisciplinary investigations of aging and diverse populations, investigations that increasingly characterize the study of aging. Methodological issues that represent opportunities for propelling the field forward are also identified, as well as barriers that challenge these efforts.

New Intellectual Frontiers

One active area of sociological study in recent years surrounds the immigrant experience, including the processes and degrees of incorporation of the so-called "new immigrants" into the broader society. Included here are the debates surrounding whether over periods of time the new immigrants will experience levels of assimilation similar to earlier European immigrants or whether they will achieve a kind of segmented assimilation versus various forms of entrenched stratification, highlighted by little progress in residential segregation, income inequality, and so forth. Scholarship on immigrants and immigration offers promise for the sociology of aging, race and ethnicity, representing a potentially rich area of theoretical development that has not yet been systematically incorporated into the discussion. For example, we know much about the residential segregation of younger immigrants but virtually nothing about the implications of this form of spatial segregation for older immigrants. A well-developed literature exists on the implications for working-age immigrants of living in ethnic enclaves (e.g., Logan et al. 2003; Xie and Gough 2009), but little is known about the implications for older immigrants. We have a significant body of research on homeownership, residential crowding, and home values for younger immigrants (e.g., Friedman and Rosenbaum 2004), but little for older immigrants. We also know very little about how the variable nature of reception into the structure of American culture impacts quality of life among immigrant elders.

Sharpening our understanding of how the advantages and disadvantages associated with race and ethnic group membership play out across the life course may yield better insights regarding the differences that we observe in later life, and help us identify appropriate targets of intervention. One step toward this goal may be the continued development of the cumulative advantage and cumulative disadvantage perspective as represented in the cumulative inequality theory offered by Ferraro et al. (2009). Ferraro et al. (2009) conceptualize the implications of linked stratification processes occurring over a lifetime. This approach invites a focus on childhood effects on late-life well-being (e.g., Crosnoe and Elder 2004; Palloni 2006; Warner and Hayward 2006), acknowledges the importance of life-long inequalities, and directs our attention to how the impact of discrimination in its many forms helps to accelerate the aging process among some minority groups; this is sometimes referred to as the "weathering hypothesis" (Geronimus 2001; Taylor 2008).

Useful linkages may also be forged between a more comprehensive theory of life-long inequality over the life course and stress theory (Pearlin 2010). Specifically with respect to race or ethnicity, experiencing chronic discrimination and subtler forms of bias may be a source of stress that yields a cascading trajectory of negative mental and physical health outcomes that last a lifetime (see also Williams 2004). However, some research suggests that African Americans and perhaps some other ethnic groups may be more successful in coping with stress. For example, African American women may more effectively cope with the stress of caregiving – for grandchildren as well as for family members in need of long-term care (Musil and Ahmad 2002; Roff et al. 2004; Sands and

Goldberg-Glen 1998). The way in which racial and ethnic group membership shapes the matrix of exposures to potentially stressful circumstances, as well as the coping behaviors and social capital that may mediate stress response, is a topic for further consideration.

Another promising area is the expansion of theory relating to the importance of community or neighborhood characteristics, coupled with improved methods for analyzing these relationships. Understanding the importance of the connection between individual and social context, a hallmark of life course sociology, may be particularly important when studying race and ethnic differences in health in later life. Thus, increased attention is also usefully directed toward spatial and environmental features that extend beyond one's intimate social network, into the neighborhood, the community, and the service environment. The extent to which differences in behavior or experiences across older members of different race and ethnic groups – such as use of medical services and income supports, or co-residence with younger relatives – are conditioned by features of the communities in which they live (e.g., cost of living, availability of services, transportation options, crime) has not been fully explored (however, see Mutchler and Burr 2003). The availability of methodological tools that permit more robust examinations of these multilevel effects promises to support the expansion of sociological insights relating to macro-level and meso-level influences on micro-level behavior. Recent research using such techniques demonstrates, for example, that both individual and neighborhood SES contribute to differences in self-rated health among older African Americans and whites (Yao and Robert 2008). Similarly, among both Hispanics and Chinese Americans, immigrant ethnic composition of the neighborhood has been shown to be related to health behaviors (specifically, healthier food choices, but less physical activity) (Osypuk et al. 2009).

One area in which sociologists are making substantial contributions to multidisciplinary investigations of aging and diverse populations is in the area of health disparities (Williams 2004). Members of some groups, most notably African Americans and Native Americans, are less likely to survive to old age, and more likely to enter old age in a disabled state than are older whites and Asian Americans (e.g., Goins et al. 2007; Hayward and Heron 1999). The Institute of Medicine concludes that disparities exist in the quality of formal care received by members of ethnic minorities, and suggests that eliminating these disparities will require a multi-dimensional approach that considers providers, patients, and service environments (Smedley et al. 2003). Yet much of the research focus has been on documenting differences in health care and health outcomes, rather than explaining them (LaVeist 2004). Over time, it has become clear that no single discipline can provide a comprehensive understanding of the origin of health disparities relating to race and ethnic group status, nor adequate remedies or interventions.

The biopsychosocial approach to health research highlights the combination of biological, psychological, and social structural influences on well-being in later life; this approach lends itself to the inclusion of race and ethnic group status, immigration, and cultural context (e.g., Bengtson et al. 2009; Berkman et al. 2000). Sociologists have made and will continue to make important contributions to understanding and correcting the modifiable bases of health disparities by highlighting the role that race and ethnic group membership may play in influencing health outcomes, through health behaviors such as diet and exercise, as well as along pathways relating to bias and inequality, such as unequal access to health care and poor interactions with health care providers. We need additional research on how psychological characteristics (e.g., anger, hostility, self-efficacy) and health behaviors and health life styles (e.g., obesity, smoking, alcohol consumption, physical activity) mediate and modify the relationships between race and ethnic group status and a large range of indicators of well-being. Finally, we need to explore and explain how being a member of a minority group is related to so-called "under the skin" biological factors (e.g., immune system and sympathetic nervous system) that impact health and mortality differences. Fortunately, several new data sources are available to help us begin this research journey. An example of a question that needs continued evaluation is whether long-term exposure to racial discrimination impacts the psychological characteristics, health behaviors, and biological functions that lead to disparities in health.

On balance, the literature on race and ethnic issues in aging emphasizes the disadvantages experienced by members of racial and ethnic minority groups, vis-à-vis their non-Hispanic white peers. A more limited literature suggests sources of strength within minority populations, lending new insights to build on in future investigations. Cultural attributes – such as strong religious or spiritual beliefs or healthy behaviors relating to diet or exercise – along with meaningful culturally defined roles may yield measurable advantages to older members of ethnic groups. Resilience, or the capacity to generate well-being despite adversity (Ryff and Singer 2009), may be associated with many cultural beliefs or practices in ways that are not yet understood. For example, some evidence suggests that African Americans may have better mental health than their white counterparts, despite circumstances that would be expected to yield more negative outcomes (Keyes 2009). Specific religious beliefs may not only be more common among some race and ethnic groups, but also have a more positive impact on emotional well-being (Krause 2005).

Cultural meanings associated with being an older person, or playing age-graded roles, may yield benefit to older members of some ethnic groups. The familistic values expressed by members of some ethnic groups, and the resulting support received by many older family members, are frequently highlighted as defining cultural features (Dilworth-Anderson and Burton 1999). Some ethnic groups, such as Native Americans, value grandparents and other older family members as carriers of traditional practices and values, and older individuals may draw great satisfaction from participating in the intergenerational transmission of cultural beliefs (Schweitzer 1999). Yet culturally based behaviors may not always prove beneficial. Although it is well established that older Asians and Latinos are less likely than their non-Hispanic white counterparts to become institutionalized, and more likely to live in intergenerational households (Angel and Hogan 2004; Burr and Mutchler 1993, 2003), some of these individuals may be housed in environments that are inadequately supportive, or in homes in which they are socially isolated or economically dependent (Treas 2008–2009). Although the expectation of intergenerational family support may not always benefit older individuals, familistic norms may prove to be advantageous if policies shift to place more emphasis on "private" sources of support for economic security or for long-term care in later life. Should policy shifts in this direction occur, groups with stronger norms for family-based support may experience unexpected benefits.

Methodological Barriers and Opportunities

As noted above, the development of specific theories focusing on race and ethnic group status and aging processes and outcomes is only beginning. Inductive theory, a common form of theory building in the social sciences, is based on the accumulation of sound information from rigorous exploratory and descriptive studies; to date this approach has yielded some verifiable hypotheses in this area. However, a clearer, comparative portrait of the landscape of aging among ethnic and race groups is limited in part by the shortage of data adequate to test those hypotheses that have emerged. Our strongest conceptual material focuses on processes relating to aging that may take different forms across subgroups, and about processes that occur across decades and even lifetimes. Questions that arise from these frames require longitudinal data spanning many decades (lifetimes would be ideal, but generally are not available) with adequate sample sizes. Key aspects of the aging process are put in motion before old age begins – in the womb, infancy, childhood, early adulthood, or middle age – making clear that long spans of high quality, comprehensive longitudinal data are necessary for methodological as well as theoretical reasons (Lynch 2008). Relatively few longitudinal data sources are available focusing on targeted race or ethnic groups that permit in-depth examination of life course features and cultural characteristics as they relate to life course outcomes and trajectories (the Hispanic Established Populations for the Epidemiologic Studies of the Elderly

is one excellent example, although it does not offer comparative data for other ethnic groups; for a review of the longitudinal data available for life course sociology see Mayer 2009).

One of the best examples of a data source with adequate sample size capturing the U.S. experience is the Health and Retirement Study (HRS; another example is the Panel Study of Income Dynamics). Although the sample size of the HRS is sufficiently large to permit comparisons of non-Hispanic whites and African Americans with Hispanics, for confidentiality reasons the data do not allow for examination of other major racial groups (e.g., Asians; Native Americans) or national-origin groups within Hispanic ethnic categories (e.g., Puerto Ricans, Cubans). The HRS also begins observing its sample members in mid-life, making it more difficult to explore fully the impact of earlier life experiences, although some retrospective questions on childhood experiences are available. Moreover, multi-purpose data sets such as the HRS often do not include sufficient measures of cultural traits, such as reliance on a language other than English; measures of culturally based health beliefs; or indicators of the extent to which social support networks are composed of members of the same ethnic group. Themes highly relevant to immigrant and minority populations, such as how social capital impacts social support in later life, are thus difficult to examine (Angel and Angel 2006a).

Several methodological innovations offer optimism with respect to advancing the field. Of special interest is the broader application of growth curve models that allow for the examination of change over time within and between individuals, and hierarchical models that offer the ability to properly estimate the independent and joint effects of individual level and contextual level factors. Strategies for examining the effects of mortality selection bias are also being implemented. While continuing to look at the main effects of race and ethnic status, it is also necessary to examine more thoroughly the interaction effects of race and ethnic status with other characteristics, such as gender, immigration status, kinship characteristics, economic status, and so forth. The implementation of interaction models is employed with increasing frequency to examine race and ethnic differences in the developmental trajectory of health and disability-related outcomes (Kelley-Moore and Ferraro 2004; Shuey and Willson 2008; Yang and Lee 2010).

Social Origins and Consequences

The intersection of race, ethnicity, and aging provides an especially fertile area for observing the implications of social processes. Two areas of particular strength in the sociological approach – attention to the importance of structural or contextual influences on individual behavior and experiences, and a focus on the forces that produce inequality across social groups – are especially relevant. At this intersection, social processes related to group membership, intergroup relations, environmental settings, and access to opportunities and resources converge.

Settersten (2006) has issued a call for bringing "the social" back into the study of the sociology of aging and social gerontology. We agree that a greater focus on the life course provides a vehicle for achieving this goal. For this to be beneficial in the area of race, ethnicity, and aging, the conceptualization of the life course must be broadened and must be flexible. We need to identify places in the life course where race, ethnicity, and culture matter the most, and to explore the social forces at work in those areas that result in different consequences for members of different groups. Moreover, we need to understand the points at which forces relating to inequality and discrimination intersect with the life course, and in fact shape the life course, having life-long implications. It is likely that remedies for many of the problems experienced in later life will be found in interventions occurring much earlier in the life course.

Several challenges must be overcome to ensure the accomplishment of this goal. One of the challenges relates to the sometimes competing goals of theoretical breadth and the acknowledgement of

meaningful differences among cultural groups. The descriptive literature on diversity in aging is replete with studies that target particular race or ethnic groups quite narrowly, often in specific, local contexts. Even among theoretically motivated studies relating to culture and process, difficulties in obtaining data and lack of consensus surrounding the measurement of key constructs relating to cultural beliefs and ethnic identity prevent the investigation of large-scale questions that span subgroups. To be both relevant and theoretically informative, our thinking about race and ethnic dimensions of aging needs to reflect aspects of the "particular" (e.g., of culturally based beliefs associated with specific race or ethnic groups) while also informing conceptual themes that span subgroups, such as those relating to discrimination, linguistic barriers, or other commonly shared experiences.

An emerging issue that makes this all the more challenging, yet timely, relates to the theme of multiple race and ethnic group identities. A number of familiar data collections now include opportunities for respondents to report more than one race (e.g., in the U.S. Census and other federal data). This provides researchers with both challenges and opportunities. Although multiple race group identification has been invited in the Census Bureau data collections since the 2000 Census, a relatively small share of the population actually reports multiple races (U.S. Bureau of the Census 2009). In the 2008 American Community Survey, just over 2% of the population reported two or more races, but the percentage doing so differs substantially by age. Whereas 4.6% of children under the age of 18 are reported as having two or more races, less than 1% of adults 65 and over report multi-racial identities. Although the source of this age difference remains unclear, it is likely that it reflects increasing levels of inter-racial coupling as well as a higher acceptance of multiple racial identities among younger cohorts. The multiple race issue is far more important for some racial groups than for others. For example, the size of the American Indian and Alaska Native (AIAN) population for all ages combined reporting a single race is 2.4 million, but this increases by almost double to 4.7 million when those reporting AIAN in combination with another race are also included (U.S. Bureau of the Census 2009). Because the behavior of individuals reporting AIAN only may differ in meaningful ways from those reporting AIAN in combination with another race (e.g., Mutchler et al. 2007a), the evolving measurement of race and ethnic group membership promises to challenge continued efforts to strengthen our understanding of diversity in later life. Both the shrinking share of the older population that is non-Hispanic white and increases in the population reporting multiple racial and ethnic identities suggest that the significance of ethnic identity for social and economic experiences throughout the life course is likely to evolve in coming decades.

Policy Implications

The expanding diversity of the older population will have implications for virtually every aspect of social policy (Angel and Torres-Gill 2010). Differences among older members of racial and ethnic groups are well described in the literature: in terms of their financial resources (such as Social Security credits, pensions, and wealth), their family configurations (including partner status, coresident household members, and number and geographic proximity of children), and their levels of health and disability. Sociological insights yielding better understandings of the sources and scope of these differences are valuable in building better and more comprehensive social policy. As well, a better understanding of the needs, preferences and goals of the full complement of the expanding older population, rather than just segments of it, will provide important bases for evaluating the success of policies in development.

The major public programs targeting the older population (Social Security, Medicare, and Medicaid) will be heavily stressed in the coming decades as the absolute numbers of individuals entering those systems increases dramatically and as federal and state governments wrestle with mounting debt and competing priorities. As the financing difficulties associated with these programs

become even more pressing, there is a strong likelihood that continuation of benefits in their current form will be challenged. Because minority populations – especially African Americans and Hispanics – are reliant on these programs more than the white majority, they are likely to be most strongly affected by program modifications (Burr et al. 2010). Higher risk of employment instability and disability among middle-aged and older minority workers means that these individuals may be most inclined to leave the labor force early; but with the increasing age at which full eligibility for Social Security occurs – people born at the peak of the baby boom in 1957 cannot retire with full Social Security benefits until age 66.5 years, and those born in 1960 or later are not eligible for full benefits until age 67 (Social Security Administration 2009) – this may impose financial disadvantages on members of minority groups. For older workers with chronic disease and disability, an extended work life is unlikely to be a realistic solution to late-life economic shortfalls. Anticipated demographic shifts make it likely that the absolute size of the groups who could most benefit from needs-based transfer programs such as SSI and Medicaid will increase just at a time when policy makers and some members of the general public will be inclined to reduce these programs or shift the burden to families or the private sector (Wilmoth and Longino 2006). These changes may challenge the pact between generations that formed the basis for developing these programs (Angel and Angel 2006b).

Summary

Although scholars have been interested in race and ethnic issues as they relate to the older population for several decades, the development of concepts and especially theory that would help guide research in these important areas is limited. We believe that useful inroads may be made by blending existing conceptual frameworks such as cumulative advantage and the life course, as well as by reflecting on how cultural features of ethnic groups intersect with broad theoretical ideas such as the stress process, resilience, and adaptation. Longitudinal examinations drawing out the elements of well-being that are structured by race and ethnicity not only will inform our understanding of late-life disparities in health, social support, and economic security, but will also yield insight to the ways in which macro-level social forces shape outcomes over the life course more generally. A great deal can be learned about how social processes and policies have differential effects, and how advantages and disadvantages impact the life course and well-being outcomes, by examining race and ethnic issues relating to aging.

Yet it is likely that historical advantages, and disadvantages, attached to racial and ethnic group membership will shift over time. “Majority–minority” communities are becoming increasingly common (Frey 2006), and attracting racially diverse and immigrant populations is increasingly viewed as essential to the continued vitality of some areas (Myers 2007). The advantages historically experienced by non-Hispanic whites may erode when that group is no longer numerically in the majority. However, should the significance of racial or ethnic group membership for later-life well-being become more limited in the future, it is likely to take multiple generations to be realized. Sizable disparities in education, earnings, household income, and asset accumulation, especially among African Americans and Hispanics, are evident among Baby Boomers and are likely to persist in later life (Mutchler and Burr 2008). Gains for some segments of the minority population – in the form of rising economic well-being and movement into the middle class – may be countered by losses in other areas, such as engaging in poorer health behaviors or increased alienation from valued roles and identities. Whether the gradual improvements in life circumstances experienced by segments of the racial and ethnic minority population will ultimately result in a lessening of minority group-based inequality, or just expanded heterogeneity within ethnic groups, remains to be seen (Angel and Torres-Gil 2010).

We anticipate that the sociological literature on race, ethnicity, and aging will look quite different in the coming decades. Shifting demographics will yield a U.S. population that is older and that includes more persons of color; but for now, these processes are occurring at opposite ends of the age distribution. For some time, the non-Hispanic white population will be far older than the African American, Latino, and Asian populations, on average, giving rise to potentially challenging political debates about public funding for education (which will disproportionately benefit populations of color, who are younger) as well as for Social Security and other old-age programs (which disproportionately benefit white populations, who are older) (Angel and Torres-Gil 2010; Myers 2007). Within a few decades, however, the racial and ethnic diversity that currently characterizes the younger population will be realized in the older population as well. The significance of this demographic shift for reshaping what we know about aging and aging policy will ultimately depend on the extent to which the interests are shaped more heavily by age, by racial and ethnic group membership, or by some unique combination of these two aspects of identity. As non-Hispanic whites become a proportionally smaller share of the total older population, will their "majority group" identity become more solidified, or more diffused? Will older Hispanics perceive more affinity among younger Latinos, or among their older, non-Latino peers when choosing among programs to support? When choosing between public schools and senior centers in public funding decisions, how will more diverse older populations weight the value attached to each option? If in the future the older population is to successfully secure public support for programs and services that it values, common ground must be identified that transcends race and ethnicity, and that respects the "intergenerational social contract" (Myers 2007) linking well-being across cohorts and ethnic groups.

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Chapter 7
Immigration, Aging, and Health in the United States

Kyriakos S. Markides and Kerstin Gerst

Given the rising numbers of immigrants to the United States, in recent decades there has been increasing interest in better understanding the health status and the health care needs of immigrants and how they impact the host societies' health and social service systems. Recent evidence has suggested the existence of a health advantage among immigrants, especially those from non-western origins, which has challenged our previous and often stereotypical notions regarding immigrants from poor countries. Early research in North America was almost exclusively focused on the negative impact of immigration on mental health (Malzberg 1967). The negative aspects of immigration were also the dominant theme of early studies in Europe (Friis et al. 1998). It is now commonly assumed that early research was often culturally biased, methodologically weak, and based on small numbers of immigrants (Friis et al. 1998; Markides 2001).

Recent studies, which include adequate numbers of immigrants and employ better study designs, provide compelling evidence that most immigrants to the United States and other western societies enjoy a health advantage. Below we focus on the health of immigrants to the United States, how their health changes over time, and we examine evidence regarding the association between aging and the health of immigrants. Since the majority of immigrants to the United States are from Mexico and Latin America, we give them particular attention. There has also been currently increasing interest in the health of immigrants of Asian origins, but studies of the influence of aging on health in such populations are lacking. Because of problems inherent in early research, we are unable to identify significant cohort differences in the impact of immigration on health. Although we may be unable to identify cohort differences in the health of immigrants, the volume of immigration is so much higher than it was just a few decades ago so that the impact of immigration on the overall health status of Americans as well as its impact on the health care system is considerably higher now.

Explanations of the health advantages of immigrants have focused on several major factors, including migration selection, return migration of less healthy people or "salmon bias," strong families and social networks, and better health behaviors. Some time ago Friis et al. (1998) proposed that the association between migration and health can be approached using the "stress-illness" model where immigration is a major life event conceptualized as a source of stress. At the same time, the process of acculturation into the host society can be a stressful experience that can impact physical and mental health. As immigrants become more acculturated and assimilated into the larger society, the level of stress they experience and its impact on health are reduced. It has also been suggested that immigrants arriving later in life often become linguistically and culturally isolated as

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their children become more acculturated into the large society, often leading to intergenerational frictions (Markides and Black 1995).

While immigrants arrive with better health status than the native-born, they appear to experience a convergence to native-born health status levels with time in the United States, and these health advantages disappear by the next generation. Reasons for convergence have focused on worsening health behaviors resulting from the stresses of acculturation (Friis et al. 1998), or "unhealthy assimilation," or the adoption of unhealthy behaviors (Antecol and Bedard 2006). With respect to the worsening of health status into old age, there has been some focus on the influence of physical labor over a life time accompanied by substandard medical care (Markides et al. 2008–2009), as well as on the impact of cumulative social and economic disadvantages over the life course (Wakabayashi 2009).

Below we review recent evidence regarding the health status of immigrants to the United States and evaluate the viability of explanations offered in the literature. We focus on major health status indicators such as mortality and chronic diseases and disabilities. We also examine how the health of immigrants changes with age and time in the United States. Special focus is given to the Hispanic population especially Mexican Americans on whom adequate data are available. We also refer to research in Canada and Australia which corroborates research findings in the United States.

Overview of Immigration Trends

Current international migration levels are at an all-time high, with 175 million persons (about 3% of the world's population) residing in a country that they were not born in (United Nations 2002; Jackson and Howe 2008). Most advanced western societies are receiving increasing numbers of immigrants, many of whom are arriving from nonwestern countries (Markides et al. 2008–2009). While immigrants tend to be relatively young, their large numbers will assure rising numbers of foreign-born older people who may have special health concerns. The United States, Canada, and Australia have been the three major immigrant destinations where most immigrants have gone and stayed, unlike some other European nations where return migration to the country of origin is common. In 2006, the United States received 1.2 million immigrants, Canada 250,000, and Australia 125,000 (Martin and Zürcher 2008). Although Canada and the United States make up only approximately 5% of the worlds' population, these two countries receive over half of the world's immigrants (Martin and Zürcher 2008).

In 2008, the United States had nearly 38 million persons that were foreign born (12.5% of the total populations), of whom approximately 12.3% were aged 65 years and older (Migration Policy Institute 2010). The immigration patterns to the United States have shifted dramatically in recent decades. Whereas immigrants used to be predominantly from Europe, increasing numbers are arriving from Latin America and Asia. In 1960, 75% of all immigrants to the United States were from Europe, less than 10% were from Latin America, and only 5% came from Asia. This is in stark contrast to 2008, where only 13% of immigrants were from Europe, over half (53.1%) were from Latin America, and 27.3% came from Asia (Migration Policy Institute 2010).

Mortality and Life Expectancy

A great deal of attention has been given recently to mortality and life expectancy among ethnic and minority populations in the United States. This literature has consistently shown higher mortality rates among African Americans at every age except at very advanced ages, typically 85 or 90 years and older when African Americans appear to have lower mortality rates than non-Hispanic whites.

The black/white mortality crossover has been controversial primarily because of questions about the quality of data for African Americans at advanced ages. Others feel that the crossover is real and can be explained in terms of greater selective survival among African Americans (Markides and Black 1995; Manton and Stallard 1997). That is, the few African Americans that survive to very advanced ages are "hardier" and experience lower mortality rates than non-Hispanic whites of the same age. A relatively new phenomenon has been the attention to the recent increase of foreign-born African Americans who appear to have quite favorable mortality rates. Favorable rates have been attributed primarily to immigrant selection forces including good health and good healthy behaviors (Hummer et al. 1999; Singh and Hiatt 2006).

The overall mortality disadvantage of African Americans has been attributed to socioeconomic forces including low education, low financial resources, as well as the stresses associated with racial prejudice and discrimination. In contrast, the negative effects of such socioeconomic forces have not translated into poorer health and mortality among most Hispanic/Latino populations who now together constitute the largest minority population in the United States at around 48 million. Some 25 years ago Markides and Coreil (1986) proposed an "epidemiological paradox" with respect to the health and mortality situation of Southwestern Hispanics who were overwhelmingly of Mexican origin. Data from around 1980 suggested that mortality rates for Southwestern Hispanics were similar to those of the non-Hispanic white population and were considerably lower than mortality rates of African Americans with whom they shared similar socioeconomic circumstances. This seemed paradoxical at that time because of the high rates of poverty among Mexican Americans and most other Hispanics given the established association between poverty and socioeconomic status with health and mortality. There were other risk factors that made similar mortality rates paradoxical including high rates of obesity, diabetes, and sedentary life styles among Mexican Americans especially at older ages. Mexican Americans had lower mortality rates from cardiovascular diseases and major cancers, especially among men. Explanations suggested included strong family supports, certain cultural practices, and health selective immigration. Hispanics were disadvantaged on certain health factors including diabetes and infectious and parasitic diseases (see also Hays-Bautista 1992; Vega and Amaro 1994), but overall they were in relatively good health.

By the 1990s, studies began showing a mortality advantage among Mexican Americans and other Hispanic groups. Puerto Ricans living on the mainland were an exception. The literature commonly referred to the epidemiological paradox as the "Hispanic Paradox" or "Latino Paradox." Franzini et al. (2001) performed a review of the literature over a 20-year period and concluded that the mortality advantage was most pronounced among infants and among older people. They suggested that the paradox might be explained by problems with vital statistics data, a healthy immigrant effect, and a "salmon bias," or return migration to Mexico by less healthy older people. They concluded that these three factors may explain part but not all of the mortality advantage. Abraido-Lanza et al. (1999) employed data from the National Longitudinal Mortality Study and found evidence of salmon bias. However it was too small to account for the mortality advantage. One study using the National Health Interview Survey – Multiple Cause of Death (NHIS-MCD) data set found evidence of selective outmigration of unhealthy Mexican Americans and argued that indeed such salmon bias explains the Mexican American mortality advantage (Palloni and Arias 2004). However, questions about limitations of the NHIS sample cautioned against such definitive conclusions (Markides and Eschbach 2005, 2011).

Hummer et al. (2007) examined a potential salmon bias in infancy. They employed data from the United States birth and infant death cohort files from 1995 to 2000 and found that death rates for infants born to Mexican immigrant women were approximately 10% lower than for infants born to non-Hispanic white U.S.-born women or to U.S.-born Mexican origin women. The large sample yielded stable rates for the first hour of life, first day, and first week. The authors concluded that favorable rates so early in life were unlikely to result from outmigration of immigrant women and their infants.

Perhaps the most definitive test of the salmon bias in old age was performed by Turra and Elo (2008) using data from the Master Beneficiary Record and the NUDIMENT data files of the Social Security Administration. They found higher mortality rates among foreign-born Hispanic beneficiaries living abroad than foreign-born beneficiaries living in the United States. At the same time, a significant number of older Hispanics living outside the United States appear to return to the United States when their health worsens and thus have high mortality rates. The authors note that the influence of salmon bias on Hispanic death rates in the United States is partially offset by the high mortality rates of Hispanic emigrants who return to the United States. They conclude that indeed a salmon bias exists but it is too small to account for the Hispanic mortality advantage (see, also, Abraido-Lanza et al. 1999).

Earlier we noted limitations of the NHIS-MCD data used by Palloni and Arias (2004). An enlarged public use file that included more years of survey from 1986 through 2000, with mortality follow-up through 2002 has recently become available. Borrell and Crawford (2009) used the data and found evidence corroborating earlier findings of low mortality among Hispanics. As in previous reports much of the advantage occurs in old age with findings being inconsistent at ages 25–44 regardless of nativity. As in previous studies Puerto Ricans had higher death rates than other Hispanic groups.

Eschbach et al. (2007) used vital registration data from Texas and California for 1999–2001 linked to 2000 Census population data to examine mortality at younger ages, namely at ages 15–44. Data presented by 5-year age groups showed a mortality advantage among foreign-born Hispanics of both genders relative to non-Hispanic whites. Among men the majority of the immigrant advantage was due to lower suicide rates and lower substance abuse (other than alcohol) than among non-Hispanic whites. At the same time, U.S.-born Hispanic men had higher death rates than non-Hispanic white men from both social and behavioral causes and chronic diseases. Social and behavioral causes were related to HIV and other sexually transmitted diseases, substance abuse, alcohol, and homicide. Female Hispanic immigrant advantages over non-Hispanic white women were attributable to social and behavioral causes but also to mortality from circulatory disease and major cancers. U.S.-born Hispanic women had higher death rates from homicide, HIV, and infectious and parasitic diseases than non-Hispanic white women and lower death rates from suicide, substance abuse, and unintentional accidents. No differences were observed with respect to chronic disease mortality. The authors concluded that the Hispanic mortality paradox at younger ages is primarily an immigrant phenomenon.

The inconsistency between these findings and those based on the NDI linkage discussed above (Borrell and Crawford 2009) may be related to the accumulation of mortality over many years in the latter and thus the inability of such studies to be responsive to period effects. For example, recent rates of homicide mortality and motor vehicle accidents showed greater declines among Hispanics than among non-Hispanic whites in Texas. Now younger Hispanics regardless of nativity have lower mortality from motor vehicle accidents a reversal from earlier patterns (Markides and Eschbach 2011).

The immigrant mortality advantage in the United States is also present in other immigrant populations (see Jasso et al. 2004; Singh and Siahpush 2002; Singh and Hiatt 2006; Cunningham et al. 2008). There is an overall significant immigrant advantage which may have increased in recent years from 2.3 years in life expectancy in 1979–1981 (76.2 vs. 73.9 years) to 3.4 years in 1991–2001 (80.9 vs. 76.6 years) (Singh and Hiatt). In 1999–2001, immigrants had significantly lower mortality from lung and esophageal cancer, COPD, HIV/AIDS, and suicide, but higher mortality from stomach and liver cancer. Among women estimated life expectancy at birth was the highest among U.S.-born Asian/Pacific Islanders (86.0 years), followed by immigrant Asian/Pacific Islanders (85.0 years), and Hispanic immigrant women (84.1 years). Among men Asian/Pacific Islanders had the highest life expectancy (80.7 years), followed by Hispanic immigrants (79.0), followed by U.S.-born Asian/Pacific Islanders (78.9), and by non-Hispanic white and black immigrants (both at 75.6). For each ethnic origin, there was an immigrant advantage (except for Asian/Pacific Islander women) which likely reflects compositional differences. This is especially the case at older ages

wherein immigrants are increasingly Filipino and Vietnamese while a substantial percent of the native born are of Japanese origin (see, also, Markides et al. 2007). Singh and Hiatt (2006) note that the largest nativity advantages were among blacks and Hispanics for both men and women. They attributed the immigrant advantage to health selection and better health behaviors including smoking and obesity, as well as lower chronic disease prevalence.

The large mortality advantages of Asian/Pacific Islanders led Lauderdale and Kestenbaum (2002) to suggest that very low mortality rates may very well be the result of healthy immigrant selection and relatively high socioeconomic status. At the same time, they raised the possibility that the rates may be understated because of underreporting of Asian/Pacific Islander race on death certificates. They employed the Master Beneficiary Record of the Social Security Administration as well as the NUDIMENT data files discussed earlier which avoid problems of misclassification of ethnicity. Elderly Asian Americans from six ethnic origins – Chinese, Filipinos, Indian, Japanese, Korean, and Vietnamese – were estimated to have lower death rates than those computed for elderly non-Hispanic whites. They raised the question of whether a "healthy immigrant" effect might account for the Asian mortality advantages but found inconsistent results. One issue is that older people of some Asian origins (Vietnamese, Filipino, Korean, and Indian) are overwhelmingly foreign born, so that meaningful comparisons with their native-born counterparts are not possible. As suggested earlier, comparing native-born and foreign-born mortality rates for all Asian origin groups lumped together is not advisable because of ethnic compositional differences between elderly foreign-born and native-born Asian Americans.

Physical Health and Disability

Much of the literature in the United States shows that most immigrants arrive with better health than native-born populations and experience lower mortality rates. Their health status appears to converge to native levels over time with any health advantages disappearing in the next generation. It has been suggested that such convergence might reflect improved access to health care, which can lead to increased diagnosis of preexisting conditions (Antecol and Bedard 2006; Jasso et al. 2004) thus leading to reduced reported health status. Data from Canada do not support this hypothesis. McDonald and Kennedy (2004) suggested that an observed convergence in Canada reflects actual convergence in physical health rather than a convergence in screening and diagnosis of existing health problems. They base this conclusion on data showing that immigrants' use of health care services converges with native-born levels faster than health outcomes do. An assimilation hypothesis suggests that since with time income and employment rates increase and at some point converge to native levels, one could predict that the health status of immigrants would improve (Antecol and Bedard 2006; Jasso et al. 2004; Sorlie et al. 1993). However, the evidence is that the opposite takes place with immigrants becoming less healthy with time in the country (Antecol and Bedard 2006; Cunningham et al. 2008; Cho et al. 2004; Stephen et al. 1994).

Explanations of such convergence have focused primarily on changes in health behaviors associated with increasing acculturation into the host society, including higher rates of smoking, changes in diet, and increasing rates of obesity (Cunningham et al. 2008; Markides 2001; Stephen et al. 1994). In fact obesity might be the central mechanism through which length of time since immigration leads to worsening health. Antecol and Bedard (2006) used data from National Health Interview Survey (NHIS) for 1989–1996 and found that male and female immigrants enter the United States with lower body mass index (BMI) levels than native-born men and women. They estimate that the BMI's of foreign-born women almost completely converge to native-born levels within 10 years while men close about one-third of the gap within 15 years. However, the convergence among females appears to be largely driven by Hispanics. There is also a convergence among Hispanic

males, but only with respect to overweight and not with respect to obesity (BMI 30+). Interestingly, black immigrants do not appear to converge to native BMI levels. These patterns appear to mirror those for health conditions, self-reported health, and activity limitations. Again the conclusion is that most of the convergence in BMI and overall health appears to take place among Hispanic immigrants. Importantly, most immigrants entering the United States in recent decades have come from Latin America, especially Mexico.

Huh et al. (2008) examined nativity differences in chronic conditions and other health indicators among Asian and Hispanic populations in the United States using NHIS data from 2000 to 2001. As expected foreign-born persons reported fewer chronic conditions (hypertension, asthma, heart disease, cancer, and diabetes) than U.S.-born non-Hispanic whites. They also found evidence that the initial health advantage of immigrants diminishes over time suggesting possible adverse effects of acculturation into American society. Frisbie et al. (2001) reached similar conclusions using data from the 1992–1995 NHIS. They found that immigrant health advantages were greatest for the first 5 years since immigration had declined consistently with time in the United States. The evidence was not uniformly positive in that Vietnamese immigrants had less than average health. It is possible that since Vietnamese-origin immigrants to the United States were mostly refugees, they were not subject to the same barriers as other immigrants.

Huh et al. (2008) caution that nativity is a crude indicator and may not fully capture the complexity of the acculturation process. While both Hispanic and Asian immigrants reported better physical health, they nevertheless were more likely to rate their health as being poorer than did non-Hispanic whites. This was especially so among Asian immigrants. While such a finding may suggest greater negative consequences of poor health among certain ethnic groups (Markides and Black 1995), it also cautions against relying only on self-rated health to study health disparities, which is often the case in the literature. Self-ratings of health have been found to be less valid among Hispanic immigrants (Finch et al. 2009) as well as among older Hispanics and African Americans who tend to be health pessimistic (Markides and Black 1995; Markides et al. 1997).

In recent years, there has been interest in understanding health disparities in old age using a cumulative advantage/disadvantage perspective (Crystal and Shea 2002; Dannefer 2003; O'Rand and Hamil-Luker 2005). Health advantages/disadvantages in old age are thought to result from accumulation of stressors over the life course. It has been found, for example, that the experience of economic strains early in life is associated with higher levels of disability, prevalence of serious medical conditions, depression, and poorer general health in later life (Kahn and Pearlin 2006; Lynch et al. 1997; Wakabayashi 2009). Conversely, it has also been found that people of high socioeconomic status are less likely to experience disability and morbidity as they age than persons of lower socioeconomic status (House et al. 1990, 1994). Thus, differences in socioeconomic status and economic and other stressors over the life course may explain poor health outcomes in old age in relatively long-living immigrant and ethnic populations such as Hispanics (Markides et al. 2008–2009).

Wakabayashi (2009) examined the viability of cumulative disadvantage/advantage theory to understand the health trajectories of immigrants using data from the Health and Retirement Study (HRS) for 1996, 1998, 2000, 2002, 2004, and 2006. She found that women immigrating after the age of 34 were more likely to have poor health trajectories with respect to limitations in activities of daily living possibly because they had less time to accumulate financial resources which would be protective of health in late life. More specifically it was Hispanic men and women regardless of age at immigration who experienced the most disadvantageous health trajectories with respect to reporting poor health because of limited opportunities to accumulate economic and other resources that would benefit health in late life. Thus, while Hispanic immigrants arrive with a health advantage, they exhibit worsening health profiles relative to non-Hispanic whites with time in the United States, a pattern observed with several large data bases, as we saw earlier. Similar data on health trajectories from middle into old age are not currently available on Asian-origin immigrants.

Trends in the Health of Older Mexican Americans

Of the major immigrant populations there has been more interest in the health of older Mexican Americans. The Hispanic Established Population for the Epidemiological Study of the Elderly (Hispanic EPESE) was launched in 1993–1994 when data were collected on a representative sample of 3,050 Mexican Americans aged 65 and over from the Southwestern United States (Texas, New Mexico, Colorado, Arizona, and California). Subjects have been followed every 2–3 years. By Wave 5 in 2004–2005, there were 1,167 surviving subjects from the original cohort who were then aged 75 and over. A new cohort of 902 Mexican Americans aged 75 years and over was drawn from the same region using similar procedures giving us the opportunity to examine trends in the health of very old Mexican Americans over an 11-year period.

It has been well-documented that the health of older Americans as well as the health of older people in other western societies began showing improvements in the mid-1980s (Crimmins et al. 1997; Manton 2008; Manton and Gu 2001; Freedman et al. 2002; Waidman and Liu 2000; Zunzunequi et al. 2006). This was a reversal from the 1970s and early 1980s, a period when increases in life expectancy were accompanied by increases in morbidity and disability. There is some recent evidence that the declines in old age disability and poor health in the United States may have stopped or may have reversed (Seeman et al. 2010). We have suggested elsewhere that the Mexican American population, much like Latin American and other developing countries' populations, are at a similar point in the epidemiological transition that the more advantaged western populations were in during the 1970s and early 1980s, a period of rising life expectancy accompanied by increases in the prevalence of chronic conditions and disabilities (Markides et al. 2011).

In one analysis using data from the Hispanic EPESE (Beard et al. 2009), we observed a significant increase in the prevalence of self-reported diabetes among Mexican Americans aged 75 years and over. Such an increase was attributed to better management of diabetes in older Mexican Americans and thus increased survival with the disease. Using the same data, we also found slight increases in hypertension prevalence over the 11-year period (Al Ghatrif et al. 2011). There was also a significant increase in awareness and control of hypertension. Our results suggest better management of chronic conditions among older Mexican Americans in recent years and increased survival to advanced ages. Below we examine whether there was also a corresponding increase in disability among Mexican Americans aged 75 years and over during the same time period.

Table 7.1 presents data on trends in disability and other health indicators using data from two cohorts of Mexican Americans aged 75 years and over from the Hispanic EPESE from 1993–1994 to 2004–2005. Bivariate comparisons were made for reporting any ADL disability (toileting, walking across a room, eating, transferring from bed to chair, bathing, and dressing). The table shows that the percent with any ADL disability increased from 20.2 to 29.7% among men and from 21.5 to 41.2% among women. Also shown are significant increases in prevalence of diabetes, hypertension, obesity, and cognitive impairment. The increase in disability can be attributed partly to increases in the prevalence of diabetes and cognitive impairment. No doubt they can also be attributed to increases in life expectancy and in frailty among very old Mexican Americans (Palloni 2007).

Further analysis by nativity status (not shown) showed that immigrant women were significantly less likely to self-report diabetes than were native-born women aged 75 years and over at Wave 5 in 2004–2005. However, immigrant women were more likely to be cognitively impaired using the Mini Mental State Examination (MMSE < 21). No such differences were observed among men. In both genders, both the foreign-born and native-born older Mexican Americans experienced significant increases from 1993–1994 to 2004–2005 in the prevalence of diabetes, obesity, cognitive impairment, and ADL disability. Thus, our data support the hypothesis of increases in morbidity and disability in a relatively disadvantaged population experiencing significant increases in life expectancy.

Table 7.1 Sociodemographic characteristics and prevalence of medical conditions in older Mexican American men and women in 1993–1994 and 2004–2005

	Men		Women	
	1993–1994 (n=470)	2004–2005 (n=371)	1993–1994 (n=662)	2004–2005 (n=531)
Age (mean ± SD)	80.9 ± 5.2	81.3 ± 4.7	81.0 ± 5.0	81.5 ± 5.4
Married	67.50	66.00	25.10	29.80
Chronic diseases				
Hypertension	57.00[a]	66.00	66.80[a]	72.60
Self-reported diabetes	21.30[b]	32.70	21.50[b]	38.10
Self-reported heart attack	14.60	13.40	13.40	10.10
Self-reported stroke	9.60	9.80	10.00	8.30
Self-reported cancer	6.60	8.40	6.80	7.30
Self-reported hip fracture	3.60	4.30	7.30	7.20
Any ADL limitation	19.90[b]	28.80	26.60[b]	42.30
Years of education (mean ± SD)	4.4 ± 3.9	4.9 ± 4.4	4.2 ± 3.7	5.1 ± 4.2
Obesity (BMI ≥ 30 kg/m^2)	17.90	22.40	26.70	28.90

[a] $p < 0.05$
[b] $p < 0.01$

Census Disability Rates for Older Hispanics by Nativity

While the Hispanic EPESE data are interesting and suggest important trends, they are limited only to the Mexican-origin population. A useful resource with data on large samples of older people from all major ethnic groups can be found in the 2000 United States Census. In a recent analysis, we computed disability rates for people 65 and by race/ethnicity and by type of Hispanic origin using the 2000 Census 5% public use micro data sample (PUMS) file, which includes data on approximately 1.8 million Americans aged 65 years and over (Markides et al. 2007). Rates were directly standardized to the total United States population of people aged 65 years and over in 2000 for ages 65–69, 70–74, 75–79, 80–84, 85–89, and 90+.

The 2000 Census obtained data on each person aged 5 years and over in the sampled households on six disabilities items (Stern 2004). Items were (1) *Sensory disability*, defined as blindness, deafness, or a severe vision or hearing impairment; (2) *Physical disability*, defined as a long-lasting condition which substantially limits one or more basic activities; (3) *Mental disability* referred to difficulty in learning, remembering, or concentrating; (4) *Self-Care disability* referred to difficulty in dressing and bathing; (5) *Going outside the home disability* asked about difficulty going outside the home alone to shop or to visit a doctor; (6) *Employment disability* asked about difficulty working at a job or business (persons aged 16 years or older). We used the first five items only and dropped the employment disability item because it has little relevance to most older people.

Our analysis showed that older Native Americans of both genders were the most disabled, followed by African Americans, Hispanics, Asian Americans, and Non-Hispanic whites. Among Hispanic groups, Puerto Ricans were the most disabled followed by those of Dominican origin, those of Mexican origin, and by Cuban, Central, and South American origin groups, the latter three having rather similar rates. As expected, the most favorable rates were for those whose origin was Spain (Markides et al. 2007).

Below we used the PUMS data to compute "any disability" rates (any of the five items) by nativity for major Hispanic groups at ages 65 and over. We had previously hypothesized (Markides et al. 2007, 2008–2009; Markides and Eschbach 2005) that there are likely to be gender differences in migration selection at least in the older generation. The rationale was that men immigrated for

occupational reasons while women more often immigrated to be with their spouses and their families. Thus, one would expect possible health advantages among men but not among women. Figures 7.1 and 7.2 present any disability rates by nativity for men and women, respectively. Rates were computed for Non-Hispanic whites, all Hispanics, and people of Mexican origin. Other Hispanic groups excluded because they were overwhelmingly immigrant in old age were Cubans, Central Americans, South Americans, and Dominicans. Puerto Ricans were also excluded because there are no immigrants among them since all are U.S. citizens. Thus migrating to the United States mainland from the island is not subject to any barriers and thus migration would not be as selective. Figure 7.1 indeed shows a small but noteworthy health advantage of foreign-born men among all Hispanics,

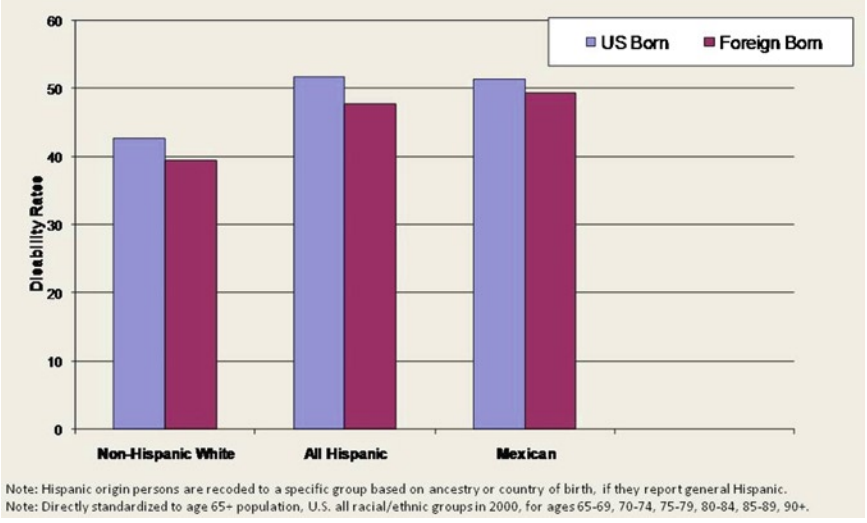

Fig. 7.1 Age-standardized census disability rates (percents) for U.S. born and foreign born males aged 65 years and over by type of Hispanic origin: United States Census, 2000

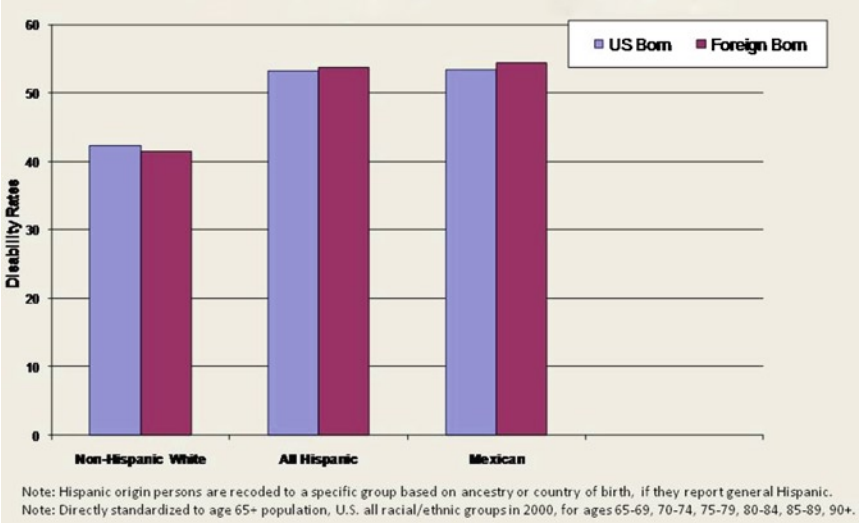

Fig. 7.2 Age-standardized census disability rates (percents) for U.S. born and foreign born females aged 65 years and over by type of Hispanic origin: United States Census, 2000

the Mexican origin, as well as among non-Hispanic whites. Figure 7.2 shows no nativity differences for the three groups giving support to the theory of gender differentials in migration selection in the older generations. Such differences are not thought to exist among younger immigrants in more recent years (Markides et al. 2007).

Conclusion

To summarize, it appears that while immigrants to the United States arrive with relatively good health and health behaviors, their health status appears to converge to native levels, a process that is more rapid among women than among men. A key mechanism of the convergence appears to be obesity. Such convergence is driven primarily by rising obesity rates among Hispanics. By old age Hispanics (and to a lesser extent other immigrants) appear to generally have more health problems than the general population even though they may experience favorable mortality rates. Poorer health can be attributed to a life-time of socioeconomic disadvantages as well as substandard medical care. The data lend support to cumulative disadvantage theory. Analysis of trends in the health of Mexican Americans aged 75 years and over from 1993–1994 to 2004–2005 using data from the Hispanic EPESE shows increases in the prevalence of obesity, diabetes, cognitive impairment, and ADL disability. The data suggest that Mexican Americans, like Latin American and other developing country populations, might be at a similar stage of the epidemiologic transition as were western nations during the 1970s and early 1980s when rising life expectancy was accompanied by increasing health problems and higher rates of disability. Finally, analysis of 2000 Census disability data on older Hispanics lend support to the hypothesis that immigrant health selection favors men over women at least at this generation of older people.

We began by noting the increased interest in the health of immigrants to the United States. The vast and rapidly increasing numbers of immigrants are having a major impact on American society. Because of their youth, they are changing the ethnic complexion of our schools, cities, as well as the occupational structure of both urban and rural areas. They are coming primarily from Latin America, especially from Mexico. Asian immigrants are moving primarily to the west coast where their presence and impact have been growing steadily. Immigration has been the topic of considerable political attention primarily because large numbers of immigrants are undocumented. There has also been considerable opposition to providing medical coverage to undocumented immigrants through public funds. The argument often is based, at least partially, on the notion that immigrants bring with them significant health problems and would constitute a burden on the health care system. As we have seen such stereotypical notions are not supported by the evidence. In fact, some of the healthiest people in the United States are immigrants originating in Mexico as well as Central and South America (Vega et al. 2009).

We also noted that much of the earlier literature in North America through the middle of the twentieth century gave great focus to the negative effects of immigration on mental health. This literature has been challenged more recently on the basis of cultural and scientific bias of much of the early research. In more recent decades, immigration has been viewed from a social stress-illness perspective wherein immigration is a major stressor (Friis et al. 1998). From such a social stress perspective, one would expect that immigrants, especially early on, would experience health problems resulting from the stresses of adjusting to the host society. There is no evidence that this is so because new immigrants, those in the United States less than 5 years, enjoy the greatest health advantage relative to the native born. Data from Canada and Australia show similar results. It could be argued that since most immigrants are young, it is unlikely that acculturative stresses will significantly influence their physical health in such a short time. However, an argument could be made that acculturative stresses are likely to have an impact on immigrant mental health.

This perspective has been dominant in the field. With respect to Mexican Americans, Escobar et al. (2000) examined the psychiatric and mental health literature and found no evidence in support

of the notion of a negative effect of acculturation on the mental health of Mexican Americans. In fact, the shorter the time since immigration and the lower the level of acculturation, the lower the prevalence of psychiatric disorders (see, also, Vega et al. 2009). It has also been found that the mental health advantages of foreign-born Mexican Americans may extend to foreign-born non-Hispanic whites (Grant et al. 2004). As with physical health, most major immigrant populations appear to enjoy mental health advantages over the native born. Again, healthy immigrant selection is likely a major factor in such advantages as is the protective influence of traditional Mexican culture retention (Escobar et al. 2000).

The good health of immigrants from poor countries has also challenged our traditional notions regarding the association of social class and socioeconomic status with health. It could be hypothesized that a significant number of immigrants in an ethnic population is likely to depress the usual inverse SES gradient in ethnic populations. In fact, this was the case in the mortality study using national data by Turra and Goldman (2007) who found a much lower SES gradient among Hispanics than among Non-Hispanic whites. Similar findings were obtained with respect to other health indicators and health behaviors in the Mexican-origin population using data from three studies. Goldman et al. (2006) found an absence of significant educational differentials for several health-related variables among Mexican-origin adults as well as among adolescents and infants. The absence of such differentials was especially present among immigrants. Both studies conclude that the Hispanic health advantage pertains primarily to lower SES people.

Again, immigrant health advantages disappear by the next generation, driven primarily by psychosocial factors related to health behaviors, substance abuse, HIV and other sexually transmitted diseases, as well as homicide (Eschbach et al. 2007). As also shown in an examination of differences in biological health profiles, the Hispanic Epidemiologic Paradox is primarily an immigrant phenomenon (Crimmins et al. 2007).

We also saw that immigrant health advantages appear to converge to native levels with time. This finding was also replicated in Canada (Chen et al. 1996; McDonald and Kennedy 2004; Gee et al. 2004) and Australia (Biddle et al. 2007). Because of a number of factors we outlined earlier, by the time immigrants reach old age, they do not exhibit any health advantages and at least most Hispanic populations appear to be more disabled than older non-Hispanic whites.

At present, older immigrants are having a relatively small influence on the larger society. However, their numbers are projected to increase dramatically between now and the middle of the century because of continuing high rates of immigration and relatively high life expectancies. If their morbidity and disability rates remain at the current high levels, the impact of older immigrants on the health care system, as well as on their families, is likely to be substantial. Increased attention by scholars and policy makers to the rapidly growing and rapidly aging immigrant population is paramount. An unresolved issue in the literature in the Hispanic population is the presence of high morbidity and disability among Hispanics in old age when most of the evidence suggests the existence of favorable mortality in old age. It would be highly important to monitor trends in life expectancy as well as in morbidity and disability at all ages and in all ethnic and immigrant populations as their presence and impact on the larger society are likely to grow steadily between now and the middle of the century. It is also possible that the Hispanic mortality and health advantage, driven by immigrants from Mexico and Central and South America, is a cohort phenomenon which may well disappear in the future. For example, obesity rates in Mexico are only slightly lower than obesity rates in the United States which raises the possibility that future immigrants may be less health selected in the years to come. Monitoring trends in the health of the Mexican population as well as in the health of other immigrant sending countries would be important to health and social policy in the United States.

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Chapter 8
Global Aging

Masa Higo and John B. Williamson

In the sociology of aging and life course, global aging is relatively a new issue; but it has become an increasingly important subject since the early 1990s (Estes and Phillipson 2002). Many factors are contributing to population aging. The single most important factor is the decline of fertility that is taking place in many countries around the globe (Lloyd-Sherlock 2010). Another major factor is decline in mortality rates at all age levels, a trend which translates into increases in life expectancy (Uhlenberg 2009). Because people have come to live longer, including more disability-free years, population aging can and should be viewed as a positive achievement associated with improved healthcare, more government spending on social security, and other age-related social welfare programs, as well as changes in life style, such as less smoking and more exercise (National Research Council 2001).

However, the unprecedented increase in the relative size of the older population has also created major challenges for many countries around the world. It strains existing systems of social and financial support for older people as the burdens of intergenerational dependency increase. In addition to these demographic changes, the trend toward ever-increasing economic globalization is in many countries transforming existing social institutions including the social welfare policies that support older people (Phillipson 2005). Population aging and economic globalization are two major social forces that will be shaping social change around the world throughout the twenty-first century. Research on global aging must give considerable attention to the ways in which these two major social forces affect the lives of older people around the world (Uhlenberg 2009).

As the processes of population aging and economic globalization vary among countries and regions of the world, the consequences of changes linked to these social forces can be expected to vary as well (Phillipson 2005). In general, the economically developed parts of the world – Europe and North America in particular – have been experiencing gradual changes in the age composition of their populations for decades. In contrast, many developing (as well as many transitional) countries are currently experiencing demographic changes at a much faster pace than are the developed countries of the world (United Nations 2009a). In the early twenty-first century, the developing countries are being referred to by some as the *new-old world*, whereas the developed countries are being viewed as the *old-old world* (AARP 2003; Perkins et al. 2004).

Global aging is going to create new challenges and risks, particularly with respect to the allocation of resources to older people for informal care-giving, formal healthcare provision, financial security, and long-term care (LTC). To date, much of the research on global aging has focused on assessing how the implications of population aging and economic globalization for the developed countries differ from those for the developing countries. In the decades ahead, the risks and challenges attributed to global aging are likely to be much greater for developing countries than for

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developed countries (United Nations 2009a). Global aging may create or increase risks for vulnerable populations, such as unmarried older women and widows, particularly in developing countries (Browne and Braun 2008).

The purposes of this chapter are twofold: First, this chapter reviews the main areas of research to date on global aging, including issues such as (1) family structure and living arrangements; (2) epidemiological transition and healthcare burdens; (3) retirement and old-age financial security; and (4) LTC and healthcare worker migration. In each of these areas, the research suggests that in the decades ahead developing countries are likely to be confronted with even greater challenges than the developed countries linked to population aging in an ever more competitive global economy. Second, this chapter suggests three directions for future research on global aging.

Global Population Aging and Economic Globalization

The twenty-first century will witness a rate of population aging without parallel in past history. Considering the global population, young children (aged 5 and younger) have always outnumbered older people (aged 65 and older). However, between 2020 and 2025, for the first time in history, older people will outnumber young children. In 2000, the numbers of young children and older people worldwide were about 627 and 473 million, respectively; by 2025, the figures are projected to increase to about 650 and 714 million. By 2050, the figures are projected to increase to 592 million and 1.5 billion (United Nations 2009a).

Between 1975 and 2000, the median age of the world population increased from 22.4 to 26.4 years. It is projected to rise to 32.8 years by 2025 and to 38.4 years by 2050 (United Nations 2009a). The old-age dependency ratio is another important measure of population aging. Calculated by dividing the number of people aged 65 years and older by that of those of working age (aged 15–64 years), the old-age dependency ratio is an indicator of both the formal and informal burdens of providing for an older population's economic security and well-being (Schulz and Binstock 2006). Globally, the ratio increased from about 8.5% in 1950 to about 10.9% in 2000, and it is projected to steadily increase to about 15.8% by 2025 and to 25.3% by 2050 (Organization for Economic Co-operations and Development 2009a).

Two major determinants of global population aging are increasing life expectancy and decreasing fertility (United Nations 2009b). Globally, the average life expectancy at birth increased from 46.6 years for the 1950–1955 birth cohort to 66.4 for the 2000–2005 cohort. The figure is projected to further increase to 72.1 years for the 2025–2030 cohort and to 75.5 for the 2050–2055 cohort. The world has also experienced an overall decrease in fertility rates since the mid-twentieth century. The world's total fertility rate (average number of children born to each woman over the course of her lifetime) was 4.92 between 1950 and 1955 and the figure decreased to 2.67 between 2000 and 2005. It is currently projected to fall to 2.21 between the years 2025 and 2030 and to 2.02 between the years of 2050 and 2055 (United Nations 2009a).

Generally, the process of population aging differs between the economically developed and developing parts of the world (Lloyd-Sherlock 2010). In most developed countries, European countries in particular, population aging began slowly during the late nineteenth century as birth rates entered a phase of sustained decline and life expectancies began to gradually increase. As of 2008, the percentages of older population (age 65 and older) are highest for Japan (21.6%), Italy (20.0%), Germany (20.0%), Greece (19.1%), and Sweden (18.3%) (United Nations 2009a).

The number and proportion of older people have also been growing in developing regions of the world. By 2015, there will be more people aged 65 and over living in China alone (132 million) than in all of Europe (128 million) (United Nations 2009a). As of 2008, some 62% of the world's population

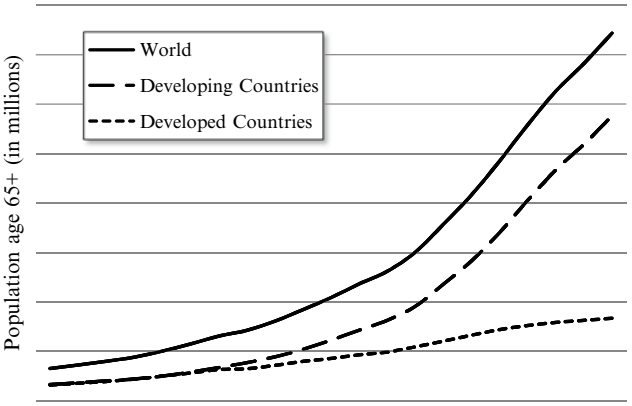

Fig. 8.1 Population age 65 and older, 1950–2050, World, Developed Countries and Developing Countries (United Nations 2009a). *Note*: In United Nations' (2009a) definition, the category of developed countries includes all regions of Europe, Northern America, Australia, New Zealand, and Japan, and that of developing countries comprises all regions of Africa, Asia (excluding Japan), Latin America and the Caribbean plus Melanesia, Micronesia and Polynesia

aged 65 and over lived in developing countries – an estimated 313 million people. This figure is projected to increase to 71% (690 million) by 2030. By 2050, almost 1.2 billion of the expected 1.5 billion people aged 65 or older are projected to live in countries that today are classified as developing nations, a designation which very likely will change for some of these countries by 2050 (see Fig. 8.1). Old-age dependency ratios are projected to at least double between 2000 and 2030 in many East and Southeast Asian and Latin American countries, and to triple in South Korea (United Nations 2009a).

The demographic changes that many developing countries are now experiencing have happened at a much faster rate than experienced by most countries currently classified as developed (Uhlenberg 2009). Most of today's developed countries had many decades to adjust to the gradual graying of their age structures. For example, it took 115 years (from 1865 to 1980) for France's population aged 65 and over to increase from 7 to 14% of the total population. To make this same shift it took Sweden 85 years (1890–1975), Canada 65 years (1944–2009), and current projections suggest that it will take Australia 73 years (1938–2011) and the United States 69 years (1944–2013). In contrast, many developing countries are projected to experience similar increases in the proportion that are old much more rapidly, with much less time to make the adjustments needed to deal with the policy implications of these changes. The following illustrate how much more rapid the shift is, according to current projections, going to be in many developing nations: Colombia (2017–2036) 19 years, Brazil (2011–2032) 21 years, Thailand (2002–2024) 22 years, Sri Lanka (2002–2026) 24 years, and China (2000–2026) 26 years (United Nations 2009a).

In addition to these demographic changes, economic globalization has become a social force with major implications for social institutions and public policies that impact the well-being of older people (Higo and Yamada 2009; Phillipson 2005). Globalization takes many forms, both cultural and economic. Of particular relevance for this chapter are the consequences of economic globalization including the process by which local, regional, or national markets become integrated into the global economy and the consequences of this process (Tonkiss 2006). By some accounts, economic globalization has been taking place since the fourteenth century (since the end of restrictive merchant economies). The rate of this process has increased quite dramatically over the past 20–30 years. Modern economic globalization is characterized by integration of developing countries into the global market economy, under terms which has been dominated largely by the developed countries and their multinational corporations (Estes and Phillipson 2002).

This economic globalization involves increases in international trade, foreign direct investment (FDI), and migration. *World trade* as a percentage of *gross world product rose from 8.5% in 1970 to 16.1% in 2001* (World Bank 2008). FDI for the United States, the world's largest economy, has been on the rise around the world since the 1970s. Both inflows and outflows of FDI for the United States have grown from an annual average of $45.3 billion in the 1970s to an average of $117.5 billion in the first half of the 1990s. Between 2000 and 2006, inward FDI stock in Brazil, Russia, India, and China grew from 8 to 14% of global FDI stock. Today, China is by far the leading emerging destination of FDI; in 2008, China ranked second behind the United States in the inflow of FDI, receiving $67.3 billion in FDI inflow (World Bank 2008). In tandem with the flow of trade and investment, economic globalization in the form of the flow of people among countries has also been increasing. Between 2000 and 2005, some 16 million people emigrated form developing to developed nations. This figure is nearly triple the number for the period between 1970 and 1975 (United Nations 2009b).

Family Structure and Living Arrangements

The global trend of decline of birth rates has implications for family size and structure. Most people in the world today eventually have children, grandchildren, and siblings. However, as the proportion of women and men who have only one or two children has been steadily increasing, in future generations it is likely that many who are old will have few, if any, siblings (Uhlenberg 1996). Changes in family structure will have implications for living arrangements. These changes in turn will affect the availability of economic resources and potential sources of informal care (care and support provided by family members) for older people. It is generally known that it will be a problem for the elderly in the developed nations. What is less well known is that this is going to become a big issue in developing countries as well (Agree and Glaser 2009).

In developed countries, over roughly the past three decades, multigenerational living arrangements have been steadily declining. Reflecting rising rates of divorce, delayed marriage, and increasing percentages of never-married and childless adults, an increasing proportion of older people are living alone. In Sweden, Finland, Denmark, and the United Kingdom, well over one-third of older people (aged 65 and older) live alone (Agree and Glaser 2009). In Greece, the proportion of unmarried older people living with a married child dropped from 23% in 1974 to less than 9% in1999. The share of unmarried older people living alone almost doubled (10–19%) during the same 25-year period (Karagiannaki 2005). The growth in the number of households consisting of one older person in developed countries has increased, particularly for women; as of 2006, of all the older people (aged 65 and older) living alone in the United States, women account for about 77% (U.S. Census Bureau 2009). In developed countries, where social support systems outside the immediate family have been well developed, this trend has been fueled by a combination of factors: greater longevity and increases in pension benefits as well as greater emphasis on care and support in the community (Lloyd-Sherlock 2010).

In contrast, older people in less developed countries rely heavily on their family members for well-being and survival. The majority of older people reside with their adult children and/or grandchildren. In Bangladesh, Indonesia, Singapore, and Taiwan, more than 80% of older parents live with one or more children (Ghuman and Ofstedal 2004). While many older people in developed countries report that they prefer living alone, those in developing countries prefer to live with, or at least close to, their children and to see them on a daily basis (Bongaarts and Zimmer 2002). In addition to these cultural preferences and the availability of kin, the lesser development of old-age financial security or social welfare programs is another reason for the prevalence of multigenerational co-residence in many developing countries (Frankenberg et al. 2002).

Such changes in the family size and structure are global phenomena. Over the next few decades, however, population aging in many developing countries is going to create problems particularly for the elderly poor due to the relative lack of familial resources for informal care and support in later life. Due to the decline of family size and traditional living arrangements, some older people, particularly unmarried older women or widows without any children and with fewer social resources, can be left with little support and nowhere to live if extended family members are not available to provide care for them (Lloyd-Sherlock 2010).

Epidemiological Transition and Healthcare Burdens

The world is experiencing an epidemiological transition due to changes in leading causes of death (Wilkinson 2004). Globally, while populations have become less vulnerable to acute and infectious diseases and are living longer, the number of deaths due to chronic and non-communicable disease has been rapidly increasing. Chronic and non-communicable diseases, including ischemic heart disease, cerebral-vascular disease, chronic obstructive pulmonary disease, and lower respiratory infections, are characteristic of old age (World Health Organization 2008). The number of deaths from cardiovascular diseases and cancers in 2004 worldwide was about 19 million; that number is projected to increase to more than 40 million by 2030. Overall, chronic and non-communicable diseases are projected to account for about three quarters of causes of all deaths worldwide in 2030 (WHO 2008).

The epidemiological transition takes on major importance in connection with research on global aging. Changes to leading diseases and causes of death posit challenges for allocating resources for formal care and social intervention such as public expenditures on healthcare (Crystal and Siegel 2009). Worldwide, healthcare costs are rapidly rising – in many countries, the growth rates of expenditures on public healthcare are projected to exceed the national economic growth rates in the decade ahead (WHO 2008).

Although most countries around the world have undergone such an epidemiological transition, developed and developing parts of the world have taken different paths for this transition (Wilkinson 2004). In developed countries, Europe and the United States in particular, the transition began in the late eighteenth century, when birth rates began gradually falling in some countries. In most developing countries, the transition did not start until well into the twentieth century, but since the mid-twentieth century it has been taking place at a much faster pace than in developed countries (Crystal and Siegel 2009). In developing countries, while infectious diseases accounted for about 40% of all deaths in 1990, by 2020 non-communicable diseases are projected to account for more than three quarters of all deaths (WHO 2008).

Research on global aging often refers to *burden of disease* as a measure of the region-specific economic burden caused by diseases in a baseline year. Burden of disease is calculated by combining years of life lost due to premature mortality and years of life lost due to time lived in less than full health (WHO 2008). During the next several decades, the burden of non-communicable disease (as opposed to the burden of infectious disease), already a major problem in the developed nations, is projected to increase rapidly in developing countries as well. The World Health Organization (2008) estimates that in 2004 the share of the total burden of disease attributed to non-communicable diseases was about 85% for developed countries and about 44% for developing countries. By 2030, those figures are projected to increase to 89 and 54%, respectively.

The challenges of the burden of diseases associated with the epidemiological transition are likely to be greater for developing countries than for developed countries (Crystal and Siegel 2009). Chronic and non-communicable diseases are imposing a growing burden on developing countries, many of which have limited resources for informal healthcare relative to developed countries. Simultaneously, in many developing countries, infectious diseases such as malaria, tuberculosis,

and HIV/AIDS are likely to remain a devastating health issue; by 2030, while the share of the burden attributed to infectious diseases in developed countries is estimated to be about 3%, the figure for developing countries is estimated to remain quite high at 32% (WHO 2008). While their health systems are already being stressed due to limited funding, many developing countries are likely to face a double burden of disease – high rates of infectious diseases including HIV/AIDS will co-exist with increasing rates of non-communicable diseases (Wilkinson 2004). Thus, developing countries need to mobilize and allocate resources to address the non-communicable diseases that are characteristically the leading cause of death in aging societies while they continue to struggle with the high prevalence rates for infectious diseases.

Retirement and Old-Age Financial Security

Changes in the patterns of work and retirement among older people have implications for their financial security in later life and for the younger, working-age people who support them (Kohli and Rein 1991). Population aging around the world has contributed to what many analysts refer to as a global pension crisis. At the core of this discussion is the debate over the sustainability of existing public pension programs (Blackburn 2006). The fear of possible public pension fund insolvency is common among policy makers in many countries around the world today. Research suggests that older workers in developing countries are particularly vulnerable as they are more likely than those in developed countries to be exposed to high levels of individual financial risk (Walker 2006).

Public pension schemes were first institutionalized in what are today considered the developed countries. Later, such schemes became widespread throughout most parts of the world including many currently referred to as developing countries. While the origin of public pension schemes can be traced back to Germany at the end of the nineteenth century, such schemes have come to play an increasingly important role in providing financial security to retired workers in developed countries, particularly since the 1950s (Macnicol 2006). By 2000, public pension programs covered more than 90% of the workforce in OECD countries (OECD 2009b). Most public old-age pension schemes around the world are based on the pay-as-you-go defined benefit (PAYG-DB) model. With a DB scheme, the pension benefit is based primarily on some measure of average or final wage and the number of years the worker has contributed; it is not dependent on fluctuations in financial markets. Under the PAYG-DB model, pension benefits are for the most part not pre-funded, although in some countries such as the United States today, a modest amount of pre-funding is introduced by building up substantial reserves in a trust fund, often with a plan to draw down those assets to deal with an anticipated demographic bubble such as the retirement of the baby-boom generation (Williamson, forthcoming). With a PAYG scheme, revenues from the current working population's payroll taxes are used to finance the benefits of current retirees, with a very modest trust fund used to assure that there will be sufficient funds on hand to pay pensions during dips in the revenues collected due to short-term fluctuations in unemployment rates (Macnicol 2006).

From the 1950s through the end of the 1980s, retirement was institutionalized in most developed countries due largely to availability of relatively generous public pension benefits for many retirees (Gruber and Wise 1998). Old age became synonymous with retirement as a phase of individuals' life courses in which workers were encouraged to leave the labor force (Phillipson 2005). During this period, paid labor force activities of older men declined sharply in most develop countries. In the United Kingdom, the labor force participation rate for men aged 65 years and older in 1921 was 60%, but by 1951 the rate had dropped to 32%. The figure continued to fall to 23% by 1971 and then to only 11% in 1981 (Macnicol 2006). With the increasing paid labor force participation of women, they too have increasingly been incorporated into the institutionalization of retirement in later life (Phillipson 2005).

Today, the number of pensioners (retirees) relative to contributors (workers) is increasing and this has raised serious questions about the sustainability of the traditional, PAYG defined-benefit pension schemes in many countries. Many are calling into question the viability of the implicit intergenerational contract that such schemes are based on. In 2003, total public pension expenditures in 25 European Union (EU) countries consumed one-eighth of the EU's total gross domestic product. In Italy in 2004, old-age pension expenditures absorbed 15% of the nation's gross domestic product (OECD 2007). In recent years, pension reform has become a highly charged issue in most developed countries; more than half of the OECD countries have made major changes in their public pension schemes during the past 15 years (OECD 2009b).

In recent years, one pension reform option that has received a great deal of attention has been to shift from a traditional PAYG-DB to a multi-pillar scheme that includes a defined contribution (DC) pillar (Williamson 2004). With a DC pillar what is promised is that a specified amount will be contributed each month, but no promise is made with respect to the size of that actual pension that will be paid based on those contributions. An individual or personal account is created for each covered worker with the funding based on contributions from that worker (often supplemented by contributions from the employer) via payroll taxes and the earnings (or loses) on those assets over the years when those assets are invested by private sector money management organizations in financial markets. This is typically done as part of a set of reforms designed to reduce the government's pension obligations and shift much of the risks associated with paying those pensions from the government to the individual worker.

Although public pension schemes in a majority of OECD countries are still based on the PAYG-DB model, an increasing number are introducing mandatory DC schemes (Cushing-Daniels and Johnson 2008). This trend has been particularly true in some developing parts of the world such as Latin America and Eastern Europe (Bockman and Eyal 2002; Brooks 2004). Because a DC scheme links pension income to the contributions to the account, this alternative provides workers with incentives to delay retirement and remain economically active longer than is the case with the traditional PAYG-DB alternative. DC schemes also reduce demographic risks, such as growth of the older population relative to the younger one, since pension benefits under a defined-contribution scheme do not rely on the earnings of younger generations (Williamson 2004).

Researchers on global aging are starting to pay increasing attention to a new pension model which some countries such as Sweden, Italy, Poland, and Russia have introduced; it is a new type of DC pillar. These countries have implemented notional defined-contribution (NDC) schemes which are based on PAYG financing, but like the DC schemes they also more closely link pension benefits to the individual worker's lifetime contributions than is typically the case with DB schemes. Workers have individual accounts, which record how much has been paid into the pension system via the payroll tax (sometimes including matching contributions from the employer). Under the NDC scheme, the individual account is notional (unfunded) and the analog of interest is the annual credit added based on the size of the account and trends in wage rates, not trends in financial markets (Williamson 2004).

By 2004, public old-age social insurance programs had come to be established in 167 countries, including some of the economically poorest countries (United Nations 2009b). However, in developing countries, public pension programs typically cover a much smaller fraction of workers than in most developed countries. Coverage rates of under 10% are not uncommon in very poor countries. For example, in Malaysia and Thailand, public pension coverage is restricted to certain categories of workers such as public sector employees, civil servants, and military personnel. Nearly one-third of countries in Africa that offer public pension benefits have a life expectancy less than the statutory pensionable age both for men and women. While the projected future costs of public pension schemes are a major concern, many developing countries are even more concerned about how they are going to finance their strategic development plans, particularly those linked to infrastructure, security, education, and health (United Nations 2009b).

Many countries around the world are facing less than enough government resources to cover all workers with pension benefits or in many cases even to pay the promised benefits to the few who are covered (Williamson, forthcoming). Globally, many are looking for ways to reduce the government obligation via reforms that at least partially privatize their existing PAYG-DB schemes. Many of these governments, including those of both developed and developing countries, are attracted to market-oriented partial privatization schemes that: promise less pension support from the government, shift much of the risks to workers, and creative incentives for works both to save more and remain in the labor force longer (Madrid 2003). More than 20 developing countries, including Chile, and many other countries in Latin America and Eastern Europe have introduced funded individual accounts DC pillars thereby partially privatizing their national pension schemes (Phillipson 2005).

The increasing prevalence of pension privatization worldwide, that in developing countries in particular, is of concern to some sociologists and economists who study global trends in pension policy (Schulz and Borrowski 2006). With such schemes financial security in old age depends on a number of factors that involve different forms of risk, of particular note in this context are: what worker is able to save, how those savings are invested, the fees assessed for managing these assets, and fluctuations in financial markets. The combined impacts of population aging, increasing global competition, and the potentially dramatic corrections in financial markets just before retirement, represent a huge shift of risk in many countries from the government to individual workers, many of whom can expect to end up with less than an adequate pension in retirement (Williamson, forthcoming).

In the midst of economic globalization, an increasing number of developing countries such as China are experiencing economic expansion and urbanization. As we know based on the past experience of many of the now developed countries, such social structural transformations tend to weaken informal, familial support for the elderly (Tirrito 2003). Without the protections provided by the traditional DB or the new NDC schemes, the trend toward greater pension privatization is putting millions of workers in both developed and developing countries at financial risk. These risks are problematic for most workers but particularly problematic for low-wage workers, older workers, and single widows in today's developing countries (Walker 2006).

Long-Term Care and Healthcare Worker Migrations

Over the last few decades, the demand for healthcare workers for older people has been increasing in many countries around the world (Kingma 2006). There will be a demand for home and community-based LTC workers to service the frail and disabled elderly. In 2004, there were 60 million healthcare workers worldwide, the majority of whom were LTC workers (WHO 2006).

Since the mid-1980s, many developed countries including Canada, the United Kingdom, and the United States, have promoted aging-in-place for the care of the elderly. In many of these countries, an effort is being made to shift the major site for elderly healthcare from institutions (e.g., hospitals and nursing home) to home and community-based locations (Center for Health Workforce Studies 2006). This promotion of aging-in-place has increased the demand for home and community-based LTC services designed to provide older people with social, medical, and health support in their residential settings and local environments (Connell 2008). In addition, the ever-increasing cost of LTC in an institutional context has also contributed to the demand for home and community-based LTC services. Compared to traditional, institutional care, home and community LTC is much less costly. In the United States, whereas the LTC average cost is $70,900 per year for nursing home care, 4 h/day of care from a home health aide only averages $36,500 a year (Feder et al. 2007).

Many countries around the world have been formulating a global market of LTC workforce. Due partly to declining birth rates, increasing divorce rates, and increasing female employment, developed

countries are increasingly facing shortages of LTC workers. In the United States, over $207 billion was spent on LTC in 2005, and by 2010 the demand for LTC workers is projected to increase by about 64% (Center for Health Workforce Studies 2006). This growing demand has made the developed countries major employers and importers of LTC workers from the global LTC workforce. Over the last three decades, the migration of healthcare workers has increased significantly. In the United States, where foreign-born workers accounted for only 5% of the total LTC workforce in 1980, the figure increased to 17% by 2003 (Clearfield and Batalova 2007).

In the midst of global concern over the LTC workforce shortage, developing countries are being gradually integrated into the global market for LTC workers. Many are becoming major suppliers of LTC workers for the developed countries (Browne and Braun 2008). Over the last two decades, the governments of many developing countries have encouraged their younger workers, women in particular, to provide LTC services for the elderly in developed countries. The Philippines is the world's leading LTC workforce exporter. Since the mid-1990s, the Philippine government has supported the education and exportation of many Filipinas as LTC workers, mainly as nurses and nurse aides. The reason is the financial benefits to the country from money remitted by these workers back to their families in the Philippines (Ball 2008).

Many developing countries currently benefit economically from their role as exporters of LTC workers (United Nations 2008). However, there are also potential long-term costs to these same countries do to labor shortages in their own countries (Hussein and Manthorpe 2006). By some projections, the need for elderly healthcare in developing countries will increase by as much as 400% over the next 20 years (WHO 2006). According to the World Health Organization (2006), health worker density (the ratio of health workers to the total population) needs to be at least 2.5 workers per 1,000 people. Among 186 countries worldwide, 75 countries do not meet this condition. About 45 of these 75 countries are in sub-Saharan Africa area (WHO 2008). While countries in Sub-Saharan Africa today have about 11% of the world's population and 24% of the global burden of disease, these countries have only 3% of the world's healthcare workers (WHO 2006). As developing countries are further integrated into the global labor market for LTC providers, more of their younger workers will be immigrating to developed countries in search of economic opportunities in the LTC area. This trend is likely to make it more difficult from many of these countries to adequately meet their own needs for long-term elder care (Browne and Braun 2008).

Directions for Future Research

We have presented evidence suggesting that, in the decade ahead, population aging, economic globalization, and the intersection of these two global trends are likely to be powerful determinants of the quality of life for the older population around the world. As mentioned in the introduction of this chapter, global aging is partly a result of improved healthcare and development of age-related social welfare programs around the world. It can be viewed as an indicator of a society's ability and commitment to providing well for its older population. Many of these older people continue to make important contributions to society, some as paid workers, some as family caregivers, and some through their unpaid service to the local community (Harper 2006; National Research Council 2001).

However, the global aging and economic globalization are also creating major challenges in both the developed and the developing countries around the world. Elders living in the developing countries will generally be at greater risk than those in the developed countries. Today's developing countries are relative newcomers to the challenges of population aging. Many developing countries are confronting the burden of adequately providing for the well-being of their elderly while at the same time contending with both the fiscal problems associated with rapid population aging and the economic challenges with respect to their integration into the ever more competitive global economy.

The burdens of providing for their elders are likely to be particularly difficult in the areas of living arrangements, healthcare policies, financial security in later life, and LTC for the elderly. These burdens will be very challenging when dealing with the needs of some high-risk groups such as the disabled and various categories of economically vulnerable and socially marginalized elderly women, such as widows, the never married, those without adult children, and, in some regions, women responsible for the care of their grandchildren due to the death of their adult children often linked to diseases such as AIDS. In many developing countries around the world, during the decades ahead, population aging in combination with economic globalization is going to pose a number of major risks for the older population (Brooks 2004; Estes and Phillipson 2002).

While there has already been a substantial amount of research and much has been said about the potential global impact of population aging on the well-being of the older population around the world, there has been very little research that has attempted to deal with this set of issue using life course analysis. Further research is needed to better understand and help policy makers prepare for the impact of population aging and the risks associated with population aging in the context of economic globalization at different life course stages. This is particularly true for the developing countries. For those interested in conducting research designed to help meet this need, we suggest the following three directions for future research on global aging.

First, it would be very useful to have data, particularly for developing countries, on both objective and subjective quality of life measures suitable for life course analysis, including data from both men and women. The relative lack of such data makes it difficult to compare various forms of inequality across the life course in developing countries and between those in developed and developing countries at comparable life course stages (Phillipson 2005). More high quality data would also enable researchers who deal with the issue of global aging to come up with more useful and well-informed policy suggestions.

Second, research on global aging would benefit from paying greater attention to the roles of transnational financial organizations in shaping the future of old-age policy and the related experience of being old, particularly in developing countries. The International Monetary Fund, World Bank, and World Trade Organization, to name a few, have played key roles in facilitating economic globalization and in promoting market-oriented old-age social policies (Estes and Phillipson 2002). Since World War II, these transnational organizations have actively lowered barriers to international trade between countries and have been attempting to limit spending on social security programs by introducing market-oriented alternatives (Deacon et al. 1997). In the area of public pension reform, for instance, these organizations have argued for reducing state PAYG-DB schemes to the minimal or residual role of providing a very modest old-age pension and promoting an expanded role for individualized and capitalized private pensions (Brooks 2004; Estes and Phillipson 2002). The World Trade Organization has also placed enormous pressure on its member countries to further open-up health and social welfare programs to competition from global corporate providers (Campbell and Pedersen 2001).

As global social forces, population aging and economic globalization are best analyzed in tandem, rather than independently. Transnational financial organizations have taken active roles linked to both these social forces (Phillipson 2005). In order to gain a better understanding of the unequal distribution of the risks associated with aging and old age, particularly the likely differences between old-old and new-old parts of the world for the decade ahead, research on global aging would benefit from a close observation and detailed critical examinations of the roles played by these organizations. The impacts of these organizations are not limited to the elderly; it would also be useful to apply life course analysis to the assessment of these impacts, particularly for those living in the developing world.

Finally, theoretical work is needed to more adequately theorize the links between global aging, economic globalization, and social policies designed to deal with the well-being of workers across the life course up to and including old age. The social forces associated with population aging and economic globalization have implications for the forms that inequality takes, the consequences of

those inequalities, and the risks that workers and their families are subjected to at all stages of the life course.

What is needed is more effort to modify or extend existing theories to better account for the trends that are emerging. To dates the links are under theorized. Hitherto, research on global aging has largely failed to theoretically address the ways in which inequalities between developed and developing parts of the world and vulnerable populations in developing countries are being produced (Estes and Phillipson 2002; Phillipson 2005). In their theorizing about globalization, Bauman (1998) and Beck (2001), characterize our contemporary societies as operating in an age of individualization, privatization, and of each worker being responsible for his or her own risks. In this era of rapid global aging, there has been a ideological shift to the right in thinking about social welfare issues, a shift from less focus on looking to the government programs for answers and more focus on individuals being responsible for coping with risk during old age and over the life course (Beattie and McGillivray 1995). At the same time that demographic pressures associated with social welfare programs are increasing, transnational financial organizations have been fostering a shift to greater individual responsibility for securing resources for healthcare, financial security, and LTC in later life, particularly for those living in developing countries (Deacon et al. 1997; Walker 2006). From Bauman's (1998) and Beck's (2001) theoretical view, these transnational financial organizations can be understood as one of the main agents that have been promoting an ideology of individual or local solutions for globally generated problems.

In light of a twenty-first century characterized by unprecedented global population aging and an ever intensifying global economy, research on global aging may need to reclaim the sociological imagination that Mills (1959) called for. Future research on global aging is needed to construct theoretical accounts that trace the links between individual risks in later life and the broader social structural forces including global population aging and economic globalization. Despite the growing ideology of individual solutions for global problems, future research on global aging framed by critical sociological imagination is needed to better inform social policies calling for greater attention to social, collective, solidaristic, and communitarian solutions for the globally generated problems associated with aging and old age around the world.

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Chapter 9
Diversity and Family Relations in an Aging Society

Judith Treas and Christopher Steven Marcum

To appreciate the changes that have occurred in American families over the last three decades, consider the occupants of 1600 Pennsylvania Avenue. In the 1980s, Nancy and Ronald Reagan called the White House home. Members of the "Greatest Generation" shaped by World War II, the Reagans were prototypical empty nesters with grown children pursuing their own, sometimes awkward, way in the world. Famously devoted, the President and First Lady seemed to have a storybook marriage, albeit one with a twist. He had been married before, creating what sociologists call a blended family of divorce and remarriage.

Today, three decades later, the First Family is a prototypical once-married, heterosexual couple with two young children. This family type is now a minority in U.S. households due to fewer and later marriages, more divorces, fewer remarriages, more cohabitation, and more non-marital births. While they represent one family ideal, the First Family's diversity is illuminating. Besides being the first African-Americans to call the White House home, other aspects of the Obamas address the growing multiplicity of American family life. The President was raised by a single, working mother. With children born in her mid-thirties, the First Lady has been a working mother and speaks from personal experience about the difficulties of balancing work and parenting. Her own mother moved into the White House to help out with the grandchildren. Also telling is the diversity of the President's kin. With a Kenyan father, Barack Obama is closer to his immigrant heritage than Ronald Reagan was to his Irish-Scots-English roots. Thirty years ago, a family with ties to three continents was almost unimaginable, but transnational families are familiar to the many Americans today whose lives have been touched by the great immigration of the past half century.

The changing context and growing diversity of American family life have fascinated sociologists of aging and the life course. In this chapter, we explore four broad changes in American society which have impacted family relationships as we grow older. First, we consider generational change, particularly the Baby Boom which is arriving at old age with different family experiences than generations that went before. Second, we address growing family diversity. New family forms, whether stemming from racial-ethnic immigrant diversity or increased visibility of sexual minorities, point to less uniformity for families. Third, we examine the changing terrain of gender. Men's lives and women's lives have converged with notable consequences for family relationships. Fourth, we consider the demographic and technological developments that impact the intergenerational relationships that sustain us through childhood, old age, and adversity. We conclude by commenting on how developments from life course research will continue to inform scholarship on these changes in the future.

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Aging Baby Boomers

The Baby Boomers are a defining feature of American society and a touchstone for research on aging and the life course. Boomers have embodied many trends, from the sexual revolution to rising women's workforce participation to changes in intergenerational relationships. While unique for its sheer size, the cohort is also unique for its trajectory. The Baby Boomers came of age during a period of great technological and social innovation. With important implications for family life, their aging is a testing ground for theories of cohort and generation, and it underscores the importance of research on the older population and later life.

To review facts well known to sociologists, the Baby Boomers were born between 1946 and 1964. Their defining feature is the cohort's size. Much to the surprise of demographers accustomed to the low fertility of the 1930s, the U.S. birth rate remained high for nearly 20 years before it fell to the low levels we know today. The Baby Boom has been hypothesized to stem from post-war prosperity, which encouraged young adults who grew up during the Great Depression to marry earlier and raise larger families (Easterlin 1961). Whatever the causes, the Baby Boom would set the context for family politics in the twentieth century.

In childhood, the Baby Boomers taxed the educational system. New schools, colleges, and universities were built to educate them. With liberal and technical educations, more Boomers obtained white-collar and service sector jobs. While hardly homogeneous in attitudes and values, they fueled social reform by protesting the Vietnam War and fighting for gender and racial equality. Despite general parent–child value congruence (Glass et al. 1986), a vanguard of Baby Boomers questioned the model of American society dominated by white males. A smaller cohort might not have had as big an impact on social change.

One distinguishing feature of educated Baby Boomers was an orientation towards self-actualization (Hughes and Waite 2007). Their values were more individualistic than their parents' and more concerned with personal gratification than with adherence to institutional demands (Bengtson 1975). Rather than just sharing common birth years, their values set them apart as a self-aware "generation" in the tradition of Mannheim (1953). Abetted by economic constraints, individualism was a force for later marriage and smaller families. Higher education and women's work force participation, along with liberal family and divorce laws, transformed family life (Caldwell 1980). As *U.S. Monthly Vital Statistics* reports, marriage rates between 1964 and 2004 plummeted while mean age at first marriage rose from 21 to about 26. The divorce rate rose to a record high of 5.3 per thousand people in 1981, before declining to 3.5 per thousand in 2008. Total fertility stabilized near replacement level (i.e., 2.1 children per woman); fertility rates for unmarried women more than doubled. Today, nearly four in ten births are non-marital.

Looking forward, family will remain important, but aging Baby Boomers will have different support systems than older people today. There will be: (1) more childless and more never married or divorced seniors (Himes 2002); (2) smaller sibships but more siblings surviving together into old age; and (3) a deteriorating economic support ratio as relatively few workers, taxpayers, and kin support growing numbers of older adults (Knickman and Snell 2002).

The Baby Boomers' retirement brings new challenges. Foremost is funding living costs and healthcare for a very large older population. Besides a smaller tax base, fewer children mean fewer family resources for aging parents. However, the demands of retiring Baby Boomers may be no greater than the strain they placed on schools in the 1960s (Knickman and Snell 2002). The trend towards working longer, due to changes in policies and expectations (Pienta and Hayward 2002), may offset some of the immediate costs of an imbalanced age-pyramid. Whether focusing on late-life employment, volunteerism, civic engagement, or family contributions, "productive aging" offers a conceptual counterweight to the stress on old age dependency and incapacity (Uhlenberg 1992). At least until the recent economic crisis, demographic adaptations by the Baby Boomers

(e.g., fewer children, women's higher labor force participation) compensated for any competitive disadvantage of large cohort size (Easterlin et al. 1990). Baby Boomers accumulated more wealth than their parents; as of 2001, they were in good shape for retirement (Keister and Deeb-Sossa 2001). Their wealth stemmed from the prosperity of whites, however (Lusardi and Mitchell 2007). Blacks and Hispanics had median net worth only 1/8th and 1/4 whites', respectively. It remains to be seen whether non-white and Hispanic racial and ethnic groups will be able to afford a retirement characteristic of the "second youth" (to borrow the name of the AARP's Spanish language magazine for seniors) that white Baby Boomers appear economically prepared for.

These findings on Baby Boomer wealth need to be updated in light of the global economic collapse. Their wealth is concentrated in home ownership and retirement savings accounts that dropped in value between 2007 and 2009 while home values plummeted 30–40% (Rosnick and Baker 2009). With high unemployment, reduced employee benefits, and lower pay for people of all ages, the crisis led families to look to each other for support. At the end of the recession, Baby Boomers may wind up less wealthy, albeit it perhaps still better off than the young whom they may be called on to support.

Immigration and Diversity

Changes in U.S. immigration law in 1965 led to a remarkable increase in Americans who are foreign born – from about 6 to 15% between 1980 and 2008 (Migration Policy Institute 2009). This new wave of immigration contributed to racial and ethnic diversity. Looking ahead raises questions about how immigration will impact older adults. Are we investing enough in the schooling of the coming generation of Hispanic taxpayers? Can the intergenerational contract of the young supporting the old be sustained if taxpayers are increasingly minority and older adults are largely non-Hispanic whites? Meanwhile, the very definition of "minority" includes more and more racial and ethnic groups.

The growth in the population of Asian and Hispanic origins has blurred the racial color line (Lee and Bean 2007). Inter-racial relations no longer mean just black and white. Growing numbers of Americans define themselves as multi-racial. Race still plays an important role in pairing off (Feliciano et al. 2009), but racial intermarriage has increased in recent decades, as has marriage between immigrants and non-immigrants within racial-ethnic groups (Qian and Lichter 2007). By birth, marriage, or adoption, more Americans point to family members of a different race. Many bring together different heritages within their own homes. Families negotiate different cultural expectations even as diversity offers new possibilities for parent–child support, marital relationships, and elder care.

Since *The Polish Peasant* (Thomas and Znaniecki 1996), an immigration research tradition has addressed adaptation, intergenerational socialization, family relations, and other life course topics. Immigration research has focused on the adaptation of working age immigrants and their children, because most people immigrate at young ages and their incorporation determines their well-being and their contributions to the broader society. This research is rich in life course insights, including how age-related variation in the pace of acculturation within immigrant families contributes to divergent expectations between generations (Pyke 2004; Treas and Mazumdar 2002). Incorporation depends not only on time in the host country but also on age at arrival. Children who immigrate at older ages lag behind younger siblings. Therefore, those who immigrate before adolescence are labeled the 1.5 generation, whose acculturation falls between first (foreign-born) and second (U.S.-born) immigrant generations.

Older immigrants receive little attention outside their ethnic communities. As Treas (2009:40) observes, "They never win spelling bees. They do not join criminal gangs. Nobody worries about

Americans losing jobs to Korean grandmothers." Until recently, older immigrants were mostly long-time U.S. residents with socio-demographic profiles much like U.S.-born seniors. Because of the recent arrival of Asians and Latinos, immigrant aging means that older Americans are growing more diverse. Immigration law, which puts no numerical limits on aging parents sponsored by U.S. citizen children, adds about 80,000 older newcomers annually. Compared to U.S.-born counterparts, Hispanic and Asian immigrants, 65 years and older, are more likely to be poor and to receive public assistance, despite 1996 welfare reform measures curtailing non-citizen eligibility (Burr et al. 2009).

If immigration research has neglected older immigrants, so have studies of aging and the life course in which sociologists' interests focused on older minority populations, not immigrant status. The proposed 2007 immigration policy reforms died without mention of aging parents whose numbers would have been cut in half by the law (Treas 2008b). Yet, older newcomers are a textbook case of the intersection of age, life course events, and history in human lives. Without the influence of U.S. schools and workplaces, late-life immigrants seldom master the English language or embrace American customs as thoroughly as younger kin. They do not catch up to long-term immigrants who arrived at young ages and grew old here. We have dubbed these older newcomers the ".5 (point five) generation" in recognition of their limited acculturation.

Older newcomers challenge assumptions about intergenerational relations. Unless poor health makes them too frail to contribute to their families, they are often important resources, not just family dependents. Grown children sponsor aging immigrants, in part, because they keep house and look after grandchildren for busy, two-earner couples (Treas and Mazumdar 2004). As hands-on caregivers, they offer a model of intergenerational ties contrasting with U.S.-born grandparents' largely fun-loving, or sometimes distant, relations with grandchildren (Cherlin and Furstenberg 1986). Older newcomers rely on families for companionship, financial support, and help navigating social institutions, because they have few opportunities to make friends of their own age, are unfamiliar with American society, cannot get paid jobs, and are mostly ineligible for government benefits and services.

Being more likely than other older Americans to live with younger kin, elderly newcomers enjoy the benefits and protections of close family ties. Their experiences, however, point out the limitations of family support. Despite high rates of multigenerational residence, older immigrants – especially recent ones – are more vulnerable to depression than younger immigrants or other older Americans. Being more likely to be widowed, they report being lonely and bored (Treas and Mazumdar 2002). Family members are often too busy going to school and earning a living to provide the desired companionship or to help to navigate an unfamiliar culture. Valued for transmitting cultural traditions and sustaining transnational ties, older relations are not household authority figures and must often defer to others' needs. Older immigrants present an opportunity for aging and life course studies that tests our understanding of how sweeping historical events such as immigration reform impact the course of human lives, how age intersects with social structures such as labor markets and pension systems, and how our intimate relations with others channel our development and aging.

New Family Forms

Although racial and ethnic diversification calls for new understandings of family relationships in an aging society, family life has also diversified along other dimensions. Cohabitation, single-mother families, and non-marital births point out the new family forms and norms that have emerged. These trends underscore the significance of starting points and demonstrate the growing heterogeneity of the life course. The earliest childhood experiences have life-long consequences for health, socioeconomic well-being, and intimate relationships (Shapiro and Cooney 2007). Furthermore, new family

forms show that normative pressures and social institutions (e.g., welfare rules, inheritance laws) that once standardized family behavior are less compelling today. As Americans marry late, if ever, and often only after cohabitation and parenthood, sociologists point to a deinstitutionalization of marriage (Cherlin 2004). Life course sociologists stress the "destandardization" of the family life course (Brückner and Mayer 2005), the growing disarray in the orderly attainment of marriage and parenthood that once certified adult status.

Life course destandardization has far-reaching implications. Once confined to the young, cohabitation is now favored by middle-aged divorced persons, older adults, and even parents raising children. More children will spend some time growing up without two parents, sometimes creating lifetime disadvantages. Serial partnering complicates family relationships, fusing blended families and creating ghost relationships, ties to meaningful kin (e.g., grandparents) that are ruptured when romantic unions end. With the rise in childlessness, a larger share of successive generations will lack intergenerational support in old age (Himes 2002). Increased divorce has negative consequences for older fathers' relations with grown children and for children's own marriages (Shapiro and Cooney 2007). The rise in age at first marriage, divorce, and cohabitations (with their higher rates of dissolution) points to new groups to study (singles and non-cohabiting romantic partners "living apart together"). More needs to be learned about the potential of new family forms to bring meaning and support to our lives. New welfare initiatives, for example, have identified distant kin willing to adopt previously unknown relations, teenagers who have languished for years in foster care (Eckholm 2010).

The increased acceptance of homosexuality highlights the interplay between institutionalization and deinstitutionalization in new family forms. Non-heterosexuals have challenged traditional institutions by insisting on new definitions of family that recognize voluntary networks of reciprocity and affection, rather simply ascribed relationships based on blood, marriage, or adoption. But, same-sex couples have also asserted their rights to marry and enjoy all the benefits traditionally accorded by marriage. Of the half million same-sex couples living together in 2008, a quarter reported their partner as their husband or wife (although the meaning of the term is in flux due to a patchwork of state and federal marriage and domestic partnership laws). Research is quicker to acknowledge the family relations of non-heterosexuals today. In the past, gays were stereotyped as family-less "confirmed bachelors" or adults whose sexual orientation distanced them from disapproving kin. In a domestication of homosexuality, discourse about gays and lesbians no longer focuses on sexual lifestyles but rather on familiar family and relationship concerns (adoption, parenting, blended families, getting health coverage for dependents), issues with which many heterosexuals can identify. Aging and life course principles are valuable tools in understanding these changes. At the macro-social level, separating cohort turnover from intra-cohort change shows that acceptance of same-sex relationships increased less because liberal cohorts replaced conservative ones and more because cohorts changed their views over time (Treas 2002). At the micro-social level, post-Stonewall cohorts of gays and lesbians – consistent with Mannheim's (1953) concept of self-aware generations – pride themselves on living open lives in contrast to older generations for whom successful identity management meant passing as heterosexual (Rosenfeld 1999). Thus, the life course perspective informs and is informed by the growing diversity in family relationships.

The Changing Gender Terrain

A tenet of life course sociology recognizes that men's and women's lives traverse different paths. This is still the case, but their life courses have converged and even crossed in recent decades (Brückner and Mayer 2005). Women once left school earlier than men, getting less education. Today, more women than men enroll in higher education in developed nations. Gender convergence

is seen in women's greater workforce involvement and men's greater involvement in the home. Most young American women will work, typically full-time, over much of their lives. Poorly educated women with poor employment prospects were once more likely to marry, but today well-educated women have the best marriage prospects. As women have spent more time in paid work, they have cut back on the time they spend in housekeeping (Treas and Drobnic 2010). Their husbands have taken on more of the household chores. Couples have fewer children, but fathers are more active in their care. Indeed, single-fathers are not as rare a family type as just 30 years ago. Given social expectations that middle-class parents spend time with offspring, mother–child relationships continue to be intensive ones despite the competing demands of employment.

Inequality and difference remain part of the gendered life course, but the lives of men and women are more alike than in the past. Their skill sets are less specialized. Their experiences share more in common. Where gender specialization once called on partners to complement one another's activities (he worked for pay, she kept house), they now substitute (she works more hours if he loses his job) (Treas 2008a). More women have parity with their partners, and many even earn more than their husbands. With male and female life expectancies converging, widowhood will be a less gendered experience.

Rethinking Kinship

With demographic changes, kinship may be a more important resource for young and old. Improved infant mortality and healthier lifestyles raised life expectancy from 65 to 79 years over the last century. The number of centenarians and super-centenarians grew by a factor of 7 between 1950 and 1990 (Krach and Velkoff 1999). The lives of children, parents, and grandparents overlap more often. Higher divorce and remarriage rates among Baby Boomers and their grown children bring step-parents and step-grandparents into children's networks. Some say that kinship relations will become more multigenerational (Bengtson 2001). As Settersten (2007) cautions, however, episodic and contingent relations may not translate into meaningful support. Not all ties will be positive ones, nor will the circumstances under which multigenerational households are formed.

Grandparents and grandchildren have become more likely to share lives and households (Fuller-Thomson et al. 1997). By 1999, over 10% of grandparents were responsible for the full-time care of at least one grandchild (Minkler 1999). More than 4.5 million children under 18 were living with grandparents, whether in their grandparent's or parent's home (Simmons and Lawler 2000; Mader 2009). Life course sociologists stress the benefits, as well as burdens, of multigenerational households. While Baby Boomers may be "sandwiched" between filial and parental responsibilities, they can benefit from an extra pair of hands and eyes around the house. Children growing up in extended family households are sometimes seen to be healthier than children in single generation homes (Kanaìaupuni et al. 2005). Grandparents benefit from social support in the face of loss and from learning about developments in popular culture from grandchildren.

Social networks decline in size and become more kin oriented with age. To explain how aging affects individual network size, membership, and frequency of interaction, social psychologists point to changes in goal-attainment strategies at the end-of-life (Carstensen 1991), risk minimization (Rohr and Lang 2009), and maintenance of companionship in the face of loss (Rook and Schuster 1996). Many explanations imply that age-related changes in social interaction reflect older adults' preferences, rather than structural changes that shape opportunities to make and keep social ties. For instance, the age-structure constrains interaction based on the availability of cohort and non-cohort members. Group size can explain a lot (Mayhew 1973). Numerically, younger and older cohorts should have a higher likelihood of interacting with Baby Boomers, because there are so many Boomers. Assuming random mixing, small cohorts have fewer opportunities to maintain

relationships with each other (all things being equal, the young are likely to have elderly neighbors to befriend). Of course, because these generalizations are challenged everyday by retirement communities, universities, and workplaces that integrate or segregate age groups, life course sociologists need to test the limits of the assumption that young and old mix freely.

Why do older people's social networks have a concentration of kin? Older adults' networks are trimmed of age-peers, because they are less likely to replace a friend lost to declining health or death and to be sought out by age-peers for the same reasons. Continuing ageism, differing physical capacities, and generational differences in tastes mean that older adults are less likely to be sought out by younger people outside the family. This results in kin-dominated networks. Current old-age cohorts are smaller, had more children, are less mobile, and probably have more health problems than the Baby Boomers will have in old age. Reluctant to identify as old – with fewer children but more surviving siblings – Baby Boomers may have more within-group and between-group diversity in their social networks than older people in the past, a hypothesis to challenge sociologists chronicling the trajectory of the cohort.

Staying Connected

Technology has changed the way families interact. In 1960, 22% of households had no telephones. By 1980, only 7% lacked phones. Today, nearly 20% of U.S. households are "wireless" with no landline at all; only 2% have no telephones (Blumberg and Luke 2009). Cellular phones highlight how remote communication for families has shifted, very quickly, from household-centric to egocentric. Seniors account for the largest share of households with landlines, and wireless-only households are most prevalent among 18-to-35-year-olds. The Internet allows family members to live further apart but remain in touch. At home, families use baby monitors and webcams to keep watch over one another. YouTube™ videos share the baby's first steps or the nephew's wedding with kin across the globe.

Despite stereotypes of tech-savvy teenagers, older people now use technology to stay connected and informed. Many Baby Boomers have had jobs that required computers, exposing them to information technology long before they reached retirement age. Earlier cohorts pick up technology in an ad hoc way (e.g., being taught by grandchildren). According to the Pew Internet American Life Project, Baby Boomers use on-line banking, travel booking, and emails to kin and coworkers more than younger and older generations. Younger people do homework, socialize via chat and social networking sites, play games, and use email. Older Internet users, ages 73 and up, limit their use to email and information searches, particularly for health information. Very old people are also less likely to use cellular phones.

Information technology has implications for how family members stay in touch. Although the geographical distance between adult children and their parents has increased over time, a study of seven Western nations shows 1988–2001 increases in the frequency of "other" (not face to face) contact between adults and their mothers, a trend tracking the diffusion of telephones and email (Treas and Gubernskaya 2009). Distance has always mattered for maintaining relationships, but technology decreases its significance for many forms of interaction (Mok et al. 2007). Even face-to-face interaction is possible at a distance with videochat services, but the need for in-person contact may diminish as technology changes the content of interactions. For instance, the 1990s' increase in older adults' use of assistive technology (grab bars, walkers, etc.) coincided with declines in the personal care (e.g., help bathing) often provided in person by kin (Freedman et al. 2006).

The risks of not having localized kin may be greater for older people than for younger ones, however. Preferring phone and in-person visits over newer technologies, very old adults risk social isolation – a major predictor of bad health and mortality. Geriatric care technology, however, has

evolved from assisted devices, such as hearing-aides, to health and environmental solutions incorporating the Internet and monitoring devices embedded in "Smart Houses." Technologies allow doctors and kin to monitor the health, safety, and well-being of older adults when local contact is impossible. As elder outreach programs teach seniors how to use computers, the Internet promotes successful aging by allowing people to connect with family, health, work, and consumer relations – all while aging in place, at home.

In summary, new technologies compensate for the growing geographic distance between young and old. In the home and on the go, they bridge disconnected kin and become a key feature of successful and productive aging. While the oldest-old have been slower to adopt new communication tools, the Baby Boomers will narrow the generation gap in technology.

Looking Back, Looking Forward

Diversity and change may challenge our knowledge base, but they also validate the theoretical perspectives that guide research on aging and the life course. Social change calls into question taken-for-granted assumptions. Thirty years ago, it seemed that contact between aging parents and grown children might become a casualty of declining residential proximity between the generations. Few anticipated that immigrant families would buoy the numbers of multigenerational households, that grandparents would step in to care for grandchildren when parents could not, and that new communication technology would sustain daily contact across vast distances. Although new family forms were recognized, few in the early 1980s anticipated how quickly same-sex relations would win acceptance. Nor did they guess that family issues would come to dominate narratives about gays and lesbians. The current financial crisis has shaken what we know about our largest cohort, but it has reaffirmed the importance of intergenerational support in adversity. Foreclosures, unemployment, and shrinking 401Ks demand that we revisit the conclusion that most Baby Boomers (despite or because of their unique family life course) will enter old age on solid financial footing.

Rapid social change is the friend of life course research, which illuminates the change in individual lives. From social changes of the past three decades have come new conceptual tools. The "destandardization" of the life course brought balance to historical accounts of "standardization," the growing regimentation of individual trajectories brought about by the state and other social institutions. "Productive aging," the social and economic contributions of older adults, unified studies on caregivers, community volunteers, and older workers. At the same time, social changes validated studies of aging and the life course. As the Baby Boomers grow older, they are driving home the practical importance of knowledge about family relations, work, health, and satisfaction in later life. Theoretically and methodologically, the concepts of cohorts and generations permit sociologists to gain a purchase on the rise of self-actualizing value orientations, the family life course adaptations of the Baby Boomers, and the growing acceptance of same-sex couples. Pursuing parent–child relationships beyond childhood, research confirms that social changes affecting early life have lasting consequences.

These social changes create new opportunities for research on aging and the life course. The twin processes of life course standardization and destandardization point to the need to understand how phenomena such as mass incarceration and international migration emerge as normative transitions in certain populations, how they color the lives of those who experience these events, and how they impact parents, children, and other linked lives. The convergent life courses of men and women invite a second generation of research on how these changes play out across different social classes and different countries. Increasing rates of labor force participation in later life, coupled with the financial crisis and the demographic challenges to social insurance systems, call for new attention to the socioeconomic life course.

The coming years offer an opportunity to influence the direction of change with research that informs public opinion and social policy. Take immigration law. Research on the dependence of an aging society on foreign-trained healthcare workers points up the need for immigration policies based on employment considerations, but studies of the interdependent fortunes of immigrant family members highlight the value in current laws reuniting kin. Research reveals thorny issues of justice, such as the lack of legal protections for young undocumented immigrants who have lived virtually their entire lives in the U.S.

As the contest over same-sex marriage makes clear, most family law is made by states, not the federal government. Given this patchwork tradition, the support for family forms – from covenant marriages to single-parent adoptions to custodial grandparenting – depends on where one lives. These variations make for natural experiments that can inform debates on how policies and contexts promote the well-being of families over the life course. New family constellations are often victims of cultural lags, whereby existing institutional arrangements are out of step with the realities of life. Sociologists can sensitize others to the challenges which the life course poses for foster families whose children age out of the system, elderly immigrants who long to go home, or same-sex couples confronting end-of-life issues. By bringing our theories and methods to the task, the sociologists of the life course can most assuredly contribute to society and sociology in coming decades.

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Part IV
Social Relationships and Aging

Chapter 10
Social Relations and Aging

Deborah Carr and Sara M. Moorman

Studies dating back to Emile Durkheim's (1897) *Suicide* demonstrate that social relationships provide emotional, social, and economic supports that enhance physical and emotional well-being throughout the life course (House et al. 1988). Over the past three decades, however, researchers have discovered that social relationships are not universally protective for late-life well-being; rather, the protective effects of social ties vary based on the structure, nature, and quality of the relationship. Methodological advances also have enabled researchers to ascertain whether the association between relationships and health reflects social causation (i.e., direct benefits of social relationships), or selection (i.e., characteristics of those people who form and maintain relationships over the life course). Social gerontologists no longer ask, "*Do* social relationships affect the well-being of older adults?" Rather, they now ask, "*Why, how, when, and for whom* do social relations affect the health of older adults?"

In this chapter, we first discuss recent innovations in the conceptualization and measurement of older adults' relationships, including their objective and subjective properties, structures, and functions. We then provide an overview of the characteristics and health implications of four types of relationships: marriage and romantic partnerships (and the dissolution thereof through widowhood and divorce); intergenerational relationships (i.e., parent–child and grandparent–grandchild); friendships; and lack of satisfying relationships (i.e., loneliness). We then discuss the consequences of late-life relationships for health and well-being., We conclude by highlighting the research topics and methods that hold great promise for future exploration, and the implications of recent research for social and health policy.

Conceptualizing and Measuring Social Relations in Late Life

General Properties of Social Relationships

Social relationships are a multifaceted concept, encompassing a variety of structures, functions, and qualities. They may be based on legal ties, blood relations, coresidential status, or simply a fondness for and a desire to affiliate with one another. Relationships also vary with respect to their voluntariness, permanence, and duration. Voluntariness refers to whether one chooses to enter a relationship; permanence indicates whether one is able to terminate a relationship; and duration describes the amount of time that the relationship has existed.

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Family ties, particularly relationships with blood relatives such as parents, siblings, and children, are involuntary and are based on a powerful sense of obligation, thus they cannot be abandoned easily (Litwak 1985). By contrast, friendships and romantic relationships are formed voluntarily in contemporary western societies; most individuals choose to befriend or marry persons with whom they are compatible. Social ties with friends and even romantic partners today may be terminated without violating important norms regarding obligation and commitment, although adults may incur some emotional or financial costs from severing these ties (Litwak 1985). For older adults, sibling relationships generally have the longest duration of any relationship; they are formed at the birth of the younger sibling and typically persist until one's death. Marriages, parent–child relations, and friendships, by contrast, typically begin later in the life course – when one marries, gives birth, or forms a new friendship.

Sociologists and psychologists have developed a range of measures to further capture important quantitative and qualitative aspects of social relationships. Early studies typically focused on simple quantitative characteristics such as the number of persons in one's social network, to capture one's social embeddedness and integration (Antonucci 1990). In the past decade, social networks researchers have developed innovative new measures to further capture quantitative aspects of one's relationships, including their density (i.e., number of people in an individual's network who know one another) and multiplexity (i.e., number of different types of interactions exchanged within a single dyadic relationship) (Smith and Christakis 2008).

One of the most influential research advances, however, has been the widespread recognition that qualitative (or subjective) aspects of relationships are more important to one's well-being than are simple counts of significant others. For instance, measures of perceived support are stronger predictors of well-being than the number of persons in one's network available to provide help. Similarly, subjective appraisals of positive and negative relationship characteristics are powerful predictors of older adults' well-being (Rook 1998). Positive aspects include feeling loved, cared for, and understood, whereas negative aspects include demands, criticism, and conflict. A recent innovation is the conceptualization and operationalization of "ambivalence," which refers to having both positive and negative sentiments toward a single person or relationship (Lüscher and Pillemer 1998). For example, a spouse's well-intended desire to provide advice may be appreciated, yet also perceived as critical. Ambivalence is a common feature of late-life relationships, especially among spouses and parents and their adult children.

Functions of Social Relationships in Later Life

Social relationships also vary widely with respect to the functions they serve in older adults' lives. Older adults often rely on members of their social network for emotional and instrumental (i.e., practical or financial) support, yet they may expect and desire different types of support based on the nature of a particular relationship. Individuals usually expect both instrumental and emotional support from family members, but emotional support only from friends. Two influential models have been developed over the past three decades to characterize older adults' support preferences. The hierarchical compensatory model proposes that older people have a rank-ordered preference for receiving support from others (Cantor 1979). Most will turn first to family members and turn to nonfamily only when kin are unavailable. Cantor (1979) further specifies that people prefer to receive support from their spouse, followed by children, other relatives, friends, and professionals or formal organizations. Empirical studies generally support the hierarchical model; older adults are more likely to both prefer and receive assistance from a spouse, followed by children, other relatives, and friends.

The functional specificity model counters that supportive relationships are best matched according to each partner's needs and resources (Litwak 1985). For example, a married woman may turn

to her best friend for emotional support or household help, if she feels that her husband is ill equipped to do so. Studies consistently show that emotional support from friends is more strongly associated with emotional well-being than comparable support from family, suggesting that support is most effective when provided by persons who are most qualified to do so.

Both the hierarchical compensatory and functional specificity models were developed to characterize relationships at one point in time, however. The "convoy model," by contrast, emphasizes that individuals maintain convoys of significant others who provide both instrumental and emotional support over the life course (Kahn and Antonucci 1980). The desirability, value, and types of support needed from a member of the convoy may change over the life course. The number of persons included in one's convoy, as well as one's level of closeness to convoy members, shifts over the life course. The model also emphasizes reciprocity and "support banks," where deposits are made early in the life course in anticipation of future needs or "withdrawals." This is one mechanism through which support to older family members becomes obligatory; adult children may feel obliged to "give back" to the parents and grandparents who supported them earlier in the life course.

All three models imply that older adults desire support from significant others. However, several theorists acknowledge that individual-level and cultural factors may affect the comfort with which one solicits and accepts help. Cohler (1983) has argued that self-reliance and autonomy are core values of capitalist societies, and they inhibit expression of dependency among older adults in the United States. For example, studies repeatedly show that older adults – even those with serious physical health limitations – do not want to reside with their adult children but prefer to remain independent and reside in their own homes: that is, they want "intimacy at a distance." Feeling dependent on significant others, especially for health-related caregiving, may be highly distressing to frail older adults and even hasten their desire for death. In sum, older adults' social relationships are not a monolithic entity; rather, they differ with respect to their number, structure, subjective qualities, and functions. As we shall see next, each of these aspects of relationships carries important implications for the well-being of older adults.

Marriage and Other Romantic Relationships

Concepts and Patterns

Heterosexual marriage is the most common type of romantic relationship among older Americans. In 2008, 73.2% of men and 42.9% of women aged 65 and older were married. A larger proportion of women (41.9%) than men (13.8%) are currently widowed, reflecting men's higher mortality risk and greater tendency to remarry. Only 10.3% of older men and women are currently divorced. Divorce was relatively rare and stigmatized during the young adult years of current cohorts of older adults, and most of those who did divorce ultimately remarried. Only 4.1% have never married (U.S. Bureau of the Census 2008).

As of February 2011, *same-sex marriage* is legally performed in five U.S. states and is recognized, though not legally performed, in three states. Exact numbers of legally married gay and lesbian couples are difficult to determine, because many couples report being "married" despite having no U.S. marriage license and because the legal status of unions may shift as new state legislation is implemented. Of those gay men and women who say they are married, 21.0 and 16.5% are 65 or older, respectively (O'Connell and Lofquist 2009). By contrast, 13% of all Americans are aged 65 and older, thus older adults are overrepresented among gay and lesbian partners who self-identify as married.

Many older adults, like younger persons, are in committed nonmarital romantic relationships. In 2000, *heterosexual cohabitation* was the relationship of choice for 4% of unmarried persons

over aged 50 in the United States (Brown et al. 2006). According to estimates from the U.S. Census, *same-sex cohabitation* is an uncommon status for older Americans. Only 5.5% of gay male and 4.5% of lesbian cohabiting couples are aged 65 or older, although this may reflect the way that gay couples are measured in the Census. Reports are based on one's own gender, one's report of the cohabitant's gender, and the householder's report of the relationship between the two (O'Connell and Lofquist 2009). By contrast, studies based on nonrandom samples indicate that as many as one-quarter to two-thirds of coupled gay and lesbian persons aged 50 or older live with their partner (Grossman et al. 2000).

Some older couples in committed romantic relationships do not coreside – an arrangement called *living apart together*. In the United States, 7% of women and 6% of men report that they "live apart together" (Strohm et al. 2008). Older adults who choose this arrangement tend to own their own homes, and neither partner wants to move and combine their possessions nor create inheritance complications for their children. Older women also may not want to take on the homemaking and caregiving responsibilities that often accompany coresidence.

Researchers know relatively little about *dating* in later life. Although the American Association of Retired Persons commissioned a national study of dating in 2003, their sample of more than 3,000 persons focused on those aged 40–69 only. Carr (2004) estimated that 18 months after becoming widowed, only one-fifth of men and one-tenth of women in their 60s or 70s residing in the Detroit area were dating – although nearly 40% of men and 15% of women said that they were interested in dating. In the next decade, we suspect that much more will be learned about dating. Aging Baby Boomers, many of whom divorced and re-entered the dating market in later life, may feel more comfortable and less stigmatized in discussing their nonmarital, perhaps even casual, sexual, and romantic relationships.

Implications for Health and Well-Being

Empirical studies consistently show that married persons are healthier than their unmarried counterparts; strong effects are found for a range of outcomes including all-cause mortality (Johnson et al. 2000) and psychological distress (Johnson and Wu 2002). *Social selection* and *causation* are the dominant explanations proposed for the so-called "marriage benefit." The social selection perspective holds that healthy and financially secure people are more likely to marry and remain married over the life course, thus accounting for the association between marital status and health. The social causation perspective counters that marriage provides social control, economic, and psychosocial benefits that directly enhance health.

Marriage is a key source of social control; married people are less likely than unmarried persons to smoke, drink excessively, and engage in risky behaviors like not wearing seat belts. Spouses, especially wives, may help their partner with health-enhancing behaviors, such as regular visits to the doctor, exercise, healthy eating, and complying with medication regimens (Schone and Weinick 1998). Partnered adults also have higher household incomes than single individuals, and economic well-being predicts good health. In general, persons in a committed relationship are more likely than the unpartnered to report that they have a confidante, and that they feel loved and supported. Although representative studies of long-term gay and lesbian relationships are rare, mounting research suggests that they provide at least some of the same benefits for older adults' well-being as do heterosexual marriages (Grossman et al. 2000).

One of the most provocative discoveries in recent decades is the recognition that the benefits of a romantic relationship vary considerably based on legal and structural aspects of the relationships. First marriages are more protective than remarriages, legal marriage is more protective than cohabitation or dating, and heterosexual relationships are somewhat more protective than gay and lesbian

relationships. For example, the "benefits" of remarriage for mental health and self-rated physical health are more modest than for first marriages (Barrett 2000). These protective effects also are short-lived, appearing only in the early stages of the remarriage transition (Blekesaune 2008). Similarly, cohabitors fare better than unpartnered persons yet worse than married persons in terms of depressive symptoms (Brown 2000), all-cause mortality (Koskinen et al. 2007), and self-rated physical health (Wu et al. 2003). A recent analysis of merged data from the General Social Survey, National Health and Social Life Survey, and the Chicago Health and Social Life Survey found that partnered gays and lesbians were similar to married persons and straight unmarried cohabitors in terms of self-rated health but fared poorer on measures of happiness (Wienke and Hill 2009).

Most scholars concur that these patterns reflect social selection more than social causation, however. For example, older heterosexual cohabitors have a greater mortality risk than their married peers, due largely to the cohabitors' relatively lower socioeconomic status. However, some studies suggest that cohabiting relationships are qualitatively different from marriages. Marcussen (2005) found that older cohabiting men receive fewer caregiving benefits than their married peers, perhaps because older cohabiting women felt less obligation than married women to provide this time-intensive care. Moreover, gay partnerships and remarriages face distinctive stressors that persons in heterosexual first marriages are spared of, including homophobia and strains of negotiating relationships with ex-spouses (and stepchildren), respectively. Future studies should explore the distinctive stressors experienced by a range of romantic relationships, including cohabitation, same-sex unions, and higher order marriages, to help pinpoint precisely why their health benefits are not comparable to those reaped in marriage.

Across all types of romantic relationships, however, health benefits are contingent upon relationship quality. Survey-based studies show that negative marital interactions increase one's risk of poor physical and emotional health (Liu and Umberson 2008). A pathbreaking development over the past decade has been the identification of the physiological pathways through which relationships "get under our skin," with particular attention to cardiovascular, endocrine, immune, metabolic, and sympathetic nervous systems (Ryff and Singer 2001).

Experimental studies typically induce either conflict or closeness among couples in laboratory settings, and then gauge physiological responses. Relationship conflict can impair immune response, slow wound healing, heighten susceptibility to infectious agents, and increase cardiovascular reactivity – all factors that may increase mortality risk among older adults (Robles and Kiecolt-Glaser 2003). Experiments focusing on positive interactions show that inducing physical contact and closeness under a stressful condition may decrease blood pressure and heart rate, and increase oxytocin, a hormone that weakens the impact of stress (Grewen et al. 2005). Negative interactions typically have a more powerful impact on health than positive interactions, and effects are stronger for women than men (Robles and Kiecolt-Glaser 2003). In sum, while long-term committed relationships provide emotional and health-enhancing supports, these benefits vary widely based on the legal status and quality of the relationship, and the personal characteristics of those who enter into (and remain in) such unions.

The Loss of Romantic Relationships: Divorce and Widowhood

Later life is marked by the loss of important social relationships, including the deaths of friends, siblings, parents, and spouses. Relationship loss via divorce is very rare among current cohorts of older adults; the vast majority of divorced older adults dissolved their marriages in young or middle adulthood, and many subsequently remarried. Studies using cross-sectional and administrative data show that currently divorced older adults have an elevated risk of all-cause, cardiovascular disease, cancer, and suicide mortality relative to married persons (Johnson et al. 2000). However, studies

based on multiwave data showed that much of this gap is due to social selection, particularly the disadvantageous health and personality traits of those who divorce and do not ultimately remarry (Sbarra and Nietert 2009). As later life divorce becomes more normative among members of the Baby Boom and subsequent cohorts, however, researchers will need to delve more fully into the distinctive ways that late-life marital dissolution affects health and well-being.

Widowhood, by contrast, is a distressing and health-compromising transition faced overwhelmingly by older adults; two-thirds of the 2 million deaths occurring in the United States each year befall persons aged 65 and older (Federal Interagency Forum on Aging-Related Statistics 2009). Older bereaved spouses lose their primary source of emotional, instrumental, and financial support along with the disruption of daily routines and practices. While early stress theories suggested that widowhood was universally and intensely distressing, emerging evidence shows that the physical and emotional consequences of widowhood vary widely, based on one's gender and the nature of one's late relationship.

Men are more likely than women to experience physical health declines, increased disability, and heightened risk of mortality after their wives die. While popular lore claims that widowers may "die of a broken heart," research shows that it is the loss of a helpmate and caretaker that is really the culprit. Wives typically monitor their husbands' diets, remind them to take their daily medications, and urge them to give up vices like smoking and drinking (Umberson et al. 1992). Widowers are more likely than married men to die of accidents, alcohol-related deaths, lung cancer, and chronic ischemic heart disease during the first 6 months after their loss, but not from other causes that are less closely linked to health behaviors (Martikainen and Valkonen 1996). Even worse for older men is that their wives often are their primary (or only) source of social support and integration; when a man loses his wife, he also loses an important connection to his social networks.

By contrast, women's more emotionally intimate social relations over the life course are an important resource as they adjust to spousal loss. Older widows typically receive more instrumental and emotional support from their children than do widowers, given mothers' closer relationships with their children throughout the life course. Women also are more likely to have larger and more varied friendship networks than men, and these friendships provide an important source of support to women as they cope with their loss (Ha 2008).

The well-being of older widow(er)s also is linked to the emotional climate of the late marriage. Early writings, based on the psychoanalytic tradition, proposed that bereaved persons with the most troubled marriages would suffer heightened and pathological grief (Parkes and Weiss 1983). This perspective held that persons who had conflicted marriages would find it hard to let go of their spouses, yet also feel angry at the deceased for abandoning them. However, longitudinal studies that track married persons over time through the widowhood transition find that the loss of high-quality marriages is most distressing. Wheaton (1990) found that the emotional consequences of role loss are contingent upon one's "role history"; widowhood is distressing when the marital relationship had been satisfying. In sum, while classic bereavement theories proposed that a romantic partner's death is universally distressing, more recent work suggests that reactions to loss are contingent upon precisely what was lost: the loss of a beloved helpmate has a more profound impact than the death of a difficult or distant spouse.

Life-Long Singlehood

Never married persons have been nearly absent from social relations research. This absence reflects the fact that only 4% of persons aged 65 and older in the United States have never married (U.S. Census Bureau 2008). As such, researchers using sample surveys often do not have enough cases to study the health and well-being of the never married. Mortality is one of the few outcomes

studied, because mortality and marital status data are available on vital registries and large administrative data sets such as the National Longitudinal Mortality Study (Johnson et al. 2000). However, these sources include only basic demographic measures, so researchers cannot explore the psychosocial pathways through which singlehood affects health.

The few studies exploring other indicators of single older adults' well-being reveal quite a positive picture. Older never married women enjoy mental health (Pudrovska et al. 2006) and physical health (Cwikel et al. 2006) equal to their married peers, and superior to their formerly married peers. These patterns partly reflect selection, where older cohorts of never married women are better educated than their married and formerly married peers, and have richer economic resources than their divorced or widowed peers. Moreover, never married women have adjusted to their status over time; they have chosen relationships that offer socioemotional support (Pudrovska et al. 2006), and they rely on formal services such as meal preparation services to help manage their instrumental needs (Cwikel et al. 2006). In sum, while research on the health of never married persons is sparse, the evidence generally reveals that singlehood may carry health advantages for women, yet these advantages typically reflect social selection factors including greater educational and economic resources of never married women in current cohorts of older adults.

Parent/Child Relationships and Grandparent/Grandchild Relationships

Thus far, we have focused solely on relationships between romantic partners; however, intergenerational relations also are a critical source of support (and strain). We now discuss characteristics and health consequences of parent–child and grandparent–grandchild relations.

Patterns and Concepts

Approximately 85% of American adults aged 65 and older are parents. Childless older adults are a heterogeneous group, including those who are child-free by choice, and those who desired children yet did not ultimately become parents. In 2010, 80% of women aged 60–64 will have at least one grandchild, but they will have fewer grandchildren than same-age women in prior cohorts. Due to increases in longevity, children will have more living grandparents than in the past: In 2020, nearly half of 10-year-olds will have four living grandparents, and four-fifths of 30-year-olds will have at least one living grandparent (Uhlenberg 2005).

Implications for Health and Well-Being

Nearly two-thirds of parents aged 50 and older rate their relationships with all of their adult children as excellent, and relationships tend to become even better as parents and children age (Birditt et al. 2009). However, even the best filial relationships can experience tensions, which may threaten older adults' well-being. Older adults who rate even one of their relationships with an adult child to be anything less than excellent report less happiness and more depressive symptoms (Ward 2008). Older parents may experience ambivalent feelings in their relationships with adult children when children face major problems, such as an illness, divorce, a legal problem, or substance abuse.

Such major problems in the life of an adult child also may affect older adults' health and well-being indirectly – via taking on the role of caregiving or custodial grandparent. Grandparents who

are raising their grandchildren are a topic of heightened concern in the United States today. More than 1.5 million children (2.0% of all children) now live with at least one grandparent and no parent, and this figure underestimates the number of children whose primary noncoresidential caregiver is a grandparent (U.S. Census Bureau 2008). Grandparents step into a parenting role, or are asked to step in by a family member or the state, when their children (i.e., parents of the grandchildren) experience serious problems such as physical or mental illness, substance abuse, incarceration, or homelessness. Love and obligation may motivate grandparents to keep their grandchildren in the family and out of the foster care system.

Serving as primary caregiver to a grandchild is highly stressful: Grandparents worry about their children's problems and the financial demands of raising grandchildren – many of whom have emotional or developmental difficulties – all while navigating their own aging process. The early stages of caregiving are especially difficult. New custodial grandparents may forgo their own preventive behaviors, and experience increased depressive symptoms and poor physical health (Hughes et al. 2007). Despite the strains imposed by coresidence with their grandchildren, grandparents provide an indispensable safety net. Moreover, for many older adults, grandchildren provide an important source of happiness and purpose.

Friendships in Later Life

Older adults are more than romantic partners or caregivers to the younger generations; most maintain vibrant friendships with peers. Research on late-life friendship has flourished over the past three decades. Friendship is distinct from family relationships in that it is voluntary, nonobligatory, and typically based on the exchange of emotional rather than instrumental support (Blieszner and Roberto 2004). Friends are usually of similar ages, whereas family relationships often are cross-generational and thus may be marked by an imbalance of power. Because of their voluntary nature, friendships require more agency and motivation than familial relationships; they must be sought out, cultivated, and maintained – or in the case of unsatisfying relationships – dissolved. Healthy friendships also tend to have an equitable "give and take." Reciprocity, or being able to give back support equivalent to what was received, is more important to the quality and sustenance of friendships than kin relations (Rook 1987). Because friendships are less institutionalized than family relationships, however, norms for affiliation may be unclear, creating potential for discord and misunderstanding (Blieszner and Roberto 2004).

Friendships carry more rewards than costs, including companionship, shared leisure, emotional support, social integration, and informational assistance. Friendship is a more powerful predictor of older adults' psychological well-being and life satisfaction than family relationships. Persons with rich friendship networks tend to have better physical health than those with more tenuous ties, yet this relationship is mutually influential; those with good health also are best equipped to maintain friendships (Rawlins 2004).

Like family relationships, friendships differ in the levels of instrumental and expressive support they provide. Rawlins (2004) has observed that friendships have "two general modes": confidantes and companions. The former are based on intimate conversation, caring, strong emotional attachment, commitment, and loyalty. The latter, by contrast, involve socializing, social interactions with groups of individuals, limited emotional attachment, and reciprocity.

Late-life friendships vary by gender and social class. Older women's friendships involve more intimate self-disclosure, whereas men's friendships often are based on shared activities. As a result, women tend to have closer same-sex friendships than men do, and this is particularly true for married individuals. Most married women have close confidants beyond their spouse, but men typically do not (Antonucci 1990). Middle class older adults tend to have more friends than their working

class peers (Phillipson 1997), perhaps due to their greater financial resources and greater likelihood of living geographically far from their kin.

An important discovery over the past three decades is that friendships change in quantity, quality, and importance over the life course, particularly as one faces late-life transitions including widowhood and the onset of health problems, and as one's needs change (Litwak 1985). Laura Carstensen's influential socioemotional selectivity theory proposes that older adults selectively choose to maintain relatively fewer, but higher quality, relationships as they age and experience declines in health. Casual, less rewarding ties may lapse while only the most meaningful relationships are maintained (Carstensen et al. 1999). Empirical evidence confirms that as adults age they evidence a reduction in the number of friends reported (Phillipson 1997). This decrease in the number of one's friendships may not entirely reflect preferences, however. As older adults retire, their ties to workplace friends weaken, while physical health declines, caregiving demands, and functional limitations may impede one's ability to maintain social ties. Some scholars speculate that online relationships may become increasingly important to older adults, especially those with serious mobility limitations, as they enable social interaction with acquaintances and "weak tie" relationships (Wright 2000).

An important avenue that researchers are only starting to explore is the identification of specific tasks for which friends are "substitutable" when family ties are not available. For example, a recent study of older adults' choices for health care proxy designations revealed that nearly all (85–90%) married persons and parents named a spouse or child to make end-of-life decisions for them. Among unmarried childless persons, by contrast, nearly one-quarter appointed a friend to play this important role (Carr and Khodyakov 2007). Other studies reveal that widows and widowers are less likely to seek out new romantic partnerships if their social and emotional needs are met by supportive friends (Carr 2004). Among future cohorts of older adults, for whom divorce rates are higher and fertility rates lower than for current cohorts, friendships may be an essential source of instrumental and emotional support.

Absent and Unfulfilling Social Relationships: Loneliness and Social Isolation

Old age historically has been considered a time of social isolation. Disengagement theory proposed that it was beneficial for both the older adult and society if the elder were to gradually withdraw from his or her social roles and relationships (Cumming and Henry 1961). Similarly, classic role theories held that the loss of the work role for men (via retirement) and loss of the wife role for women (via widowhood) would leave older adults socially isolated and despondent (see Biddle 1986, for review). More recent research counters, however, that while loneliness and social isolation are problematic, they are neither inevitable nor universal features of aging.

Over the past three decades, researchers have recognized that loneliness is not triggered by a quantitative lack of relationships, but by a lack of satisfaction with the number or quality of one's relationships. Contemporary researchers have identified two statistically and conceptually distinct subtypes of loneliness: emotional loneliness refers to the absence of an intimate confidante, while social loneliness refers to the absence of a broader social network. The two types are highly correlated; widowed persons, those living alone, or those living far away from their friends and families consistently report higher levels of both types of loneliness than persons who are more socially integrated (de Jong Gierveld and Havens 2004).

The mere presence of proximate relationships does not ward off loneliness, however. An estimated 25% of older married persons report emotional and social loneliness; this pattern is particularly common among persons whose spouses are ill, who have a dissatisfying (or nonexistent) sexual relationship, and who have infrequent or conflicted conversations (De Jong et al. 2009).

As de Jong Gierveld and Havens (2004) noted, loneliness depends on one's "standards as to what constitutes an optimal network of relationships."

Despite its subjective nature, loneliness is a serious problem for many older adults; it is linked to sleep problems, poor cardiovascular health, and elevated blood pressure, each of which carries long-term consequences for mortality risk (Cacioppo et al. 2002). Loneliness also may be a particularly acute social problem for older adults in future cohorts. Smaller families and an increased prevalence of divorce and childlessness among future cohorts of older adults may create a context where one maintains objectively fewer relationships (see Chap. 13), thus triggering social loneliness. More importantly, however, some have argued that current cohorts of midlife adults have unrealistically high expectations for what their social relationships should provide (e.g., one's partner should be their "soulmate"); if these lofty expectations go unfulfilled, then older adults may report higher levels of emotional loneliness, as well. In sum, it is not how many relationships one maintains that matters for one's late-life well-being, but the extent to which those relationships are deemed personally satisfying and fulfilling.

Looking Forward to the Next Three Decades

Over the past three decades, scholars have made major advances in conceptualizing and measuring the multifaceted nature of older adults' social relationships, and documenting the implications of these relationships for health and well-being. We anticipate that five topics are ripe for further exploration in the coming decades: sexuality; population-based studies of elder abuse; racial and ethnic differences in late-life social relationships; social relations of Baby Boomers; and the use of research methods that incorporate multiple reporters and multiple sources of health and relationship data.

Sexuality and Romantic Relationships in Later Life

Even at the turn of the 21st century, most studies of older adults' romantic relationships focus on the protective effects of instrumental and emotional support, and fail to consider another critically important component: sexuality. In the future, we expect that scholars will explore more fully the role of sexuality in older adults' relationships – regardless of whether the sexual relationship occurs within the context of a legal or coresidential relationship. Of particular interest is how sexual aspects of older adults' relationships are protective for health and well-being, and how aging-related changes in physical functioning may affect the quality and nature of sexual relations among long-term partners. Waite et al. (2009) suggest that older adults with high-quality sexual and intimate relations will have better trajectories of physical and mental health than those whose relationships function less well (or who lack such relationships). The recently collected National Social Life, Health and Aging Project (NSHAP), a nationally representative sample of community-dwelling individuals aged 57–85, provides in-depth measures of sexual behavior, practices, and health and will be an invaluable resource as social gerontologists further investigate both heterosexual and homosexual older adults' sexual relationships.

The Dark Side of Relationships: Elder Abuse

In the past three decades, researchers have documented that even high-quality relationships may be strained or ambivalent. Yet relatively little population-based research focuses on extreme negativity

in older adults' relationship. Elder abuse and neglect comprise intentional physical, emotional, financial, or sexual abuse, as well as failure by a caregiver to meet an older adult's basic needs (Bonnie and Wallace 2005). Elder abuse is a serious though understudied social problem; data historically have come from small, nonrepresentative samples; the criminal justice system; or agency or caregiver reports.

In 2004, however, the NSHAP obtained reports of respondents' recent experiences of mistreatment, and for those who reported mistreatment, their relationship to the perpetrator. NSHAP also obtained detailed demographic, health, cognitive functioning, and social relationships data (Laumann et al. 2008). These data reveal that family members are the most common perpetrators of elder abuse; verbal and physical abuse are most often committed by romantic partners and children, whereas financial abuse is most frequently perpetuated by children and siblings. In the next decade, sociologists will have the resources to fully explore the risk factors for and consequences of multiple types of elder mistreatment, with particular attention to the ways that family relations may elevate or buffer against the risk of multiple types of late-life abuse.

Racial and Ethnic Differences in Late-Life Social Relationships

Most research on late-life social relationships focuses on white Americans. This pattern partly reflects the fact that older blacks and Latinos are underrepresented in large-scale sample surveys, given their elevated rates of mortality and morbidity. However, documenting the nature and consequences of social relationships for ethnic minorities is an important inquiry. Some scholars have proposed that blacks' low rates of marriage relative to whites contribute to blacks' elevated risk of mortality and morbidity (Kaplan and Kronick 2006). However, this argument rests on the assumption that marriage benefits blacks' and whites' health similarly.

This assumption requires interrogation. Studies reveal that blacks report poorer marital quality and more marital conflict than whites, and that the economic gains to marriage are less for blacks than whites given black men's disadvantaged economic prospects (Broman 1993). Given these patterns, marriage may be less protective to blacks compared to whites. Further, given the very high levels of intergenerational integration and support in Latino and Asian families, it is plausible that the benefits of marriage *vis a vis* other social relationships are weaker than they are for whites. Identifying the distinctive contributions of marriage, parenthood, friendships, and sibling relationships to the health of ethnic minorities will be a valuable line of inquiry in the future decades. In 2006, whites, blacks, Latinos, and Asians accounted for 81, 9, 6, and 3% of the U.S. population, respectively. By 2050, these proportions will be 61, 12, 18, and 8%, respectively (Federal Interagency Forum on Aging-Related Statistics 2009).

As the demographics of older Americans shift, social gerontologists should identify the distinctive correlates of health and well-being for all ethnic and racial groups. Small-scale qualitative studies may be particularly useful in revealing the ways that the distinctive cultural views and practices of ethnic families affect late-life health and well-being. For example, Confucian values including filial piety affect the ways adult children monitor the health of aging parents among Chinese Americans (Park and Chesla 2007). Gendered cultural views such as *machismo* (i.e., men's adherence to traditionally masculine, high-risk behaviors) and *marianismo* (i.e., women's self-sacrifice for spouse and children) in Latino families affect both family relations and health practices – which may have important implications for later-life health (Cianelli et al. 2008). We are optimistic that future research blending qualitative and quantitative research may better illuminate the ways that cultural context shapes the relationship between family and health among ethnic and racial subgroups.

Social Relationships of Baby Boomers

Much of what scholars know about older adults' social relationships is based on the experiences of current cohorts of older adults, those men and women born in the early 20th century who were socialized into rigid gender-typed social roles during their formative years and who often maintained a traditional division of labor in their marriages, where men were primary breadwinners, and women were primary caretakers for their husbands and children. It is not surprising, then, that the studies reported in this chapter reveal that women have closer ties to friends and children than their husbands, that women are an important source of health control to their husbands, and that men typically fare worse than women when their spouse dies.

For members of the Baby Boom cohort, the 75 million persons born between 1946 and 1964, late-life relationships may be reinvented. Future cohorts of older women are more likely than their predecessors to have received college degrees, held professional occupations, and shared childrearing tasks with their husbands. Future cohorts of men, by contrast, may have more emotionally intimate friendships than prior cohorts of men who were socialized to be self-sufficient and independent. Thus, we might expect future cohorts to fare better in the face of spousal loss – given that women may have the economic resources and men the interpersonal resources to cope with bereavement. Further, given that Baby Boomers faced fewer social obstacles to divorce during their young and midlife years, we might expect that their late-life marriages will be of higher quality than current cohorts; older adults today may have faced social or economic pressure to remain in dissatisfying marriages. Given major shifts in family structure and gender role socialization over the past 30 years, we expect that scholars' understanding of older adults' social relationships may be transformed in coming decades.

Methodological Innovations

Sociologists overwhelmingly rely on large-scale sample survey data to document the nature and consequences of older adults' relationships. However, this approach has a number of limitations. First, survey-based studies of social relations typically focus on a single individual's report, rather than information from both members of a romantic dyad, or multiple members of a family or social network. Ironically, research purportedly exploring spousal dynamics or parent–child relationships typically relies on a single person's appraisal of the relationship.

Further, research reveals that a parent may have a very different relationship with each of his or her children, yet most standard survey items rely on an overall appraisal of one's relationship with "children" (Davey et al. 2009). It is not clear whether these measures tap one's assessment of the child with whom one is closest, most emotionally distant, or an average across children. New analytic techniques, such as dyadic data analysis, allow researchers to use information from multiple reporters to estimate how much each person's outcome is associated with both own and partner characteristics (Kenny et al. 2006). This approach enables researchers to explore questions such as: how do both spouses' reports of marital conflict affect each spouse's health and health behaviors, and to what extent does one partner's health behaviors and practices affect the other partner's outcomes?

Second, survey-based studies of relationships and health historically have relied on self-reports of symptoms and conditions, rather than physiological indicators that may capture short-term responses to relationship characteristics and strains. As such, scholars still do not fully understand how older adults' social relationships "get under the skin" to affect physical and emotional health. Laboratory research, conducted primarily by psychologists, has made important

advances, by measuring the physiological responses of older couples placed in either stressful or supportive settings (Robles and Kiecolt-Glaser 2003). In the past decade, a number of large representative sample surveys of older adults including the Health and Retirement Study, Midlife Development in the United States, National Health and Nutrition Examination Survey, NSHAP, and Wisconsin Longitudinal Study have supplemented their self-reported health data with extensive genetic and biological indicators, such as immune response measures. We are optimistic about the scientific discoveries that may develop in the next three decades, as interdisciplinary teams of researchers continue to investigate the complex ways that demographic, socioeconomic, biological, psychosocial, and genetic factors link social relationships to health and well-being among older adults.

Implications for Policy and Practice

Over the past 30 years, researchers have demonstrated that older adults maintain diverse social networks including but not limited to spouses, former spouses, children, grandchildren, siblings, and friends. Although socially integrated persons enjoy better health than those who are more isolated, the protective effects of social relations vary widely based on the quality of those relationships. These findings have important implications for social policy.

Current policies tend to privilege legal and biological ties over all other relationships. For instance, if an incapacitated older adult has not appointed a health care proxy, many states have policies that give priority to specific family members as substitute decision makers; spouses and children are typically at the top of the hierarchy. Likewise, the majority of U.S. states do not grant gay and lesbian partners the legal right to formalize their union. Public policies, and especially health care policy, should be based on an expansive definition of "family," and allow older adults to include as their decision makers, advocates, and beneficiaries whomever they consider their closest and most meaningful ties.

Although the health-enhancing effects of high-quality social relationships cannot be understated, it is essential to recognize that at least part of these benefits reflect social selection characteristics; that is, the preexisting traits of persons who enter in and out of particular relationships. For example, researchers have found that the deleterious health effects of divorce and grandparent–grandchild coresidence and the relatively weak health protection provided by cohabitation reflect the fact that those who divorce, serve as custodial grandparents, and cohabiters tend to have fewer economic resources than their counterparts. As such, a financial safety net that provides at least minimal quality housing, food, health care, and economic security may be the most effective policy for promoting physical and emotional well-being among older adults.

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Chapter 11
Intergenerational Relations in Later-Life Families

J. Jill Suitor, Jori Sechrist, Megan Gilligan, and Karl Pillemer

Relations between the generations have been a central feature in literature and popular culture throughout recorded history. The dramatic increase in life expectancy across the last century, combined with more recent changes in divorce, child-bearing, and women's employment, has challenged old assumptions and created new inquiries into intergenerational relations in later life. Thus, it is not surprising that the study of these relations in the later years has grown exponentially across the last three decades as scholars have rushed to identify and explain these new patterns of relations and their consequences on family members.

In reviewing the study of families in later life across the past 30 years, this chapter has three major goals. First, we highlight the major theoretical developments of this period. We then review the empirical research on intergenerational relationships in the family, including relations between parents and adult children and between grandparents and grandchildren. Because the literature on these topics is so extensive, we will focus our review in the following ways. First, we will concentrate primarily on interpersonal relationships among family members, referring when appropriate to related chapters in this volume that address other dimensions of intergenerational relations (e.g., caregiving, coresidence, diversity in later-life families, and demographic changes). Second, we will devote the most space to parent–adult child relations; this choice reflects the importance of this topic in the literature on later-life families. Third, we focus on later-life families in the United States; given the large body of work on cross-national differences in families, placing them in an appropriate historical and cultural context is beyond the scope of this review. Finally, consistent with the focus of the volume, we emphasize advances in the sociological study of later-life families across the past three decades, although research from other disciplines is noted where relevant.

Theoretical Roots and Conceptual Advances

The 1980s saw the emergence of an important body of theoretical work that influenced the study of relations between parents and their adult children, including Bengtson and colleagues' extension of the family solidarity model (Bengtson and Schrader 1982); Riley's (1987) essays on the significance of age in sociology; and Hagestad's (1986) and Nydegger's (1986) discussions of off-time transitions, optimum timing preferences, and filial maturity. This scholarship played a key

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role in expanding the range of approaches to studying parent–adult child relations, including new theoretical frameworks that emphasized dissensus rather than consensus and empirical studies that focused on life course transitions and within-family variations in parent–adult child relations.

Intergenerational Solidarity

Bengtson's intergenerational solidarity model was introduced just prior to the period on which we are focusing in this review, quickly becoming the dominant theoretical framework in the study of the intergenerational relations. Not only has Bengtson and colleagues' own body of work had a major impact on the field (cf. Bengtson et al. 2002), their framework has been incorporated in almost all of the major programs of research on intergenerational relations across this period (Rossi and Rossi 1990; Silverstein and Giarrusso in press).

Bengtson and colleagues posited that family solidarity is comprised of several interrelated components: (1) contact, (2) exchange of support, (3) norms of obligation, (4) value similarity, (5) relationship quality, and (6) opportunity structure. Empirical research framed by this model has been developed in three increasing complex directions. The first of these directions focused on single concepts, such as affect and support, emphasizing how they develop within the family (Rossi and Rossi 1990) and influence outcomes for parents and children (Silverstein, Chen, and Heller 1996; Giarrusso et al. 2001). In the second direction, individual concepts have been combined into a broader single measure of family solidarity. In these studies, solidarity is often the outcome, rather than the predictor (Silverstein and Bengtson 1997). In the third, most complex direction, scholars have explored the interdependence among concepts (Bengtson and Roberts 1991; Rossi and Rossi 1990), in the theoretical tradition of Homans (1950).

Most of the research drawing upon the solidarity model has explored parent–adult child relationships. However, there is evidence of the utility of this model for other intergenerational relations, particularly relations between grandparents and grandchildren (Giarrusso et al. 2001). In the early 1990s, Bengtson and colleagues (Bengtson et al. 2002) also expanded the model to incorporate negative affect. This development may have helped to fuel new theoretical developments on aging families across the past decade which have, paradoxically, challenged Bengtson's assumption that solidarity is the central factor shaping intergenerational relations.

The Life Course Perspective in Later-Life Family Relationships

Across the past three decades, the life course perspective has been one of the most influential approaches in the social sciences. Marshall and Bengtson's chapter in this volume provides a comprehensive discussion of the life course perspective; therefore, we will focus specifically on the way in which life course theories have shaped the study of intergenerational relations in recent decades.

As discussed in greater detail in Marshall and Bengtson's chapter, the life course perspective draws from both sociological theories of social change and psychological theories of individual and family development. This perspective highlights the importance of historical and social contexts and individual time and development on family relationships (Settersten 2003); further, it addresses individual change within the family context as well as how these changes are linked to other family members (Elder 1994). This perspective is complementary to Bengtson's solidarity model in that they both emphasize the importance of time and generation in explaining the relationships between members of all dyads within the family at any point in the life course.

Empirical studies of intergenerational relations across the past three decades have typically drawn upon the life course perspective to address two issues. First, studies have examined continuity in family relations across the life course, reporting that closer and more harmonious relationships

between parents and children in early life were associated with higher relationship quality and exchange of support across the life course (Rossi and Rossi 1990).

The second line of inquiry framed by the life course perspective addresses the notion of "linked lives," focusing on the ways in which life events experienced by family members shape their intergenerational relations. In some cases, the effects of transitions appear to be consistent, such as in the case of parental divorce, which almost variably lowers the quality of relations between fathers and their adult children (Connidis 2003; Wethington and Dush 2007). However, in many cases, the direction and extent of the effects are conditional. For example, adult children's divorce generally does not affect relations between the generations (Kaufman and Uhlenberg 1998), but it does when the event leads offspring to return to their parents' homes needing of high levels of support (Aquilino and Supple 1991). Further, consistent with Hagestad's classic work on timing (Hagestad 1986), the same transition may improve parent–child relations when the timing fits with normative life course expectations, but may have deleterious effects when it does not. For example, children's completion of higher education may improve relations with parents (Aquilino 1997), but not necessarily when an adult daughter returns to school while raising her own family (Suitor 1987).

In sum, the life course perspective has become an important conceptual tool in understanding relations between and within generations in later-life families. Thus far, much of the research that has drawn upon this framework has been cross-sectional, despite the obvious longitudinal character of its basic tenets; its influence is likely to become even stronger when more studies of intergenerational relations follow families across longer periods.

Ambivalence in Later-Life Family Relationships

A more recent theoretical development in the study of later-life families is intergenerational ambivalence. The concept of ambivalence has roots in classic theories in both sociology and psychology beginning in the early 1900s (Freud 1913; Merton and Barber 1963; Coser 1966); however, only since the late 1990s (Luescher and Pillemer 1998) has this concept come to play a central role in the study of intergenerational relations. Although this framework has been applied predominantly in the area of parent–adult child relations, it has also been used to shed light on other relationships in middle and later life such as those between grandparents and grandchildren.

In contrast to theoretical perspectives that focus heavily on positive aspects of intergenerational relationships, the ambivalence framework is based on the assumption that family relationships are characterized by both positive and negative feelings or attitudes. This perspective posits that family roles are often contradictory, thus producing ambivalent feelings (Pillemer and Suitor 2005, 2008). The majority of empirical work on intergenerational ambivalence has focused on parent–adult child relations, exploring the prevalence of ambivalence and identifying characteristics of parents, children, and dyads which predict this dimension of relationship quality (Pillemer et al. 2007; Wilson et al. 2006). A variety of direct and indirect measures of ambivalence have been used across these studies. Recent research comparing the most commonly used direct and indirect measures has shown that although they are moderately strongly associated, the association is not sufficiently strong to demonstrate that they capture the same underlying construct; further, the findings suggest that direct and indirect measures have different meanings for particular subgroups of parents and adult children (Suitor, Gilligan, and Pillemer 2009).

Taken together, this developing line of scholarship suggests that ambivalence is an important line of inquiry for understanding later-life families, primarily because it captures many complexities and nuances in later-life family relationships that previous research has not. Nevertheless, it is important to note that it complements both the solidarity and life course perspectives in its focus on understanding how current ambivalence is shaped by the complexity in role relationships across the life course.

Substantive Advances

Parent–Adult Child Relations

The early 1980s were a pivotal time in the study of parent–adult child relations. For much of the three previous decades, research on intergenerational relations was concerned with exploring patterns of contact and the provision of support to parents in need of care (Albrecht 1953; Winch 1970). This line of work was fueled by concern regarding the broad social changes occurring across that period, including the civil rights movement, the anti-war movement, and the women's movement. These societal upheavals led to skyrocketing increases in both women's employment and divorce, both were viewed to be particularly threatening to later-life families. However, by the early 1980s, research had demonstrated that parents and children continued to stay in regular contact and children, particularly daughters, continued to provide care to older parents in need. Thus, concerns about the demise of traditional intergenerational relations declined (Bengtson and DeTerre 1980), allowing scholars to turn to new questions regarding exchanges and other dimensions of parent–adult child relations.

Exchanges Between the Generations

From the 1980s through the first decade of the century, scholars of later-life families continued to monitor children's care to parents and also turned from asking merely *whether* children provide support to their parents to what factors lead particular children to provide support to particular parents and the consequences of parent care on adult children's physical, psychological, and social well-being. Research also turned to exploring the flow of support between the generations, as opposed to only from children to parents. In this section, we will focus primarily on instrumental exchanges with parents, including our discussion of expressive support in the section on relationship quality between parents and adult children.

Support from Parents to Adult Children. One of the patterns shown most consistently in this line of work is that, despite the concern that adult children will become overburdened with elder care, parents typically give more support than they receive until their 70s or 80s (Cooney and Uhlenberg 1992; Rossi and Rossi 1990; Umberson 2006). In fact, the flow of support generally does not change until parents' health begins to decline (Eggebeen and Hogan 1990; Rossi and Rossi 1990). The type of assistance that parents provide to their adult children varies as a function of the children's point in the life course, moving from assistance with childcare and routine housekeeping and maintenance tasks when children are raising young families to financial assistance as adult children move into later middle age (Cooney and Uhlenberg, 1992; Swartz 2009). However, it is important to remember that the support provided to adult children in the form of childcare and household tasks can also be considered to be financial assistance, in that they reduce the financial resources that children would otherwise have to direct toward these tasks. This point is best made by Silverstein and colleagues' calculation that the childcare provided by grandparents saves parents between 17 and 29 billion dollars (Gans and Silverstein 2006).

It might appear that parents provide more assistance to married adult children raising families; however, children who are not married are often in greater need, and therefore receive more support (Spitze et al. 1994; Suitor, Pillemer, and Sechrist 2006). Other life events and conditions that increase adult children's needs also lead to more parental support. For example, adult children who experience serious physical and mental health problems also receive greater support from parents (Seltzer et al. 2008; Suitor et al. 2006a, b), as do children who are divorced (Spitze et al. 1994), unemployed (Suitor, Sechrist, and Pillemer 2007), or who have engaged in deviant behaviors as adults

(Suitor et al. 2006a, b). It is also important to note that the support given to children in need is, in a sense, more costly to parents because the children's needs often render them unable to reciprocate in either the short-term or long-term (Pillemer and Suitor 1991; Greenfield and Marks 2006), which becomes more problematic as parents age and their needs increase while their ability to provide support to needy children declines (Seltzer et al. 2008).

Another way in which older parents may provide support for adult children is housing. Several studies during the 1980s highlighted the continued coresidence or return of adult children to their parents' homes not related to care for the older parent, but to the financial or emotional status of the adult child (Mancini and Blieszner 1985). Although coresidence may be beneficial for both generations, it is most often fueled by children's rather than the parents' needs and circumstances (Choi 2003; Ward, Logan, and Spitze 1992).

Some scholars argued that such coresidence would have detrimental effects on parents' marital quality and well-being (Clemens and Axelson 1985); however, findings from most large-scale surveys reported that such negative effects appeared primarily in the presence of high levels of conflict between parents and coresident children (Suitor and Pillemer 1988) and when children's coresidence resulted from problems in their own lives (Aquilino and Supple 1991; Pudrovska 2009). However, these findings suggest that the current economic crisis, involving the highest level of unemployment and home loss in nearly three decades and leading to increased coresidence (Fleck 2009), may be setting the stage for increased intergenerational coresidence and accompanying interpersonal and psychological stress resulting from the stressful circumstances that led to this arrangement.

In summary, research from the past three decades has shown that parents continue to assist their adult children, providing both routine support and support in times of particular need from the point when children enter adulthood until the parents' health or financial resources require that the flow of support begins to reverse toward the older generation. It is also worth noting that under normal circumstances, the provision of support to their children has few negative effects on parents' well-being, unless that support is needed due to children's serious problems, as discussed above, or when parents are experiencing their own stressful transitions, such as widowhood or retirement (Davey and Eggebeen 1998).

Support from Children to Parents. As noted earlier, one of the issues of greatest concern to sociologists studying older families across the past several decades has been whether adult children provide adequate support to their parents, and more recently, the effects of providing that support on children's physical, psychological, and social well-being. Both scholarly and popular interests in this subject have been so great that family caregiving has become one of the most rapidly growing bodies of literature in the social sciences since the early 1980s.

One reason for the rapidly growing interest in support to parents is the increasing number of adult children in their 40s, 50s, and 60s who have living parents (US Bureau of the Census 2010), relative to earlier decades. However, that does not mean that all of these parents are in need of care. As discussed earlier, the flow of support is disproportionately from parents to children typically until parents are in their 70s, at which point it begins to reverse. However, recent data on the health and activity of adults can be used to suggest that studies may soon find either that the flow continues toward children for a longer period than in earlier decades, or that there is an interlude in which there is little flow in either direction.

The phenomenon of "better aging" has found its way into popular culture as well as scholarly research, as illustrated by a recent cartoon in *The New Yorker* (2009) magazine which shows a wife saying to her husband with great enthusiasm, "70 is the new 50." Although that may be an oversimplification, the trends are certainly moving in that direction. First, data on chronic conditions and disability indicate that individuals are aging with fewer limitations, and thus are less likely to need care from their adult children. In fact, by 2007, only about 3% of persons ages 65–74 and

slightly more than 10% of those 75 and older in the United States had limitations in their Activities of Daily Living (ADLs); only about 6% of those 65–74 and less than 20% of those 75 or older had limitations in their Instrumental Activities of Daily Living (IADLS) (US Bureau of the Census 2010). Second, due to better health, individuals who are 65 and over have become increasingly likely to remain active and independent. For example, in the past three decades, there has been a substantial increase in the percent of individuals in this age group in the labor force, and the projections are that this trend will continue, particularly among women. Between 1980 and 2008, men 65 and over had a 13% increase in labor force participation, compared to a 64% increase for women in that age group (US Bureau of the Census 2010). By 2016, it is projected that more than one quarter of men in this age group will remain in the labor force, as will nearly one in five women.

These trends call into question whether the picture of care to aging parents is in transition. Despite recent interest in the "sandwich generation" of women caring simultaneously for parents and minor children (Spitze and Logan 1990), it is more likely that over the next few decades, parental caregivers will be well beyond raising minor children; in fact, many of these "children" will themselves be in their late 50s or early 60s when they begin parent care. Further, it may be important that adult children do not begin zealously providing support to parents who are not yet in need. In fact, several studies using data collected since the late 1980s, when the health of individuals over 65 had improved from earlier decades, have found that high levels of support from adult children had negative effects on psychological well-being (Silverstein et al. 1996), even when controlling on current health and previous depression. Perhaps, this is because many of those parents were not in need, yet received high levels of helping; such an interpretation would be consistent with Davey and Eggebeen's (1998) finding that adult children's support had positive effects on parents' well-being only when the support was warranted by the parents' circumstances.

The patterns we have just discussed raise an interesting question: When should children's support to parents be characterized as "caregiving" as opposed to part of an exchange relationship? When do parents' become sufficiently "old" to render the support they receive "caregiving" or "elder support?" The difficulty that scholars face when drawing these distinctions can best be illustrated by the age distributions of subsamples used in some of the investigations of intergenerational exchange and caregiving. In many studies, the "adult children" range well into their 60s (e.g., Cooney and Uhlenberg 1992); in fact, sometimes up to age 70 (Wakabayashi and Donato 2006). In other studies, however, the range of care *recipients* begins well below the upper limit in studies of caregivers. In fact, Davey and Eggebeen used a subsample from the National Survey of Families and Households (NSFH) with an age range beginning at 50 to study the effects of exchanges on "older adults' psychological well-being" (1998:92). Thus, there continues to be confusion about when parents become "care recipients" as opposed to exchange partners. This issue is likely to become more common as the trend toward healthy aging continues and the "sandwich generation" becomes the cohort of women 55–75 who are providing care *to* their older parents while beginning to receive care from their adult children.

Despite these changes in older parents' health and activity levels, the focus of studies of support to parents has changed remarkably little across the past three decades, continuing throughout the period to emphasize describing and explaining the flow of exchanges between parents and their adult children. This body of work has revealed several consistent patterns that we believe are worthy of note.

First, gender of both parents and children continues to play the greatest role in the study of support to the older generation. Mothers receive more support from their adult children than do fathers (Silverstein et al. 2002), and daughters are more likely than sons to be the source of that support (Spitze and Logan 1990; Chesley and Poppie 2009). On one hand, this pattern is not surprising, based on classic feminist arguments regarding women's greater investment in relationships and sensitivity to others' needs (Gilligan 1982; Chodorow 1978). On the other hand, it might be expected

that this pattern would become less pronounced as a consequence of changes in gender-role attitudes among Americans across the past three decades (Powers et al. 2004). However, this does not appear to be the case. Recent studies are equally as likely as older studies to report that both mothers and daughters are the most likely to provide and receive support than are fathers and sons (Suitor et al. 2006a, b; Chesley and Poppie 2009). Further, not only do daughters provide more support than do sons, but daughters are also typically both mothers' and fathers' preferred source of emotional support and help during illness (Suitor and Pillemer 2006; in press).

Because of daughters' prominent role in providing support to parents, one area of concern has been whether women's increasing labor force participation would reduce their ability to provide care. However, studies across the past three decades have shown that women's employment has fewer effects than was feared (Pavalko and Artis 1997; Pavalko, Chap. 37), despite the fact that women have become increasingly committed to the labor force.

Another demographic change that has been feared would shape patterns of support to parents is divorce. Most of this concern has centered on whether divorced daughters would continue to provide support to their parents; however, evidence from throughout the past three decades has shown that this is not the case (Cicirelli 1986; Spitze et al. 1994). In contrast, parents' marital instability does affect patterns of support. In earlier generations, almost all marriages ended with the death of one partner; however, for the first time in American history, the skyrocketing divorce rate of the 1970s created a notable population of older divorced parents. The consequences of parental divorce fall far more heavily on fathers than mothers. Most studies find little difference in support to older mothers (Lye 1996); however divorced fathers are far less likely to receive support than are their counterparts who remain married to their children's mothers (Lye 1996). Even if these divorced fathers remarry, support is less likely to be provided by their children (Lin 2008), although this is less pronounced when children have a long and close relationship with the stepparent (Ganong et al. 2009). Although no studies to date have followed divorced families from childhood through the later years, it is likely that the lower support to fathers follows a pattern of less closeness and contact in the early years following parents' marital disruption (Aquilino 2006; Scott et al. 2007).

The other demographic trend across the past three decades that may have greater consequences for support to parents in future decades is the increasing level of educational attainment, particularly among women. In 1970, only 8% of women had completed college, a figure that increased to only 13% by 1980; however by 2008, that figure had increased to 29% (US Bureau of the Census 2010). Although adult children who are better educated likely have greater resources to provide support to parents, college graduates are substantially more likely to be geographically mobile, thus reducing residential proximity to parents. This pattern is particularly consequential because, following gender, proximity is typically found to be the best predictor of intergenerational support, despite the greater ease of travel and communication in recent decades. It is likely to be another decade or two before we can assess the effects of women's increasing educational attainment on support to parents through changes in proximity.

Costs of Caring on Adult Children's Well-Being. Beginning in the 1980s, Pearlin and colleagues' groundbreaking theoretical work on caregiving provided a basis for viewing parental caregiving as a life course transition with much in common with other status transitions and life events studied by family scholars. One component of Pearlin's conceptualization of the stress processes that is particularly relevant to adult children's caregiving is that life events often intensify preexisting strains while also bringing older problems to the forefront (Pearlin 1989). One way in which to conceptualize the transition to caregiving is as a process that involves adhering to the norms of providing physical and emotional support to the care recipient (George 1986; Suitor and Pillemer 1990). Further, it has been recognized that successful adoption of this role includes some role renegotiation with the parent (Brody 2004). However, an aspect of the transition that is seldom considered involves the changes in role relationships with siblings, spouses, other kin, and even friends.

New caregivers must negotiate the expectations of their new role with all of these role partners, typically leading to changes in their relationships with the core of their preexisting social support networks (Litvin et al. 1995; Suitor and Pillemer 1987), a process that often rekindles conflict and ambivalence from earlier points in the relationship.

For example, the parent may serve as a source of expressive support early in the caregiving career (Walker, Pratt, Oppy 1992); however, as the parent's physical or cognitive health declines and the balance of exchange changes, the role relationship with the parent may well become a source of stress (Kramer 1997; Aquilino 1998), particularly in the case of dementia. Relationships with other role partners who were previously sources of support may also become sources of stress. In the case of siblings, caregiving often ignites tension in the relationship often stemming from earlier points in their relationship (Suitor and Pillemer 1987; Ingersoll-Dayton et al. 2003; Merrill 1996); in the case of spouses, the responsibilities of caregiving often interfere with the performance of marital and parenting roles (Suitor and Pillemer 1994; Spitze and Logan 1990). Whether preexisting role partners serve as a source of support or stress is shaped to a great extent by whether they have had direct experience themselves in the role of caregiver; consistent with studies of other status transitions, experientially similar role partners are much more likely to have a positive impact on caregivers' lives (Suitor, Pillemer, and Keeton 1995a; Umberson 2006).

Quality of Relations Between Parents and Adult Children

Have Parents and Children Remained Close? One question that has been investigated throughout the past three decades is whether parents and adult children have continued to have the high levels of closeness that was found in earlier studies (Adams 1968; Troll 1971). The answer to this question has been remarkably consistent: Dozens of studies across this period have found that most members of both generations report the relationship as very close (cf. Silverstein and Bengtson 1997; Kaufman and Uhlenberg 1998; Rossi and Rossi 1990; Sechrist et al. 2007) and relatively free of conflict (Szydik 2008; Umberson 1992). The consistency of this finding is of practical as well as scholarly significance, given that close and harmonious relations between the generations have salutary effects on both parents and children, whereas conflict and the absence of closeness have deleterious effects (Koropeckj-Cox 2002).

The Generational Stake in The Twenty-First Century. A second question enduring across the past three decades involved the generational stake proposed by Bengtson and Kuypers in the early 1970s (Bengtson and Kuypers 1971). Family scholars in the 1960s and 1970s (cf. Neugarten 1970; Hill 1970) identified differences between the behaviors and attitudes of parents and their adult children – differences that many were concerned might erode affect and support between the generations. Bengtson and Kuypers proposed that parents' and children's perceptions of one another might be as important, if not more important, in predicting relationship quality than actual differences in attitudes and behaviors. Using data from a study of students and their parents, they found that parents perceived their relations with their offspring as closer and more harmonious than did the students, and parents viewed greater similarity between the generations than did their young adult children. Bengtson and Kuypers argued that the explanation for these patterns lay in parents' stake in continuity and stability in their relations with their children, as opposed to their children's stake in individuation and change (Bengtson and Kuypers 1971:258).

Their argument, albeit compelling, was developed in a historical context in which such divisions between the generations were evident to all Americans, regardless of their political stance. Not only did the 1960s and early 1970s see divisions between parents and adult children – they also saw the

divisions that were a part of the Civil Rights Movement, the Women's Movement, and the Anti-War Movement. Perhaps neither the theory nor the data would apply to later cohorts who were not struggling so intensely with these issues. With this in mind, many studies, including several by Bengtson and his colleagues, have reinvestigated the generational stake, or as it was later renamed, the "intergenerational stake," across the past three decades. Each of these studies, regardless of whether they have relied upon data from the USC Longitudinal Study of Generations (Giarrusso et al. 1995), the NFSH (Shapiro 2004), or other sets (Rossi and Rossi 1990) have revealed the same general pattern, suggesting that the intergenerational stake is as relevant a concept as it was when first introduced nearly 40 years ago.

Explaining Affectional Closeness in Parent–Child Relations. A third question that has continued to be asked across the past three decades is how to best predict which parents and adult children have high levels of positive sentiment toward one another. The factor found to predict the quality of affective relations between parents and children most consistently is gender. Closest ties have almost always been found between mothers and adult children, beginning with the earliest studies of parent–child affect in the later years (cf. Adams 1968; Suitor et al. 1995b). Further, the preponderance of studies have reported stronger affectional ties and greater confiding between mothers and daughters than mothers and sons (for example, Rossi and Rossi 1990; Spitze et al. 1994; Suitor and Pillemer 2006).

Research on other structural characteristics of children has yielded much less consistent results. Classic theories of similarity and interpersonal relationships (Homans 1950; Lazarsfeld and Merton 1954) would lead to the expectation that parents and children would be closer when they share structural characteristics, such as education, parental status, marital status, and religion. Further, sharing parents' sociodemographic characteristics often indicates that adult children have achieved normative benchmarks in development that are highly valued by parents. However, the literature across the past three decades does not support this hypothesis. Whereas some studies have found greater closeness and harmony when adult children become parents themselves (Fischer 1986; Spitze, et al. 1994; Umberson, 1992), other studies found either no positive effects of parenthood (Suitor and Pillemer 2006) or effects specific only to particular parent–child combinations (Kaufman and Uhlenberg 1998; Rossi and Rossi 1990), some of which were negative (Kaufman and Uhlenberg 1998). Findings regarding the effects of other dimensions of status similarity, such as marital status, occupational status, and educational attainment, provide an equally inconsistent picture.

We believe that there are two reasons why similarity of normative adult social statuses is less predictive of relationship quality for parents and adult children than expected based on homophily theory. First, achieving some of these social statuses that increase their similarity to parents, such as marriage and parenthood, produces responsibilities that make them less available to their parents and may sometimes create tension, for example, conflict over child-rearing, or between parents and children-in-law (Fischer 1983; Merrill 2007).

Second, as Suitor and colleagues' (Suitor, Pillemer, and Keeton 1995a) research on support and conflict with kin and nonkin has shown, the reason that status similarity leads to better relationship quality is because such similarity increases the likelihood that associates will have similar experiences, leading to shared values and perspectives. Such similarity of values and experiences has been shown to be associated with greater closeness and less conflict and ambivalence (Rossi and Rossi 1990; Pillemer et al. 2007; Suitor and Pillemer 2006); further, it is substantially more important than is similarity of social statuses (Suitor and Pillemer 2006). Not surprisingly, studies of parent–child relations that take into consideration only structural similarity do not produce the consistent findings that might be expected based on theories of homophily.

Ambivalence in Parent–Adult Child Relations. As noted earlier in this chapter, over the past decade there has been increasing interest in examining the prevalence and predictors of ambivalence in

parent–adult child relations. Because this line of research has developed only since the publication of Luescher and Pillemer's essay on intergenerational ambivalence in 1998, there have been relatively few studies to date. This set of studies has shown that ambivalence is very common in later-life families, regardless of whether the reports are provided by mothers or their offspring (Pillemer et al. 2007; Wilson et al. 2006). Further, consistent with findings discussed above regarding the intergenerational stake, mothers report less ambivalence than do their adult children (Wilson et al. 2006).

In some cases, the findings from this line of research mirror those of studies of other dimensions of parent–adult child relationships quality. For example, higher levels of ambivalence have been found when either adult children experience problems that increase dependence or concerns about possible dependence, such as when they engage in deviant behaviors (Pillemer et al. 2007) or require financial assistance (Pillemer and Suitor 2002; Wilson et al. 2006). However, in some cases, the findings diverge from the broader literature; for example, parents have been found to express less ambivalence regarding relationships with adult children who are married, whereas marital status is an inconsistent predictor of closeness or conflict. In other cases, the findings from the extant set of ambivalence studies mirrors the broader literature in the degree of inconsistency across studies with similar methodologies. For example, Willson and colleagues (2006) found greater ambivalence between dyads of women, whereas gender did not predict ambivalence in either of Pillemer and colleagues' studies (Pillemer and Suitor 2002; Pillemer et al. 2007). There are also inconsistencies in the findings for both mothers' and children's health and several demographic characteristics of parents and children.

In sum, the study of ambivalence is greatly expanding our understanding of the complexity of parent–adult child relations, a topic that was greatly ignored in research prior to the late 1990s. However, the inconsistency found across studies suggests that we must wait for further study before we can draw many firm conclusions about how to explain this intriguing aspect of later-life family relations.

Diversity and Parent–Child Relations

The study of race differences in family relations has been of great interest among scholars for several decades. Given this level of attention, it is perplexing that there are so few consistent patterns by race. Although it has become standard to include race as a predictor in studies of parent–adult child relations, there has been almost no attempt to examine whether the same set of factors explain intergenerational relations across racial and ethnic subgroups. Instead, most studies have focused on whether there are differences in affect, support, and coresidence among these groups.

Many early studies showed strong ties and large kin support networks among minority families (Stack 1974; Taylor 1986), implying that minority families had stronger ties and support systems than White families (Hofferth 1984; Mutran 1985). Most studies making direct *comparisons* in parent–adult child relations among subgroups did not appear until the 1990s. This research has provided compelling evidence that race differences in intergenerational support are fueled primarily by structural differences between Blacks and Whites (Sarkisian and Gerstel 2004). For instance, White parents may provide higher levels of financial assistance to their adult children compared to minority groups (Berry 2006), yet multigenerational households (Choi 2003) and childcare provided by grandparents (Berry 2006) are more common among minority families. Thus, structural differences such as socioeconomic status and family structure influence the type of support exchanged, but exchanges of support are still common in most parent–adult child relationships regardless of race or ethnicity.

In contrast to findings regarding differences in intergenerational support among subgroups, studies of race differences in affect have found greater closeness between mothers and adult children

in Black than White families even after controlling on structural characteristics (Aquilino 1997; Kaufman and Uhlenberg 1998; Umberson 1992). However, there do not appear to be consistent race variations in mothers' feelings of ambivalence toward their adult children (Pillemer et al. 2007), and Black and White mothers are equally likely to differentiate among children in terms of positive affect (Suitor et al. 2007; Ward, Spitze, and Deane 2009).

Grandparent–Grandchild Relations

Research on grandparenting has experienced increasing attention in recent decades, primarily as the result of three sociodemographic trends that shaped the experience of grandparenting, and thus research on this topic. First and most important, increasing life expectancy meant that by the 1980s, most adults would occupy the role of grandparent for nearly one third of their lives. Second, high rates of divorce beginning in the 1970s and continuing through the first decade of this century affected ties between grandparents and grandchildren as well as parents and children. Third, skyrocketing rates of birth to single mothers across the past 30 years, particularly to African–American women, led many grandmothers to return to the role of primary caretaker in their middle and later years. In response to these sociodemographic patterns, research on grandparenting in the 1980s began by documenting and explaining patterns of contact, closeness, and support, followed by studies of the effects of marital instability on these patterns, and later turning to grandparents raising grandchildren. Interestingly, scholars studying grandparenting gave greater attention to race and ethnicity than was typical in the broader literature on American families across this period, thus shedding important and unique light on diversity in family relations.

The first large-scale sociological survey of grandparenting was conducted by Cherlin and Furstenberg in the early 1980s and published in 1986. This work provided a comprehensive picture of variations in contemporary grandparent–grandchild relationships and the ways in which these patterns were shaped by grandchildren's age, proximity, race, and the parents' marital status. More recent studies have corroborated these findings (Hodgson 1992; Silverstein and Marenco 2001), suggesting that these patterns have continued across the intervening years. Further, consistent with the pattern that has predominated throughout this chapter, gender played an important role in grandparent–grandchild relations, with almost uniformly greater contact and positive affect from grandchildren toward grandmothers (Eisenberg 1988; Hodgson 1992), particularly maternal grandparents in families in which parents divorced (Cherlin and Furstenberg 1986; Gladstone 1988; Matthews and Sprey 1985).

Grandparents have traditionally participated in the informal care of grandchildren, particularly when mothers were employed full-time (Cherlin and Furstenberg 1986; Jendrek 1994; US Bureau of the Census 2010); however, in recent years there has been a sharp increase in the practice of grandparents taking primary responsibility for raising grandchildren. Data from the US Bureau of the Census show instances of grandchildren living in a grandparent-maintained household have increased from 3.6% in 1980 to about 6% in 2008 (US Bureau of the Census 2010). This trend coincides with the percent of births to unmarried mothers, which has increased steadily from 18% in 1980 to 52% in 2007 (Ventura 2009). Although coresidence does not necessarily indicate that grandparents take on sole or even shared responsibility for the raising of grandchildren, of those children living in a grandparent's home in 2008, 35% did not have any parents present (US Bureau of the Census 2010) Taking on sole responsibility of grandchildren, with or without the presence of the parent, continues to occur in large part due to parents' emotional problems, substance abuse, or the need for greater support because of the absence of a partner (Jendrek 1994; Pruchno 1999; Sands and Goldberg-Glen 2000). Grandparents who provide primary care differ from those who do not by gender, economic status, and race. Most of the grandparent caregivers are women, Black or Native

American, and have low incomes and educational attainment (Fuller-Thompson, Minkler, and Driver 1997; Minkler and Fuller-Thompson 2000).

Although many grandparents report positive outcomes from raising grandchildren (Hayslip et al. 1998), this role often has negative consequences on caregivers' physical, social, and psychological well-being (Giarrusso et al. 2001), particularly when grandchildren have behavioral or emotional problems (Hayslip et al. 1998; Sands and Goldberg-Glen 2000). Further, many minority grandparent caregivers are at an even greater disadvantage because they are more at risk for being single, living below the poverty-line, and having health limitations (Burnette 1999; Pruchno 1999). Paradoxically, some studies have found that minority caregiving grandparents report less burden than do White caregiving grandparents (Pruchno 1999; Pruchno and McKenney 2002); this pattern can be accounted for by the fact that minority grandparents are more likely to have stronger family networks, family histories of grandparent coresidence, and peers within their social networks who also experience this role (Burnette 1999; Pruchno 1999).

Next Steps: Capturing the Complexity of Intergenerational Relations

The past three decades have seen cohorts of researchers turning their attention to relations between the generations in midlife and beyond. As noted at the outset of this chapter, genuinely new demographic realities have spurred this extraordinary growth in scientific interest. Because of the increased life span, in contemporary society we experience both the benefits and challenges of the lengthened shared lifetimes of generations. Indeed, many of us can look forward to continued relationships with our parents until well into late middle age, a historically unprecedented situation. Looking to the future, we anticipate that attention to the nature and dynamics of intergenerational relations will continue to expand in sociology, as well as in related disciplines such as psychology and economics.

What direction should the field take to build on the solid foundations created over the past three decades? More than a half century ago, in a classic article Weaver argued that all scientific fields engage in a predictable progression from simpler models to more complex ones. In the early stages of a scientific discipline, concern is with questions of categorization, description, and relatively simple hypotheses. As the field progresses, however, the "organized complexity" of systems is acknowledged and investigations increasingly take such complexity into account (Weaver 1948).

It is clear that such a movement is underway in the scientific study of intergenerational relations among adults (Pillemer and Suitor 2008). Scholars from a variety of disciplines are looking beyond simple models of older parent–adult child relationships to orientations and approaches that recognize the complex and sometimes contradictory world of the family in later life. Thus, over time, scholarship on this topic has moved from concerns about the weakening of intergenerational ties commonly expressed in the 1960s to an emphasis on the continued importance and influence of these linkages. Similarly, research has progressed from describing the amount and type of contact, interaction, and exchanges between the generations to more complex conceptual and empirical approaches.

What kind of research is needed over the coming years to capture the complexity of intergenerational relations? We offer a few suggestions here, but we note that our goal is to be provocative rather than definitive. One pressing need is for studies that recognize and exploit powerful within-family designs in studying intergenerational relations. Until very recently, most research in intergenerational relations involved between-family studies involving one parent and one target child or children in the aggregate. A growing body of research suggests that it is fundamentally necessary to collect data from both generations and from multiple members of each generation to fully understand intergenerational relations in later life (Davey et al. 2009; Suitor et al. 2006a, b; Ward et al. 2009).

With the knowledge that there is a great deal of variation within the family concerning most aspects of intergenerational relations, it is important to revisit past investigations with an eye to refining our understanding of these processes in light of within-family differences. Along these lines, researchers should revisit life course analyses concerning status transitions and parent–child relations; for example, by identifying how status transitions of adult children can influence changes in parental differentiation and favoritism across time. Further, current theoretical frameworks concerning dyadic processes across generations should be revisited to incorporate the complex influences of individual relationships on other relationships within the family; for example, how parental differentiation among adult children impacts grandparent–grandchild relations. Inquiries such as these can build a greater understanding of individuals' and dyads' roles within the family as well as the family as a whole.

A second tendency of past research has been to conceptualize and measure parent–adult child relations in a unidimensional manner focusing on either closeness *or* conflict. This work has been very valuable and has provided the foundation for much of our understanding of intergenerational relations. However, given what is now known about the interplay of positive and negative feelings, attitudes, and behaviors that are embodied in intergenerational relationships, future research must take such complexity into account. To be sure, longitudinal research designs that include multiple family members and assessments of positive and negative components of multiple relationships are likely to be resource-intensive. However, to advance scientific knowledge about intergenerational relations in twenty-first century families, such designs are likely to be required.

Further, just as research across the past thirty years responded to the major demographic, social, and economic changes of that time, future research must pay particular attention to current shifting trends. For instance, the characteristics of the older cohorts on which previous research is based differ considerably from those of the baby boomer cohort which is currently in late middle age and entering old age. Unlike their predecessors, the baby boom cohort has fewer children and is more likely to have experienced divorce, giving them fewer resources for support in later life. Given the projected increase in the older population overall, a shortage of caregiving resources in both the formal and the informal sectors is likely to result. Further, the baby boom cohort is experiencing their 60s and 70s in far better health than did earlier cohorts, raising new issues about the timing and meaning of caregiving, as well as about intergenerational relations more generally. The outcomes of these demographic changes as well as other social and economic changes are likely to present fertile grounds for scholarship over the coming three decades.

Finally, researchers in the field of intergenerational relations work in an area that is of considerable interest to policy makers and to the general public and is likely to increase given the growth in the older population. Throughout the social and behavioral sciences, there is an emerging movement to link progress in basic research to advances in application, described by the term "translational research." Translational research models emphasize the systematic translation of basic social science findings into rigorously tested interventions, the results of which in turn inform basic science (Pillemer, Suitor, and Wethington 2003). We suggest that translational research models are particularly appropriate for the field of intergenerational relations, and that such models can enhance both fundamental science and the development of interventions to improve family relationships in later life. Although it is typical for sociological articles on intergenerational relations to touch on policy or practice implications, there is in fact a substantial gap between research and application; in particular, interventions to improve family relations in later life are often not based on research evidence. We would argue that translational research models could be applied very productively to this field, bridging the gap between research themes discussed in this chapter and evidence-based intervention.

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Chapter 12
The Midlife Financial Squeeze: Intergenerational Transfers of Financial Resources Within Aging Families

R. Corey Remle

Due to demographic changes such as increased longevity and decreased family size, midlife adults can now expect to spend more years relating to both ascendant and descendent generations sharing co-biographical experiences (Soldo 1996; Uhlenberg 1996 Bengtson et al. 1990). Intergenerational family relations are becoming increasingly important to Americans in response to these demographic shifts (Bengtson 2001). We must seek to understand "families as context" – that is, as dynamic units with members who age concurrently and share co-biographical experiences – rather than examining the isolated life course patterns of individuals (Davey et al. 2005; Hagestad 2003). Studying "families as context" suggests that intergenerational financial exchanges deserve closer attention as concerns rise about job security, postsecondary education costs, retirement savings, and public support programs such as Social Security and Medicare.

Life course researchers must consider how multigenerational families respond collectively to economic shocks and transitions into and out of financial self-sufficiency that are experienced by one or more family members. The type, timing, and extent of support exchanges vary widely, and they are moderated by structurally ambivalent expectations and norms that influence family decision-making regarding the distribution of private resources across generations (Eggebeen and Hogan 1990; Rossi and Rossi 1990). It is unclear if, when, and how midlife adults should provide assistance to children during the transition to adulthood or to aging parents with reduced financial resources, but multiple public policies implicitly rely on the middle generation to support ascendant and descendent family members in need (Schoeni and Ross 2005; Hooyman and Gonyea 1995). Additionally, the economic costs to donors are rarely considered in sociological studies of intergenerational support.

Financial self-sufficiency is the ability to meet one's financial obligations (e.g., mortgages, credit card debts, and daily living expenses) without the need for monetary assistance from others. This can be a precarious balancing act for individuals who may have a spillover effect for others in one's kin network. In particular, the middle generation (broadly defined as aged 40–65) must adapt to a financial "midlife squeeze" that involves the conflicting responsibilities of (1) preparing for its future financial self-sufficiency via retirement savings; (2) providing support for ascendant generation members who experience declines in their financial self-sufficiency; and/or (3) assisting descendent generation members who have not yet gained full financial self-sufficiency themselves (Settersten 2007; Soldo 1996; Cheal 1983). Oftentimes, the sociological literature fails to acknowledge how financial support to family members can hinder necessary retirement preparations for those in the middle generation. To be sure, other types of intergenerational support (e.g., emotional support, advice, and practical assistance) are significant research topics in their own right that have received much attention in the literature on kin relationships (for examples, see Sarkisian and Gerstel 2004; Logan and

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Spitze 1996; Cooney and Uhlenberg 1992; Rossi and Rossi 1990). However, as these types may be given while individuals remain financially self-sufficient or in conjunction with material assistance (and can admittedly influence the flow of monetary exchanges), the focus on transitions into and out of financial independence requires that monetary transfers deserve separate attention.

This chapter has five sections. First, I describe intergenerational financial transfers – focusing specifically on inter vivos gifts or loans. Second, I discuss how various theoretical approaches are used to explain factors that influence the motives and transfer behaviors of middle generation donors in their family roles as parents *and* children. Third, I identify several life course transitions where ambiguity creates challenges for determining donors' responsibilities to assist across generational lines – the transition to adulthood, the transition out of financial self-sufficiency for elders, and marital status transitions. Fourth, I explain the significant potential costs that public policies in the United States force upon the middle generation to provide financial assistance to other generations in their social roles as both parents and children within an aging population. Finally, I suggest two areas for future research to expand our understanding of the life course effects of inter vivos transfers.

Intergenerational Financial Transfers

The most common explanation for intergenerational financial transfers is that they offer assurance for family members' financial self-sufficiency and overall well-being via a private safety net (Kohli and Künnemund 2003; Eggebeen and Davey 1998; Eggebeen and Hogan 1990). Financial status transitions are never smooth or easy. Instead, the process may involve difficult periods where an individual moves into and out of financial self-sufficiency multiple times and may receive financial support from others specifically as a means to return to a stable financial position. Material resources can flow in two directions across generations either "upward" to older family members or "downward" to descendents (Soldo and Hill 1993). Money transfers come in two forms – inter vivos transfers and bequests. Inter vivos transfers are intermittent and routine monetary gifts or loans. (See Angel (2008) for an excellent review of the literature about families, bequests, and related social policies.)

Assistance to adult children is the most common purpose for inter vivos transfers. The support may be used for educational costs, living expenses, sudden crises, and/or "upfront costs" to attain financial self-sufficiency (Schoeni and Ross 2005; Wong et al. 1999; Eggebeen 1992). A longitudinal examination of downward transfers found that 63% of all households in the Health and Retirement Study (HRS) gave money at least once between 1992 and 1998 (Shapiro and Remle 2011). From the viewpoint of recipients, Remle and O'Rand (forthcoming) demonstrated that 36.2% of adult children received one or more transfers between 1992 and 1998. This is in general agreement with Schoeni and Ross (2005) who found 34% of adult children received cash assistance, using data from the 1988 Panel Study of Income Dynamics (PSID). As adult children age, the likelihood they will receive assistance declines rapidly. For example, over 65% of adult children in their early 20s received money for schooling and/or general living expenses while 40% of those in their late 20s and early 30s, and less than one-tenth above age 35 received assistance from midlife parents (Schoeni and Ross 2005).

By comparison, upward financial transfers are rare. Estimates indicate that only 2–7% of elderly parents receive assistance from their children (Lin 2008; Furstenberg et al. 1995; Eggebeen 1992). Instead, a much greater percentage of upward intergenerational support is provided via time transfers such as caregiving for parents in declining health and practical assistance with various activities of daily living (Grundy and Henretta 2006; Sarkisian and Gerstel 2004; Furstenberg et al. 1995). Oftentimes, monetary assistance to parents varies based on the marital status and gender of the recipient. Lin (2008) found a prevalence rate of 3.9–5.1% for transfers to divorced mothers while

the range for divorced fathers was 2.4–3.6%. Furstenberg et al. (1995) also showed that transfers were unevenly distributed as more widowed and divorced mothers received financial assistance (5.3 and 3.0%, respectively) than married elderly couples, widowed fathers, and divorced fathers. When they included coresident parents who received monetary support as well, McGarry and Schoeni (1995) reported that 7.1% of elderly parents received financial assistance from midlife adults. Many more coresident parents received assistance than nonresident parents.

Multiple studies have demonstrated general consistency in the amounts transferred to other generations when education costs for adult children are excluded. For the HRS sample, Cao (2006) estimated that the average transfer to adult children in 1996 was $1,585, and in 2000, it was $1,519. For the 1988 PSID sample, Furstenberg et al. (1995) estimated the average transfer values to be $1,550 for adult children and $1,194 for elderly parents. In one of the earliest studies known to estimate transfer values, Cox and Raines (1985) found an average intergenerational transfer in 1979 to be $2,100. It is important to recognize that while cohort comparisons indicate similar amounts, inflation significantly alters the financial value of transfers across time. While transfers estimated by Cao (2006) equate to approximately $2,200 in 2010 constant dollars, the financial value of average transfers in 1979 would equal nearly $7,000 today. If middle-aged donors had instead made sound investments for retirement planning, their future financial status would have significantly better prospects.

Once they complete the transition to adulthood, many individuals may never experience a transition out of financial self-sufficiency that requires assistance from family members. However, job loss, divorce, or health-related traumas may create economic shocks that can lead individuals to reach out to family members (Rossi and Rossi 1990). Gradual transitions (e.g., postsecondary education, job market entry, retirement, disability, or entry into institutional care) can also elicit financial assistance from family members (Swartz 2009; Fingerman et al. 2011). In response to these economic shocks and transitions for older or younger generations, it is becoming increasingly common for the middle generation to provide some level of support for *either* older parents *or* adult children at any one time (and, in rare cases, both generations) (Kronebusch and Schlesinger 1994; Silverstein 2006). Research about precautionary saving among middle-aged adults has demonstrated insufficient knowledge and preparedness for retirement-associated expenses (Lusardi et al. 2009; Sullivan et al. 2000). As shown above, this does not stop some from providing financial assistance to other generations despite future repercussions, and sociologists of aging can play an important role in understanding why.

Theoretical Explanations for Inter Vivos Transfers

In this section, I review several theories that have been used by sociologists to explain family transfer behaviors. The heterogeneity of within-family contexts combined with the variety of transfer types requires a broad consideration of how the theoretical approaches complement each other in relation to intergenerational financial transfers. There are several limitations in the existing literature that should be acknowledged first. One challenge to understanding financial transfers is that many studies have examined multiple types of support simultaneously or have combined types of support to examine "intergenerational support" as a broader category (e.g., Davey et al. 2005; Sarkisian and Gerstel 2004). The high level of interdependence between support types affects how families decide to distribute time, space, and financial resources most effectively, particularly for families low on resources in one of the three domains (Silverstein 2006). However, these methods limit what we can know about financial transfers specifically. Another challenge is determining how to examine exchanges across the life course compared to measuring transfers at one point in time. One response is to use multilevel modeling techniques with longitudinal data (Remle and O'Rand forthcoming; Fingerman et al. 2011). Additional studies have examined reciprocity between parents

and children by determining how receipt of financial transfers in early adulthood influenced subsequent upward transfers of caregiving or social support by midlife adults (e.g., Henretta et al. 1997; Silverstein et al. 2002). Other researchers have studied parents' *expectations* of future monetary, caregiving, or social support in return for financial assistance in the present (Eggebeen and Davey 1998; Ganong and Coleman 2006). Even so, recipient characteristics, family structure, family-oriented transitions (e.g., parental divorce), and normative expectations have been the most common contextual factors examined by researchers in this area to date (Davey et al. 2005, Shapiro and Remle 2011). However, this has diverted attention away from donors' decision-making processes and the effects on preparations for their own financial futures.

Contingency Theory

Researchers have defined contingency theory as sharing resources across generational lines based upon the recipients' resource needs and the availability of donors' resources (Fingerman et al. 2009; Eggebeen 1992; Rossi and Rossi 1990). The theory is not always explicitly stated by researchers because it is often implied in the underlying purpose – identifying under what conditions financial *assistance* is provided. A contingency-based support system is often assumed as part of a familistic social contract – both in public policies and in privately held beliefs within families (Hooyman and Gonyea 1995; Riley and Riley 1993). Because of their higher likelihood for socioeconomic and labor force stability as well as their position in the extended kin network, the middle generation is much more likely to assist others than to receive assistance themselves (Davey et al. 2005). As we might expect, parents with higher incomes and higher educational attainment are more likely to assist adult children financially (Remle and O'Rand forthcoming; Fingerman et al. 2011; Eggebeen and Davey 1998; Eggebeen 1992). However, donors' wealth resources, risk assessments of their own life expectancy, assessments of their existing or planned retirement resources or their financial literacy have never been considered as antecedents of financial transfers, and these contingencies should be considered relevant to family decision-making processes. Recipient needs and the availability of donor resources are not sufficient comprehensive explanations, so theorists find it important to understand also why transfers are made.

Within the contingency approach, two competing explanations have been given for donors' motives: the altruism hypothesis and the exchange hypothesis. Higher levels of emotional closeness and attachment between family members lead some researchers to hypothesize that inter vivos transfers are altruistically motivated (Becker 1991; MacDonald and Kuo 2003). The second explanation proposes that donors give financial assistance while expecting reciprocation with a support transfer of similar value in the future through contact, caregiving, money, or social support (Altonji et al. 1997; Cox and Rank 1992). In many of these studies, researchers have indirectly surmised parental motives as altruistic or self-interested exchange based on the static contexts immediately surrounding transfer behaviors.

Tests of each hypothesis have provided mixed results. Some have shown unmarried adult children and those with lower incomes are more likely to receive assistance, suggesting an altruistic response to greater financial need (Altonji et al. 1997; Furstenberg et al. 1995; McGarry and Schoeni 1995). For upward transfers, Hogan et al. (1993) found that adult children gave more financial support to parents who were in poor health or widowed compared to children with healthy or married parents, also suggesting altruistic motives. MacDonald and Koh (2003) argued that all upward transfers to parents are altruistic because there is a lower likelihood of reciprocal exchange from dependent elderly family members.

On the other hand, a long-term view of the family life course reveals that reciprocal exchanges have been severely underestimated by gerontologists, and this erroneously enhances the view of the

elderly as dependent on other generations when many elderly individuals actually remain independent and may reliably provide assistance of other types to younger generations (Spitze and Logan 1992). Goldscheider et al. (2001) found that unmarried mothers planning to assist children financially favored daughters over sons because they believed daughters were more likely to provide care or practical assistance if the mothers became ill or disabled. Ganong and Coleman (2006) showed that expectations to assist elderly parents financially were higher among middle-aged adults who viewed inter vivos transfers as reciprocity for past exchanges. Earlier financial transfers from parents have been shown to increase the likelihood of caregiving and social support from adult children later in their respective lives (Henretta et al. 1997; Silverstein et al. 2002).

The life course approach and longitudinal research designs allow altruism and exchange motives to coexist. Both motives operate at various stages of the family life course because the timing, frequency, and types of family transfers vary so widely (Silverstein 2006). While there may be altruistic motives for one transfer, subsequent transfers or transfers of another currency that may be considered equitable to financial assistance (e.g., time, space, or social support) may include reciprocity expectations for "insurance" in later life (Silverstein et al. 2002). For example, intermittent financial assistance to adult children who experience short-term economic shocks through unemployment or a divorce may be altruistically motivated, but parents may find the assistance to be reciprocated by adult children later (Ganong and Coleman 2006; Henretta et al. 1997). Altruistic motives guiding the redistribution of family resources may reflect the intensity of intergenerational ties but redistribution planning by family members may also affect how such ties develop over time if financial giving is accompanied by reciprocity expectations (Kronebusch and Schlesinger 1994; Silverstein et al. 2002). Thus, theoretical developments regarding family life course dynamics suggest that the dichotomization of motives may be unnecessary.

Intergenerational Solidarity Theory

The term "intergenerational solidarity" represents a multidimensional model regarding the interdependence and intensity of ties between family members. Solidarity reflects the underlying potential of members to share instrumental, emotional, and other resources that can be activated primarily when someone within the network is in need (Silverstein et al. 1997). This theoretical model has been the primary approach applied to within-family support across extended kin over the past 25 years. It has enhanced family and aging research profoundly because its core principles acknowledge the complexity of intergenerational relationships as well as their likelihood to endure changes in individuals' lives across the life course (Bengtson et al. 2002). Much of the solidarity-based literature describes the social cohesiveness and emotional attachment between donors and recipients, and/or family structural factors that enhance or impede the likelihood of inter vivos transfers. Researchers have also examined influential demographic characteristics such as race, ethnicity, age, and socioeconomic status. (Due to space constraints, these factors cannot be addressed here. For excellent reviews, see Davey et al. (2005) and Swartz (2009).) The broad applicability of the theory across many types of support exchanges allows researchers to examine multiple contexts and family structures, and the depth of its development over time makes intergenerational solidarity theory compatible with contingency theory and both motive hypotheses.

Three of the six dimensions of the solidarity model represent what Silverstein et al. (1997) labeled "latent solidarity" and are more related to affinity between individuals. These dimensions are emotional closeness (affective), shared opinions (consensual), and the dialectic between familistic and individualistic orientations (normative). The other dimensions of "manifest solidarity" primarily represent behavioral processes. The level of contact family members have with each other (association) and co-residence or living in geographic proximity (structural) represent opportunity structures.

Finally, functional solidarity – the dimension that includes inter vivos transfers – represents instrumental assistance between generations. A latent class analysis of intergenerational solidarity in families yielded five types (Silverstein et al. 1997). Tight-knit families were those who shared higher affinity, more opportunity structures, and were more likely to exchange assistance across generational lines. The sociable and "intimate but distant" types were less likely to engage in functional assistance, but the authors point out potential recipients may not need assistance (i.e., low contingency), which may be one key reason that these family types could be differentiated from tight-knit families. The detached family type was least likely to have assistance-oriented relationships. Finally, though they were significantly less likely to exchange time or money than to do so at all, the frequency of exchanges was still higher for obligatory families than for sociable and "intimate but distant" families, suggesting intimate bonds may be strong without being positive in nature.

Ambivalence Theory

As a counterpoint to the emphasis on the strength of family bonds inherent to solidarity theory, Lüscher and Pillemer (1998) theorized that conflicts and ambivalent feelings are common in multigenerational relationships and that they influence support exchanges. Because of its life course emphasis, this theory is also compatible with contingency theory, altruism, and the exchange hypothesis. Ambivalence theorists address the lack of mutual understanding between family members, the mix of positive and negative feelings individuals may have for other family members, and the emotional and practical trade-offs that affect decision-making about sharing resources (Connidis and McMullin 2002). For example, donors' favoritism toward one child over others indicates parental ambivalence (Fingerman et al. 2009; Suitor et al. 2006; Goldscheider et al. 2001). For individuals who experience the transition out of financial self-sufficiency, the loss of autonomy also presents emotional and practical strains that are likely to become more common for many families as the population ages and older adults' retirement incomes suffer significant losses as part of the recent global recession.

Beyond the psychosocial component, Connidis and McMullin (2002) proposed ambivalence theory should also include "sociological ambivalence" – the conflicts, contradictions, and confusion that are embedded in ambiguous social structures about how families *should* behave. The influences of public policies and socially determined moral beliefs about assistance to needy family members become manifested in their intimate social and emotional ties. Multigenerational families must negotiate their relationships and uncertain fiscal responsibilities in the midst of costly life course transitions such as an older relative's entry into institutional care or a young adult's advancement to college. Ambiguity about familial responsibility in such situations forces many middle-generation kin into difficult decisions regarding the availability of private resources and their willingness to relinquish some financial security as a trade-off for helping other family members (Kohli and Künemund 2003). Donors must decide how to combine potential public assistance (e.g., Medicaid, college loan programs) with family-based financial support and usually must do so with incomplete information. For families today, preparations for others' financial status transitions and the redistribution of family resources must be flexible, are often context-dependent, and may be structured, at least in part, by sociological ambivalence.

Theoretical Synthesis

Next, we must bring together ideas from each theoretical explanation to best explain family transfer behaviors comprehensively. First, it is generally safe to assume that support exchanges are made

contingent upon recipients' needs and the availability of donors' resources. Notably, a small percentage of transfers occur in wealthy families that are not contingent upon need. However, contingency theory is limited by the relativity of defining "need" for recipients and the challenges of conflicting needs within families that require multiple contingencies be balanced. Second, lifetime emotional bonds and normative solidarity may be strengthened through inter vivos transfers, but functional solidarity reflects a dialectical juxtaposition between dependence and autonomy (Bengtson et al. 2002). This may be difficult to differentiate from the emotional and practical strains within families that can be associated with psychological ambivalence. Structural changes surrounding families such as marital instability, extended transitions into adulthood, and the risks associated with potential transitions out of financial self-sufficiency challenge the reach of intergenerational solidarity theory to offer comprehensive explanations for monetary support (Remle and O'Rand, forthcoming; Soldo 2006 1996; Wong et al., 1999). Finally, conflict and ambivalence are characteristic of family interactions and ambiguous social responsibilities (Connidis and McMullin 2002). In other words, intergenerational financial assistance is (1) most commonly contingent on needs and resource availability, (2) may be a function of solidarity within the family but (3) may also create conflict and may be affected by social structural factors that obscure the normative responsibilities of intergenerational support.

However, even this synthesis of theoretical approaches does not allow researchers to determine accurately the eventual financial costs for donors. Conceptually, we do not recognize or give sufficient attention to tradeoffs made by one generation in order to support another generation. The current global economic recession has weakened the long-term financial stability of lower-class and middle-class families. Costs have increased substantially for postsecondary education, insurance coverage, and long-term health care needs. Subsequently, for many families, one generation is more likely to be "squeezed" financially and must make tradeoffs such as reductions in overall wealth, lowered retirement savings, or limited preparation for uncertain future financial needs. This midlife financial squeeze will be more likely to occur as the population ages.

Ambiguous Transitions and Ambiguous Responsibilities

The Transition to Financial Self-Sufficiency

Establishing financial self-sufficiency and independence from one's parents is the pivotal experience identified as indicative of "adulthood" (Arnett 2004). However, social structural factors such as an increasing need for postsecondary education and difficulties in labor market entry (particularly during the recent economic recession and slow recovery) can significantly alter the timing of the transition to self-sufficiency. Additionally, the sociological ambivalence regarding when and how the transition to financial self-sufficiency is complete originates from structural contradictions as to how long parents are expected to support adult children financially, affecting parents' own financial statuses in the process. Schoeni and Ross (2005) demonstrated that parents spend approximately one-third again as much in monetary assistance to adult children aged 18–34 as they had spent raising their children.

Parents may view their material support to children as a means to provide a quicker route to financial self-sufficiency by supplementing incomes or paying "up-front" costs of housing, transportation, and insurance (Swartz 2009). Shapiro (2004) describes these as "transformative assets" that enhance children's abilities to gain human and financial capital for further gains than those whose parents cannot provide resources. Little has been said, however, of what midlife parents may be giving up as a result of providing support to others in relation to their future financial needs as aging adults (i.e., retirement, living expenses, health care, and insurance costs). When midlife parents provide financial assistance to adult children, the future value for their own financial status is rarely considered despite the opportunity costs involved.

The Transition out of Financial Self-Sufficiency

Fingerman et al. (2011) found that middle-aged adults were more likely to provide financial assistance to elderly parents who experienced crises (e.g., financial problems, crime) or to parents with functional disabilities rather than to help them meet everyday needs, suggesting contingency-based support. As described above, monetary transfers to address the transition out of financial self-sufficiency are rare in the United States. There are several possible reasons for this. First, many adults remain relatively healthy into old age and are able to provide sufficient care for themselves (and/or their spouses). Though they may experience increased disability over time and develop greater caregiving needs, health declines may be slow enough not to disrupt financial independence. Second, in our age-graded social system, elderly adults become eligible to receive funds from private pensions or annuities as well as public Social Security pensions. Combined with Medicare coverage for many formal healthcare needs, this mix of resources allows most elderly adults to maintain financial self-sufficiency beyond 75 years of age. Third, the caregiving literature has dominated research on intergenerational support to elderly adults as many middle-aged adults who help parents may be using time and coresidence as their initial "currencies of choice" and providing financial transfers only in extreme cases. Finally, financial transfers to older generations are less likely to have been examined than other types of transfers and especially less likely to have been examined separately from time and space transfers. The necessary data may simply not yet be available for researchers to examine upward transfers more fully but with an aging population, such research is more likely to occur in the near future.

The Influence of Marital Status Transitions

The widening diversity of intergenerational kinship structures in recent decades also encourages sociological ambivalence for financial status transitions. An increased prevalence of remarriages and blended families accompanied the increased divorce rate (Cherlin and Furstenberg 1994). The lack of social norms regarding how much responsibility the middle generation has toward adult children from previous marriages or their divorced or widowed elderly parents has led to ambivalence about financial and social obligations in exchanges within multigenerational kinship structures (Lin 2008; Killian and Ferrell 2005; Furstenberg et al. 1995). Parental divorce when children are young results in significant declines in intergenerational solidarity between parents and children, and especially between noncustodial parents and their children (Silverstein et al. 1997; White 1994). Other studies have found that parental divorce results in lower levels of affection and reduced feelings of obligation (Ganong et al. 1995; Cooney and Uhlenberg 1992). Obligations to assist biological children are felt more strongly than those to assist stepchildren – though not to the exclusion of stepchildren (Aquilino 2005; Killian 2004). Rossi and Rossi (1990) attributed this to what they called "differentiated norms of family obligations."

How Public Policies Influence Private Family Transfers

Current public policies may have an extensive impact on private family financial resources over the long term that puts current midlife and retirement-age individuals at risk to remain financially independent into their later years. Despite the common definition of college-age children (18–23 years old) as adults, various events associated with the transition to adulthood (e.g., postsecondary

education, leaving the parental home) often require intergenerational financial support. Additionally, families formed through remarriage face mounting pressures from socially ambiguous policies to support biological children from previous marriages, stepchildren, and in-laws (Hans 2008; Hooyman and Gonyea 1995). Such policies are based on familistic assumptions about kinship obligations that do not accommodate complex family structures where nonresident parents, step-kin, and in-laws are ambivalent about their financial obligations to others. Policymakers in the United States have attempted to ease cost concerns through legislation to expand the number of Americans with health insurance, to increase the availability of federally funded grants and loans for post-secondary education, and to institute employment guarantees for caregivers who must take time off from work (i.e., the Family Medical Leave Act of 1993). However, these watered-down solutions have exposed a pervasive reliance on private family resources stretching across generational lines to support various financial needs. The eventual effects may also unduly influence families' fiscal responsibilities over time such that the "midlife squeeze" is transmitted to future generations (Künemund 2006). Though taxation and the long-term viability of Social Security and Medicare are among the policy concerns of the American public, these are socially broader than three policies that have a more direct impact on multigenerational families' financial transfers.

First, nearly half of all uninsured Americans are young adults aged 18–30 years (Levy 2007). The 2010 Patient Protection and Affordable Care Act signed into law by President Obama reduces barriers for young adults to have health insurance. Previous eligibility of adult children was generally discontinued upon graduation from high school or college but the eligibility age of adult children has now been raised to 26 years for coverage through their parents' employer-provided health insurance, regardless of student status (Jost 2010). However, we should recognize that the requirement that all individuals be insured – a central aspect of the reform legislation – inherently relies on parents to finance adult children's insurance costs if the adult children are unable to do so for themselves.

Second, the value of parents' overall wealth and their ability to cosign loans are often included in formulas used to determine how much financial aid will be made available to college and university students. The Federal Application for Student Aid (FAFSA) collects information about parents' incomes and assets from unmarried, childless applicants under age 23 based on assumptions of parental responsibility, but as Hans (2008) points out, only residential parents' incomes and assets are considered relevant and while some state policies require nonresidential parents to maintain child support for children in college, many states have no policies to address this issue, and two states (New Hampshire and Pennsylvania) have rejected the practice of obligating nonresidential parents to support children in college. Rising tuition costs and increased expectations that job applicants have a postsecondary education force parents to make difficult choices while balancing the trade-offs of investing in children's future earning potentials and their personal future financial needs. In response to these policies, many parents are subsidizing their adult children's incomes to cover education, insurance, and general living expenses as well as acting as a safety net for unexpected emergencies. From another vantage point, public policies may encourage a "failure to launch" such that many adult children maintain prolonged dependence on midlife parents for financial assistance through at least the college-age years.

Third, the Family Medical Leave Act of 1993 (FMLA) includes only provisions for unpaid leave to care for family members (e.g., parents, young children, spouses). Thus, the financial and time-related costs associated with caregiving to the elderly are not compensated by publically funded resources. Recent attempts by some state policymakers to expand requirements for paid leave to family caregivers have succeeded by limiting paid leave requirements to accommodate the birth or adoption of a young child and ignoring compensation for those caring for spouses or elderly parents (Wisensale 2006). Either through financial support or various caregiving activities, many middle-aged children offer support to their aging parents with healthcare needs at the expense of their own future financial statuses in relation to lost wages, lost advancement opportunities, and lost pension

incomes. Meanwhile, federal policymakers have paid attention to potential fraud that could result from intergenerational transfers in late life. Regulations for entry into Medicaid require a "look-back period" where officials examine within-family financial transactions over the previous 5 years to verify that recent transfers have not occurred so that the applicant may appear erroneously impoverished for eligibility (Gearon 2006).

Each of these examples demonstrates that policy changes are necessary to offer relief and support to the many couples and individuals who privately support other generations as they move into and out of financial self-sufficiency. Otherwise, the combination of family conflicts, ambiguous policies, and diverse structures may overwhelm families, and the pattern of a financial "mid-life squeeze" may be perpetuated from one generation to the next.

Future Research Topics

Skipped-Generation Transfers

Nearly all of the research on financial transfers has focused on resource sharing between parents and adult children. However, as kin relationships change over time and grandchildren experience the transition to adulthood while grandparents remain healthy and active, they may receive financial assistance directly from grandparents when previous support was indirect (Schoeni and Ross 2005; Silverstein and Marenco 2001). Past research has been able to examine time, space, and financial transfers from grandparents to grandchildren indirectly by analyzing time spent caring for young grandchildren (e.g., babysitting), coresidence in multigenerational households, and financial assistance provided to adult children who are raising young children themselves. However, there has been little research done to date that explores direct financial transfers between grandparents and grandchildren. Hoff (2007) demonstrated that the likelihood of skipped-generation transfers increased within German families – primarily as one-time gifts from grandparents to grandchildren without a reciprocated support exchange. Even-Zohar and Sharlin (2009) examined which factors perceived by Israeli grandparents and grandchildren led grandchildren to provide upward assistance. They found that grandparents focused on the more immediate exchange of giving material assistance in return for emotional or practical assistance while grandchildren focused on reciprocating grandparents' past emotional support. While some adult grandchildren may provide physical care or emotional support in response, the general assumption has been that grandparents offer altruistic financial assistance (Silverstein 2006). Research about skipped-generation transfers in American families would greatly enhance our understanding of multigenerational kin relationships.

Providing Cumulative Advantages via Transfers

Sociologists of the life course are uniquely able to examine how wealth stratification is perpetuated from one generation to future generations. Wealth transfers are more commonly associated with bequests than inter vivos transfers and suggest cumulative advantages are accrued via inheritance (Angel 2008). The common understanding of "old money" reflects the sharing of family resources across generations that is available to a small percentage of the population based on high wealth levels experienced by the oldest generation. However, few researchers have considered how bequest and transfer patterns have changed in recent years among the country's wealthiest citizens to avoid tax penalties and maintain wealth within multigenerational families (Wolff 2002).

Studies of financial transfers that consider parental resources may include income but have not yet included wealth as a measure of the family's ability to support its own members. Rarely have retirement assets, accumulated or anticipated pensions, or other elements such as employee benefits and health insurance coverage been included in calculations of overall wealth (Spilerman 2000). For many Americans, wealth may not be accessible in the short term to provide financial assistance to a family member. In particular, housing wealth, which often accounts for the major portion of the wealth of retired individuals, is not easily convertible into cash even though it has a high monetary value. Instead, liquid wealth that can be easily accessed for multiple purposes on short notice may be a better determinant of the likelihood to provide financial assistance to kin. Net financial assets may be a valuable wealth measure, particularly in cases where the household has no occupational income due to retirement or disability but has access to other resources (Oliver and Shapiro 1995).

Conclusion

Intergenerational relationships will become increasingly important to American families as they respond to the demographic pressures imposed by an aging population and decrease in family size. To fully comprehend the dynamics of "families as context," it is essential to understand how multigenerational families respond collectively to members' transitions into and out of financial self-sufficiency. In this chapter, I have outlined the relevance of inter vivos transfers to life course research and their practical significance for aging families. The financial transfer literature to date has leaned heavily toward identifying recipient characteristics, family structure characteristics, and affinity for or commitments to other family members that elicit financial gifts and loans. Valuable and insightful observations have resulted from such studies, but we have paid insufficient attention to the present and future tradeoffs incurred by donors responding to others' needs and expectations. Donors experience a "midlife financial squeeze" by sharing finite resources and potentially losing out on the greater accumulation of valuable resources for their own financial statuses in late life. The sociological ambivalence (i.e., conflicts, contradictions, and confusion) engendered by ambiguous life course transitions and ambiguous public policies challenges multigenerational families to work together in new ways in order to respond best to economic uncertainties for all involved.

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Chapter 13
The Demography of Unions Among Older Americans, 1980–Present: A Family Change Approach

Wendy D. Manning and Susan L. Brown

The current generation of older Americans faces more complex family and marital histories than any prior generation. Moreover, baby boomers, the first cohort to experience high levels of divorce, single parenthood, and remarriage, are now moving into older adulthood. This movement will likely exacerbate the trend away from marriage among older adults. Researchers are uncovering greater heterogeneity and complexity in the family life of older Americans, which in turn portends a shift in the benefits and rewards offered by certain family circumstances (Allen et al. 2000; Cooney and Dunne 2001). The growing diversity of living arrangements characterizing older adulthood is likely to have important consequences for individual health and well-being as well as policy ramifications for the changing types of institutional support older adults require (Wilmoth and Longino 2006).

In this chapter, we document changes in the marital status and household living arrangements of older Americans over the past 4 decades, integrating explanations for and consequences of these changing patterns. The increasingly varied family life course trajectories experienced in early and middle adulthood have enduring consequences. Namely, older adults are much less likely to be married now than were previous cohorts. This trend is expected to accelerate with a declining share of the older adult population being married in coming decades (e.g., Allen et al. 2000; Cooney and Dunne 2001). A decade ago, gerontologists predicted that older men more likely will be never married, and older women increasingly will be divorced rather than widowed (Cooney and Dunne 2001).

The purpose of this chapter is threefold: describe how family change approaches can elucidate recent demographic shifts in the union behaviors of older adults; provide empirical evidence that describes the recent trends in marital status and living arrangements for older adults; and discuss the implications of these new marriage and family patterns for individuals, families, and society. In addition to examining marriage and widowhood, which have been the primary foci of earlier work on the family status of older adults, we also consider union experiences which fall outside these typical marital status categories. Specifically, we investigate cohabitation, living apart together (LAT), and same-sex unions, all of which appear to be increasing among the older adult population but have received limited attention from researchers (Bennett and Gates 2004; Brown et al. 2005, 2006; de Jong Gierveld 2005; Gates 2003; Huyck 1995).

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Family Change Approaches

There is wide recognition of rapid changes in marriage and family, but there is not a consensus about the mechanisms underlying these changes. The most commonly cited reasons for changes in marriage and family behavior include economic, normative, and institutional explanations. While the recent changes in family and marriage have been widely noted, it is important to recognize that social scientists have long been interested in the causes of family change and have invoked these theories of change across a broad range of time periods (Smock 2004).

The life course perspective is a popular approach used to study marriage and family behavior. Among older Americans, this perspective is important because it is recognizes that family behavior is age-graded and integrates social, historical, cultural contexts. Life course theory posits that one's life is a sequence of events, social roles, and changes that begin in infancy and continue until death (Caspi et al. 1989). The lives of family members are "linked" in the decisions of one member who have implications for the other family members (Elder 1985). These linked lives imply that generations are connected (e.g., parents and children) as well as family members of the same generation (e.g., siblings, spouses). Further, an individual's actions that occur earlier in the life course both directly and indirectly influence behavior in later life stages (Elder 1985). This perspective highlights interactions between individuals and their social environments. Age, timing, and sequencing are key concepts within a life course framework. The timing of transitions (e.g., parenthood or marriage) can be considered early, on-time or late which subsequently has implications in later life. A fundamental feature of the life course perspective is the individual-level progression or trajectories through life and the recognition that trajectories may shift across time or context. While the life course approach showcases how individual family experience progress over their life, it does not provide a direct explanation for the mechanisms or reasons for family change.

Most research examining family change focuses on earlier points in the life course (e.g., the twenties) with an emphasis on how young adults form and sustain relationships. This attention on young adults is based on concerns about the well-being of children, i.e., providing stable home environments for children. As many changes in families have occurred among young adults, they have reverberations among older adults. For example, divorce in her early thirties may have implications for the accumulation of wealth for a woman in her sixties. Yet studies of marriage are often based on realities of young adults, ignoring the distinct patterns of union formation and stability among older adults. The generations that have experienced the most family change have not yet reached their older years, and we have much to learn about their experiences. As a result, our theories of union formation may be useful for explaining current behavior; however, they may not adequately predict or explain future trends (Seltzer et al. 2005).

The reasons for changes in marital behavior are interrelated and include the following: shifts in economic gains to marriage, ideational changes, and institutional recognition of a broad array of families (e.g., Cherlin 2004; Seltzer et al. 2005; Waite et al. 2000). First, the gendered basis to marriage has changed. Women are increasingly valued for their economic contributions to families. Women with higher incomes and education are actually more likely to marry than their counterparts with fewer economic resources (Sweeney 2002). This shift in the traditional marital bargain calls for new approaches to studying the criteria for marriage as well as the complicated balance required to sustain marriage. These new economic realities challenge a traditional home economics perspective (Becker 1974), which focuses on a gender-based traditional division of labor with the decision-making power assigned to the male head of the household (Bianchi et al. 2008). The shift in the gendered economics surrounding marriage and the value of women's economic position are broad and have implications not only for younger but also for older Americans today.

A second explanation for family change is based on normative or cultural change brought about in part by the greater secularization or individualization of American society (Lesthaeghe and Neidert 2006). These types of normative changes are often measured in terms of attitudes, such as

beliefs about gender equity. However, it remains a challenge to measure the accepted rules of behavior and discern subgroup differences (Rossi and Rossi 1990). The change in attitudes about cohabitation, single parenthood, and the fragility of marriage have been well documented (Axinn and Thornton 2000; Cherlin 2004). A related normative shift is the fundamental reason for or meaning underlying marriage. The focus of contemporary marriage is on emotional fulfillment and love leading to shifts in the purpose and stability of marriages (Cherlin 2004). Thus, the nature of couple interactions may be altered in part because of this new normative climate. As the demands of marriage increase, there may be further shifts in the timing and stability of marriage.

A third reason for change in families is that adults now may enjoy many of the instrumental and social benefits of marriage without actually marrying. For example, social welfare benefits, property rights, and custody arrangements are not based solely on marital status. As we observe more legal arrangements, social policies, and institutions that do not discriminate based on marital status, the benefits of marriage become less clear. Further, marriage may require a level of interdependence or enmeshment (financial and emotional) that is not desirable which in turn may encourage new family forms. Certainly, marriage offers a legal commitment and bond that secures some stability and permanence. Cherlin (2004:855) refers to this as "enforceable trust" and claims that it could be "eroding." As the traditional supports for marriage are shifting, the uncertainty or ambiguity surrounding the meaning and definition of marriage may have implications for marital and family decisions and contribute to the rise in unmarried family forms (Settersten 2009).

The ramifications of these economic, normative, and institutional changes for the family behaviors of older adults remain largely unexplored both theoretically and empirically, but family changes are identified by gerontologists and family scholars as integral to our understanding of the demographic shifts taking place in an aging society (Allen et al. 2000; Cooney and Dunne 2001). This chapter aims to interpret the latest demographic patterns through the lens of the family change approach to provide a richer portrait of aging families in the contemporary U.S. context.

Measures and Data

Our empirical analyses focus on older Americans defined as men and women aged 65 and older. We compared older Americans in 1980 (65-year-olds were born in 1915) to 2008 (65-year-olds were born in 1943). The early cohort became adults during the Great Depression, and the later cohort became adults during the economic boom years (1960s). This time span includes those adults who produced the peak of the baby boom.

The United States is an aging society with older Americans representing an increasingly greater share of the total population. In 1980, persons over age 65 comprised 11% of the American population, while in 2008 those over age 65 were 13% of the population. Over the next 50 years, the population of adults aged 65 and older is predicted to double. By 2050, the U.S. older adult population will reach 88 million or one-fifth of the population (U.S. Census Bureau 2008).

Life expectancy is increasing for women and men alike, but the two groups continue to have different life expectancies. Currently, life expectancy for men is about 75 years, whereas for women is 80 years. Consequently, the majority of older adults are women (Heron et al. 2009). In 2007, there were 137 women over age 65 for every 100 men over age 65 in the United States. This ratio increases among the oldest old. By the time older adults reached their mid-eighties, there were 210 women to every 100 men (Administration on Aging 2009). The lengthening life span of Americans presents the possibility of more relationships in older adulthood including the potential for expanded intergenerational family ties and at the same time potentially more opportunities for family instability. As Settersten (2007) argues, divorce rather than death is the primary cause of family disruption.

Apart from gender, life expectancy also varies by race-ethnicity. Although the racial gap in life expectancy has declined over time as minorities are living longer, nonetheless, whites enjoy greater

life expectancies than do either blacks or Hispanics in the United States. For instance, current life expectancy among whites is about 78 years, whereas for blacks it is 73 years. Today, among 65-year-olds, life expectancy is roughly 2 years greater for white than black men and 1 year greater for white than black women (Heron et al. 2009). Consequently, the older adult population is now more racially and ethnically diverse than in the past. In 1980, 8% of the 65 and older population was black, and less than 3% was Hispanic. Today, nearly 9% of older adults are black, and more than 6% are Hispanic (National Center for Health Statistics 2009). Population projections estimate that by 2050, about 58% of the older population will be non-Hispanic white, 20% of the older population will be Hispanic, and 11% black (Administration on Aging 2009). Changes in immigration in the United States portend an increasing share of older Americans will be foreign-born, and nativity status is likely to play a role in the lives of older Americans.

Gender and race-ethnicity structure the experience of aging. Therefore, we provide gender-specific comparisons of marital status and living arrangements across age groups. We focus on similarities and differences in the experiences of older men and women. Where possible, results are shown for specific racial and ethnic groups.

This chapter draws on several data sources. A primary source of data is the United States decennial Census, which offers a view of the trends in marital status and living arrangements of older Americans. The recent American Community Survey provides specific measures about marriage that are not available in the Census data. We also present findings from published results from surveys, such as the Current Population Survey March Supplement and the Health and Retirement Study. In the concluding section, we discuss future data needs for research on the family demography of an aging population.

Marital Status

Marriage

Overall, there has been a decline between 1980 and 2008 in the proportion of older men who are married, as shown in Fig. 13.1. In 1980, more than three quarters (76%) of older men were married. By 2008, there was a modest decrease, and 71% of older men were married. In 1980, the proportion of men married was negatively associated with age. In 2008, the proportions married were less sensitive to age than in 1980, with those ranging in age from 65 to 79 almost equally likely to be married. The trend in proportion married between 1980 and 2008 varied by age, such that among the young old (65–74), smaller proportions of men were married in 2008 than in 1980, whereas among the old old (75–84) and oldest old (85 and older), married men were a bit more prevalent in 2008 than in 1980. For instance, 83% of 65–69-year-old men were married in 1980, but just 75% of men in this age group were married in 2008. In 1980, 48% of men 85 and older were married. By 2008, 54% of oldest old men were married.

Among older women, the proportion married appears to have changed little over the past 4 decades Fig. 13.2. In 1980, 37% of older women were married compared to 40% in 2008. This overall pattern characterizes young old women, too, but not old old and oldest old women, who now compose larger shares of the population. Among women 65–69, there was essentially no change between 1980 and 2008 in the proportion married (55 and 56%, respectively). All other age groups witnessed increases in the proportion married over time. Among 75–79-year-olds, the proportion married grew from 29% in 1980 to 41% in 2008. Similarly, among the oldest old, the proportion married rose by 50% from 8% in 1980 to 12% in 2008.

Comparing the proportions of men vs. women who were married reveals that more men were married than women, regardless of age or time period. Gender distinctions in marital status were

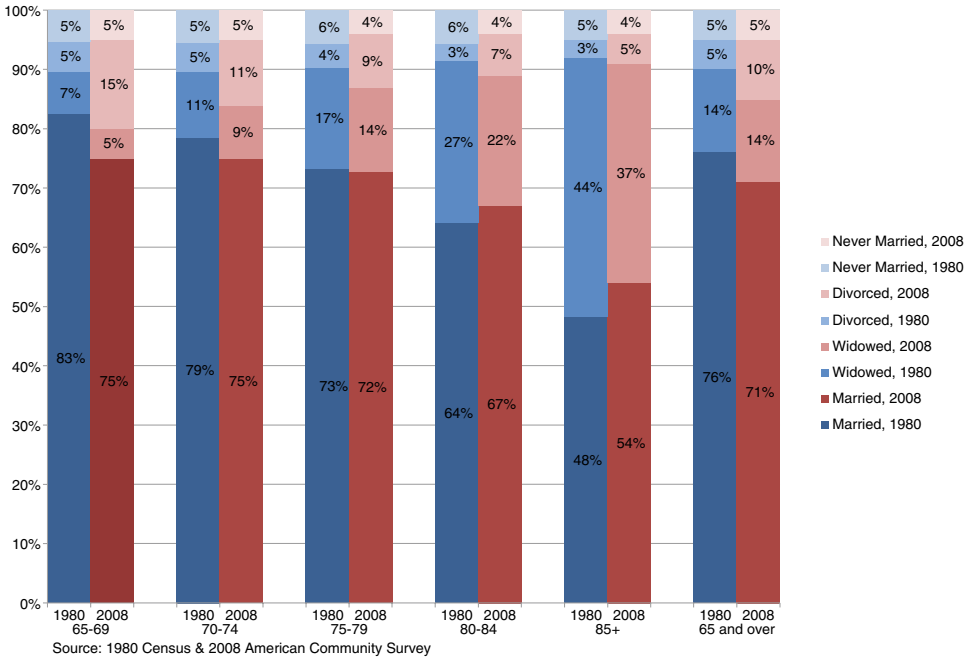

Fig. 13.1 Marital status by age for males, 1980 and 2008

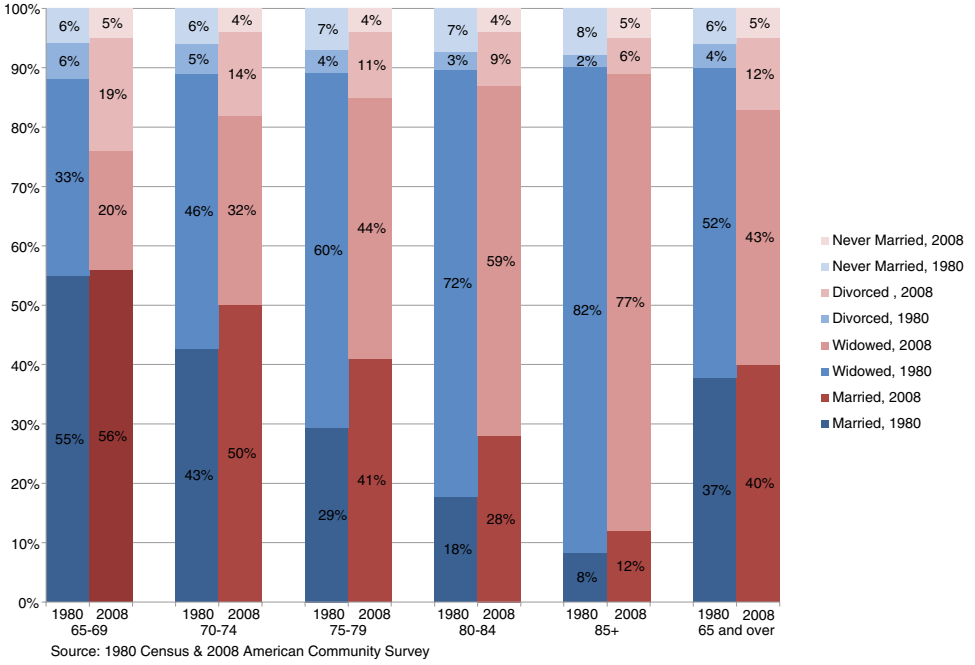

Fig. 13.2 Marital status by age for females, 1980 and 2008

due in part to the substantial gender differentials in mortality and life expectancy and the tendency for women to marry men a few years older than themselves. Indeed, at all ages, older men were more likely to be married than older women, and this differential became more pronounced with age. Nonetheless, the gender differential was smaller in 2008 than it was in 1980. Six times as many

men as women aged 85 and older were married in 1980 (48 and 8%, respectively) vs. 4.5 times in 2008 (54 and 12%, respectively).

These trends reveal the distinct gendered patterns characterizing marriage in later life. Married is the modal marital status for men, but not for women. It is notable that the proportions married have declined modestly among older men at the same time they have increased slightly among older women. This convergence is consistent with the family change approach, which suggests increasing gender similarity in the mate selection process.

Widowhood

Widowhood remained consistent among older men over the past 4 decades: 14% in 1980 and 2008 (Fig. 13.1). Despite this overall stability, the pattern varies by age group, with the growth in widowers concentrated among the oldest old men. In 1980, less than one-fifth of men aged 65–79 were widowers, about one-quarter of 80–84-year-old men were widowers, and nearly half of men over age 85 were widowers. In 2008, less than 15% of men aged 65–79 were widowers, 22% of men 80–84, and 37% of men over age 85 were widowers. Stated differently, widowhood has declined most precipitously among the oldest men.

By contrast, there have been declines in widowhood among all older women, from 52% in 1980 to 43% in 2008 (Fig. 13.2). In 1980, the proportion of women widowed ranged from one-third among 65–69-year-olds to 82% among women aged 85 and older. The proportion of women who were married outpaced those who were widowed only at ages 65–69. At every other age, the proportion of women married was less than the proportion widowed. In 2008, one-fifth of the youngest older American women were widowed, and 77% of women aged 85 and older were widowed, but the proportion married was higher than the proportion widowed not only for 65–69-year-olds but also for 70–74-year-olds. These results suggest that we may be observing a slight delay in widowhood among women, which is consistent with lengthening life expectancy.

As expected, widowhood increased with age, but the age gradient was steeper among women than men. A greater proportion of women were widowed than men at every age. Among the oldest old, widowhood was 50% higher among women than men (77 vs. 37%, respectively, in 2008). The modal marital status category among women is widowed, although the proportion of older women who are widowed has declined since 1980 and a corresponding increase over this time period occurred for the proportion divorced. This pattern is in line with predictions by Cooney and Dunne (2001). Widowhood, while common, brings a host of stress in terms of emotional loss, social network shifts, financial concerns, and instrumental support. Men and women respond differently to widowhood with men much more likely to remarry (see Chap. 10 for further discussion). Family change approaches do not provide much insight into the changing patterns of widowhood, but they reflect both lengthening life expectancy and arguably shifts in preferences for remarriage formation. Future research should attend to whether the propensity to remarry following widowhood has changed in recent decades as well as the extent to which these changes are gendered.

Divorce

Sustained high levels of divorce over the past few decades in the U.S. population have contributed to the declines in the proportions of older adults who are married. We combine separated and divorced into one category. In fact, the proportion of older men who were divorced (or separated)

doubled between 1980 and 2008 (Fig. 13.1). Only 5% of older men were divorced in 1980, whereas the figure rose to 10% in 2008. This growth is concentrated among the young old. In 1980, 5% of men ages 65–69 and 6% of men ages 70–74 were divorced. In 2008, the corresponding figures were 15 and 11%, respectively. At older ages, the proportions of divorced men did not change much over time. Among the oldest old, 3% of men were divorced in 1980, and 5% were divorced in 2008.

Among older women, there is a similar pattern. The proportion of older women who were divorced climbed from 4% in 1980 to 12% in 2008, nearly identical to the proportions documented earlier for older men (Fig. 13.2). The rise occurred among all older women. Among 65–69-year-old women, 6% were divorced in 1980 vs. 19% in 2008. For women ages 80–84, 3% were divorced in 1980, and 6% were divorced in 2008. The proportion of the oldest old that is divorced increased from 2% in 1980 to 6% in 2008.

Comparing the trends for men and women, the proportions divorced in each 5-year age interval were essentially the same in 1980. By 2008, older women were somewhat more likely to be divorced than were older men, at least at younger ages. There were no gender differences in divorce among the oldest old. With sustained high levels of divorce in the U.S. population coupled with the weakening propensity to remarry following divorce (the divorced increasingly favor postmarital cohabitation), it is likely that the proportions of older men and women divorced will rise in the coming years. The implications of divorce most likely depend on its timing (Shapiro and Cooney 2007). Early divorce in the life course has been found to influence later relationships between adult children and older fathers (Shapiro and Cooney 2007), and divorce in older adulthood may translate into declines in social and economic support. Throughout the life course, the costs of divorce appear to differ according to gender. From a family change approach, the normative and institutional constraints supporting marriage continue to erode, opening up the possibility of other forms of family outside of marriage (e.g., cohabitation) and increasing the acceptability of living alone.

Never Married

The percentage of the older population never married has not shifted over the past 4 decades, nor does it differ for men and women (Figs. 13.1 and 13.2). Between 5 and 6% of the older adult population was never married in 1980 and 2008. In 1980, only 2 or 3% of old old and oldest old men and women were never married. By 2008, between 4 and 5% of both older women and men in all age groups were never married. Even though men and women are equally likely to remain never-married, there is a gender gap in the well-being of never-married men and women. Never-married women appear to fare as well as married women in old age while never-married men appear to fare worse than their married counterparts (see Chap. 10). The proportion of older adults who are never married is expected to rise in the future, especially among men (Cooney and Dunne 2001), reflecting more inclusive normative expectations about families and loosening institutional constraints.

Racial and Ethnic Variation

Most research on the marriage and living arrangement patterns of older Americans focuses on gender and age distinctions. However, given the striking racial differences in marriage and divorce rates, it is important to consider race and ethnicity when studying marriage and other close relationships among older Americans.

In 2008, the majority of older white, black, and Hispanic men were married. Nearly three-quarters of white men, two-thirds of Hispanic men, and about half of black men were married. Widowhood levels were similar across race and ethnic groups, with slightly higher levels among black men (18%) than Hispanic (14%) or white (13%) men. The proportion of older men who were divorced was twice as high among black as white men. A substantial minority (9%) of black men had never married in contrast to 5% of Hispanic and 4% of white men.

Older women were less likely to be married than men, and less than half of each racial and ethnic group was married. White older women were more often married (42%) than Hispanic (36%) or black (23%) women. Nearly half of black older women were widowed, and about two-fifths of white and Hispanic women were widowed. The levels of divorce were higher among black (20%) and Hispanic (17%) women than that of white (12%) women. The vast majority of older American women was ever married; however, black (9%) and Hispanic (7%) older women were more often never married than white (4%) older women. Racial and ethnic variation in family formation behaviors earlier in the life course is likely to have persistent effects as people age, yet few researchers have considered racial and ethnic differences in family behaviors among older adults (although see Calasanti and Kiecolt 2007; Coward et al. 1996). Indeed, from a family change perspective, the economic and normative factors may vary considerably by race and ethnicity for older men and women, but this remains largely unexplored.

Marriage and Divorce in 2008

We rely on the American Community Survey to specifically examine marriage and divorce among older Americans. While we typically think of brides and grooms as young men and women in their twenties, according to the American Community Study there were about 91,000 marriages among older Americans, including 31,500 brides and 59,300 grooms, over the age of 65 in 2008. In 1985, nearly 25 years ago, 71,000 persons over age 65 married (Meyers and Wilson 1988). The increase was not necessarily due to an increase in marriage rates among older Americans but a shift in the age structure of the population. The American Community Survey data indicate that most older Americans who married in the last year were not first time brides or grooms; only 10% were first marriages. About half (54%) of marriages in the last year to older Americans were second marriages, and one-third (35%) were third marriages. The patterns and levels are similar for men and women. In 1985, one-quarter of grooms over age 65 were divorced, and three-fourths of the brides were widowed (Meyers and Wilson 1988). In 2008, about three-quarters of married older Americans were still in their first marriage, which is similar to 76% among the population over age 15 (National Center for Family and Marriage Research 2009).

In the American Community Survey 2008 data, there were approximately 119,700 divorces among older Americans. The ratio of marriages to divorces among older Americans in 2008 is opposite of what it is among the total population. Among older Americans, there were only 0.8 marriages for every one divorce, indicating divorce is more common than marriage. Among the total population over age 15, the ratio is two marriages for every one divorce. Given the stabilization of high divorce rates among the total population (Raley and Bumpass 2003), we expect divorce rates among older Americans to follow the broader population trends. What is notable for older Americans is that they are relatively unlikely to marry again following divorce. Whether they form an unmarried cohabiting union or remain single is unclear, but both pathways are consistent with the family change approach.

The most common marital status change in older adulthood is widowhood. As indicated earlier, widowhood is prevalent among older Americans, and over one million older Americans were widowed in 2008. Women were 2.3 times more likely to experience widowhood than men.

Projections provide a glimpse into the relationship patterns of older Americans in the next few decades and indicate that by 2040, 42% of older women and 69% of older men will be married (Wade 1989). Wade argues that women's decline in marriage will be the result of declines in widowhood and growth in divorce, while men's decline will be due to older men's lack of marriage (never married status). These predictions mirror those of Cooney and Dunne (2001). Updated projections suggest that the proportion of older adults never married will increase, the proportion married will decline, and the proportion divorced will stabilize in recent years (Tamborini 2007).

Living Arrangements

The living arrangements of older Americans are tied to their marital status but living arrangements offer a unique lens on the potential sources of support available to older adults within the household. For instance, marital status per se does not reveal whether an individual lives alone or with other family members. The rapid rise in older adults living alone is of considerable policy interest to the extent that it portends growth in the share of elderly without the supports required to delay or avoid institutional care (Mutchler 1992). Transitions in living arrangements among older adults sometimes follow a different pattern than that documented at a single point in time (Wilmoth 1998), but they are beyond the scope of this chapter.

We examine changes in living arrangements among older adults over time, distinguishing among four categories: living alone, married and living with spouse, living with family members, and living with nonfamily members. Older Americans also may live in group quarters but are not included in our Census estimates below. The term "group quarters" may include a variety of circumstances. The Administration on Aging (2009) reports that, in 2007, 1.57 million or 4.4% of older Americans lived in institutional settings, and 2–5% lived in senior housing with support services.

Living Alone

Figure 13.3 shows that the proportion of older men living alone has increased slightly from 15% in 1980 to 19% in 2008. As men age, a greater proportion were living on their own; the oldest old were about twice as likely to live alone as the youngest old. In 1980, 11% of men ages 65–69 lived alone, and 26% of the oldest old men lived alone. Similarly, in 2008, 15% of men 65–69 years old lived alone, 32% of men aged 85 or older also did so.

There was a consistent pattern in the proportion of older women who lived alone in 1980 and 2008: 40% in 1980 and 37% in 2008 (Fig. 13.4). The proportion of older women who lived alone increased sharply according to age. In 1980, 30% of women 65–69 lived alone, and 46% of the oldest old lived alone. In 2008, there was a steeper age gradient, 26% of women ages 65–69 lived alone, while 56% of women over age 85 lived alone.

Women more often live alone than men, and this is true for every age group of older Americans. In fact, the gender gap in living alone increases with age. In 2008, among the oldest old, about one-third (32%) of men and over half (56%) of women lived alone. Solo living in older adulthood is related to fewer economic resources in addition to lower levels of social support. As the population ages and life expectancy increases, living alone will be more prevalent among older adults and its consequences for society more salient.

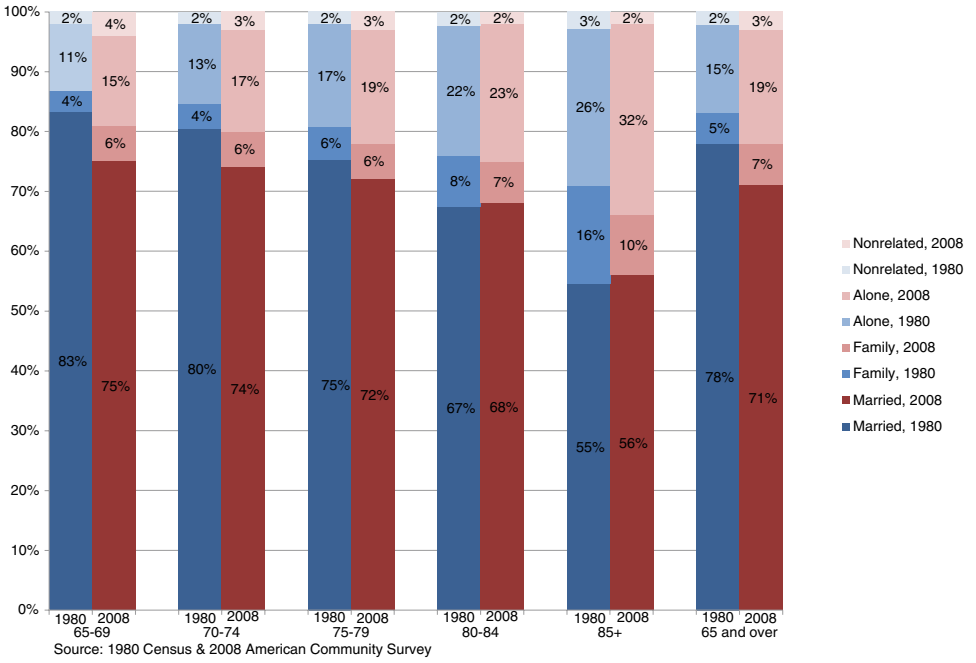

Fig. 13.3 Living arrangements by age for males, 1980 and 2008

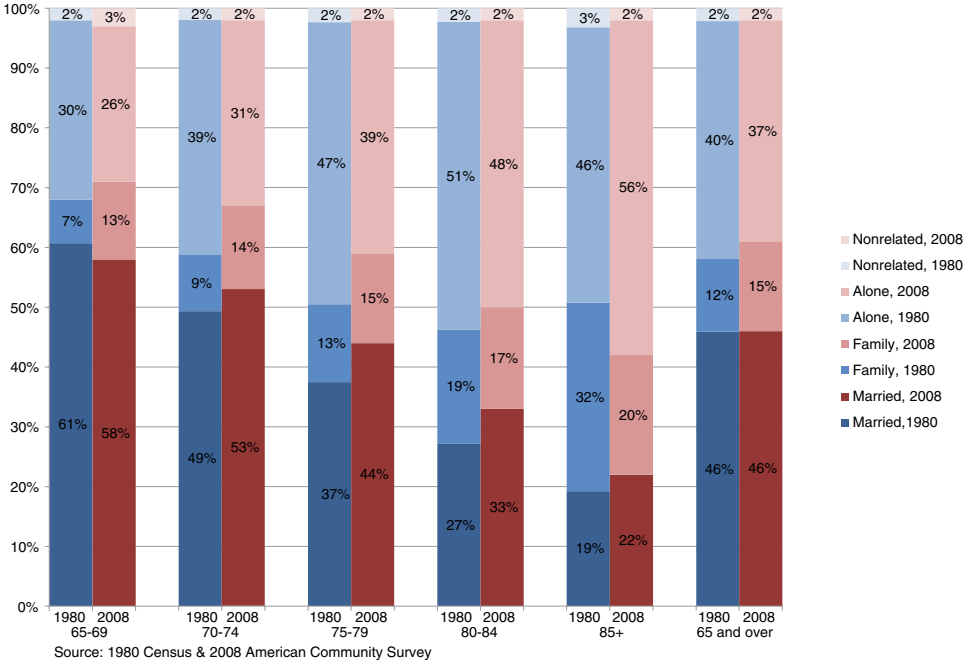

Fig. 13.4 Living arrangements by age for females, 1980 and 2008

Married with Spouse

These estimates differ slightly from the levels discussed earlier because we exclude in the denominator older Americans living in group quarters. Accordingly, these estimates are limited to older Americans who are not living in group quarters. Over the last 40 years, there has been a small decline in the proportion of older American men who were married, from 78% in 1980 to 71% in 2008 (Fig. 13.3). In 1980, young old men experienced the highest levels of living with a spouse (80–83%), and this declined to 55% among the oldest old. A similar age pattern existed in 2008.

There has been no change in the proportion of older women who live with a spouse (46%) in 1980 and in 2008 (Fig. 13.4). About three-fifths (61% in 1980 and 58% in 2008) of women 65–69 lived with their spouse. In both 1980 and 2008, oldest old women experienced a sharp decline in coresidence with their spouse; only 19% in 1980 and 22% in 2008 lived with their husband.

As discussed earlier, a greater proportion of older men than women lived with their spouse. In 1980, 46% of women and 77% of men were living with their spouse. The gender gradient in marriage increased with age, and the levels remained consistent in 1980 and 2008. In 2008, men 65–69 years old were 1.3 times more likely to be living with a spouse than women, while men 85 years old and older were 2.5 times more likely to be living with their spouse than women. Most women not residing with a spouse live alone, meaning they are at risk of lower levels of economic, socioemotional, and physical well-being.

Living with Family or Nonfamily Members

In 1980, it was relatively rare for older men to live with family members (5%) or nonfamily members (2%) (Fig. 13.3). Coresiding with family (7%) or nonfamily (3%) members remained uncommon in 2008. The proportion of men living with nonfamily members remained nearly constant across age groups. By contrast, in 1980, there was fourfold gap in the proportion of men living with family between the youngest and oldest age groups. About 4% men ages 65–59 and 16% of oldest old men lived with family members. In 2008, 6% of men ages 65–69 lived with family, and only 10% of oldest old men lived with family. Thus, there was a decline in the proportion of the oldest old men who were living with family members.

In 1980 and 2008, a similar proportion (2%) of older women lived with nonfamily members (Fig. 13.4). The low level of nonfamily coresidence persisted across age groups. In 1980, 12% of women lived with family members, and in 2008, about 15% lived with family. In 1980, 7% of 65–69-year-old women lived with family, and 32% of 85+ year-old women lived with family. By 2008, there appears to be an increase in family living among young older women (65–69) and a decline among older (85+) women. Consequently, in 2008, 13% of 65–69-year-old women lived with family members, and 20% of women aged 85 or older lived with family members.

There is no gender gap in the proportion of older Americans living with nonfamily members. However, in 2008, older women more often lived with family members (12%) than men (7%). At each age, women were more likely to live with family than men, and the proportion living with family increased with age. The gender gap is consistent across age groups at both time periods; women experience about 2–3 times higher levels of family coresidence than men. These patterns illustrate the closer family ties enjoyed by women relative to men. Among those residing without a spouse, both men and women are most likely to live with family members, but this is more pronounced among women and accounts for a larger share of all women. As family instability weakens men's ties to their children and other family members, we can anticipate that older men's coresidence with family members will proceed at a slower pace than that for older women.

Racial and Ethnic Variation

As discussed earlier, there were racial and ethnic distinctions in the proportion of older Americans who were living with a spouse. White men and women more often lived with a spouse than did black men or women. Very few (5%) white older men lived alone, while 15% of black and 16% of Hispanic men lived alone. About one-quarter of black men lived with family members in contrast to only 18% of white and 16% of Hispanic older men. Living with nonfamily members is relatively rare and quite similar across race and ethnic groups.

The majority of older women did not live with a spouse; two-fifths (42%) of white women, 36% of Hispanic women, and only about one-quarter of black women lived with their spouse. One-third of older black women lived alone, while 28% of older Hispanic women and 12% of older white women lived alone. Nearly two-fifths (38%) of black women lived with family members, representing the most common living arrangement among older black women. Similar proportion of black and white older women lived with family, and 28% of Hispanic older women lived with family. Only 2% of older women lived with nonfamily members, and this was similar for each race and ethnic group considered here.

New Union and Couple Forms

There are several union and couple experiences that are not captured with the traditional indicators of marital status and living arrangements, including cohabitation, LAT, and same sex unions. Although these less traditional couple relationships have received comparatively little attention in the gerontological literature, aging scholars have begun to call attention to the importance of examining these emerging union types (Cooney and Dunne 2001; Huyck 1995). As fewer older adults are married, a larger share is available to form nonmarital relationships. Whether these relationships offer benefits akin to marriage is largely unknown although some research has compared either the relationship quality (Brown and Kawamura forthcoming) or the psychological well-being of older cohabitors and marrieds (Brown et al. 2005) and shows that the union type gap in well-being is relatively modest. Here, we document the demographic trends in cohabitation, LAT, and same sex relationships.

Cohabitation

In recent decades, cohabitation, or the sharing of a household by an unmarried opposite-sex couple, has increased dramatically in the United States. This growth is not limited to younger adults but rather extends through older adulthood (Brown et al. 2006; Chevan 1996). The reasons for cohabiting later in life are distinctive. For instance, older adults may prefer to cohabit to retain financial autonomy and protect their wealth for eventual transfer to their heirs (Brown et al. 2005; Chevan 1996; King and Scott 2005). Among older adults, cohabitors tend to be younger than marrieds. Cohabitors are disproportionately black. Most older cohabitors are divorced (71%) as opposed to widowed (18%) or never married (11%) (Brown et al. 2006). Chevan's (1996) estimates using indirect measures of cohabitation revealed sustained growth in cohabitation between 1960 and 1990 for adults aged 60 and older. Direct measures indicate that by 2000, more than 400,000 persons in this age group were cohabiting (Brown et al. 2006). In 2008, the number of older Americans who were cohabiting increased, 4% of cohabiting couples had a member aged 65 or older (U.S. Census

Bureau 2009). Among older Americans living in an opposite sex relationships, about 2% were cohabiting, and 98% were married (U.S. Census Bureau 2009).

Living Apart Together

The concept of LAT relationships evolved from research in Europe (Levin 2004; Haskey and Lewis 2006) and has extended to the United States (Strohm et al. 2009). These relationships are committed, long-term intimate unions in which couples do not share a home but rather maintain separate residences. Most of the United States and European studies are limited to younger age groups, and only a few examine patterns among older adults. De Jong Gierveld (2004) focused on Dutch respondents aged 50 and older who experienced widowhood or divorce and found that one-third of those who repartnered after age 50 were in LAT relationships. She concluded that older adults are more likely to live apart together than their younger counterparts (De Jong Gierveld 2004). Research in Sweden indicates that this arrangement is increasingly common among older couples as a strategy to engage in emotional support with some level of autonomy (Karlsson and Borell 2002). This seems to be a relationship that may be especially well suited to older Americans who can afford to live separately and want to maintain some autonomy while experiencing the benefits of a close intimate bond. Unfortunately, estimates of LAT relationships among older adults in the United States are not available.

Gays and Lesbians

Research on gay and lesbian family experiences is typically restricted to young ages, excluding older Americans. Of course, older Americans are part of same sex couples, too. Recent data permit measurement of the prevalence of same sex households in the United States. In the 2007 American Community Survey, just over 10% (11.3%) of same sex couple households had one member over the age of 65. A greater proportion of these were male (60%) than female (40%) couples. Seventy-one percent of same-sex older couple households had coresided for 5 years or more (Bennett and Gates 2004). According to the 2000 census, almost every county (97%) had an older same-sex American (Gates 2003).

Given new legislation about marriage among same-sex couples and the development of domestic partnership agreements, there are more options available for older Americans. The legal definitions of these relationships are significant when one member of the couple dies (Bennett and Gates 2004). The social security benefits are lower, and taxes on inheritance and retirement plans are larger among gays and lesbians than among married couples (Bennett and Gates 2004). Gay and lesbian older Americans also face constraints due to Medicaid and property laws that may make it difficult for partners to remain in their home following their partner's move to a nursing home or death (Bennett and Gates 2004).

Conclusion

The aging of the U.S. population coupled with rapid changes in family formation and dissolution earlier in the life course has contributed to shifts in the marital status and living arrangements of older men and women over the last 30 years (Chevan 1996; Cooney and Dunne 2001). This chapter documents

changes in the marital status and living arrangement distributions of women and men between 1980 and 2008 using data from the decennial census and the American Community Survey. We also describe racial and ethnic variation in these patterns. These changes are discussed in terms of the family change approach, which emphasizes how shifting economic, normative, and institutional constraints have contributed to family change. These patterns are informative for researchers and policymakers alike, as an increasingly diverse older population likely will require an array of both informal and formal supports as they age. Specifically, with fewer older adults married and more living alone, increased institutional supports will be needed. New family forms, such as cohabitation, LAT, and same sex relationships also merit careful study to determine the costs and benefits of these unions relative to other living arrangements. These new living arrangements appear to be here to stay and represent the future of families. Moreover, much can be learned by considering the full range of families which move beyond just legal heterosexual marriages. For example, family change means that traditionally taken for granted intergenerational family ties are more complex and disrupted. Among younger samples, there is lower social support for gay and lesbian couples (Kurdek 2004) and cohabiting couples (Eggebeen 2005), which is suggestive of what may happen among older Americans who do not engage in traditional marital relationships.

Similar to the overall U.S. population, marriage among older adults has declined since 1980. This decline has been more pronounced among men than women. For women, the proportion married has changed very little. Consistent with the projections made in prior research (Wade 1989), widowhood has fallen, whereas divorce has risen among women. Men are also much more likely to be divorced today than they were in 1980. The share of men who are never married remains essentially unchanged, even though it was projected to double between 1990 and 2040 (Wade 1989). More recent projections indicate that the proportion of older adults married will continue to decline with a corresponding increase in the never married. The proportion divorced should stabilize in the coming years (Tamborini 2007). These levels of divorce will most likely have negative implications. Lin (2010) reports that divorced parents expect less support from children, and divorced men are most likely to experience a retraction of their children's support in old age.

Living alone is more common today than in 1980, and a larger share of women than men reside solo. Family and nonfamily living arrangements remain rare. The vast majority of older adults are residing either with a spouse or alone, and this is especially true among whites. Blacks are relatively less likely to be married and more likely to reside with family, reflecting the racial and ethnic variation characterizing the living arrangements of older adults (Himes et al. 1996).

This examination of changes in marital status and living arrangements does not capture all family and relationship types that exist among older Americans. For instance, our measure of marriage does not distinguish between first and higher order marriages. Remarriage among older Americans in 1980 was largely a function of widowhood rather than divorce. In 1980, most widowed older Americans did not remarry; just 1% of women and 25% of men remarried (Moss and Moss 1981). More recent analysis of remarriage is warranted, as remarriage and stepfamilies are linked to variation in support in older adulthood (Curran et al. 2003; Lin 2010).

Our descriptive analyses rely on cross-sectional data to provide a snapshot of older adults at two points in time. This approach is useful because it illustrates the distribution of older adults across marital status or living arrangement categories, but it obscures the broader trajectories of relationship histories that unfolded earlier in the life course. Increasingly diverse family and living arrangement experiences during young and middle adulthood have enduring consequences for later life (Cooney and Dunne 2001). At the same time, older adults experience living arrangement transitions and, from a life course perspective, these transitions are contingent upon earlier events and experiences (Wilmoth 1998). Voluntary (e.g., marriage or divorce) vs. involuntary (e.g., widowhood) transitions may have differential effects on older adult well-being.

For these reasons and to better test union formation and stability theories, future work on the demography of unions in later life would benefit from a longitudinal approach that incorporates

family and living arrangement transitions both prior to and during older adulthood to provide a more nuanced portrait of the family and relationship experiences of older adults. In the last 30 years, new and on-going data collections have offered longitudinal (e.g. NLSY, NSFH, WLS) and periodic cross-sectional (e.g., NSFG, CPS, Census) assessments. To best understand the experiences of family life among older Americans in the next 30 years requires investment in longitudinal data collection of young and middle age adults today. In addition, men and women experience relationships differently, but few large-scale studies include information from both men and women or couples. Indeed, intimate relationships outside of marriage have risen in recent years. Growing attention has been paid to unmarried intimate relationships among older adults, including cohabitation, LAT, and same sex relationships (Cooney and Dunne 2001). Still, little is known about the prevalence of these union types or the determinants of entry and exit from these unions (Brown et al. 2006). As they become more common, especially with the movement of the baby boom cohort into older adulthood, it will be more feasible to incorporate these emerging relationship types in large, national surveys to generate new scholarship on the demography of these unions. This line of inquiry will be enriched by theoretical developments concerning the meaning and significance of these new partnerships for the health and well-being of older adults.

We focus on *coresidential* relationships, including marriage, cohabitation, and family household membership and therefore do not examine romantic or sexual relationships. Qualitative evidence suggests that dating among older adults following widowhood or divorce is fairly common (Bulcroft and Bulcroft 1991; Cooney and Dunne 2001), although women are less likely to desire remarriage than men (Talbott 1998). There are few empirical studies of dating, with Carr's (2004) recent work a notable exception. She finds that widowers' interest in dating is greatest when they lack other forms of social support, whereas widows' interest in dating does not depend on levels of support from friends.

In addition to dating relationships, new research is emerging on sexual activity among older adults. Waite (2009) maintains that sexual functioning is integral to overall well-being in later life. Even though research often assumes that older Americans are not sexually active, Lindau et al. (2007) report that in a sample of partnered older adults, 67% of men and 40% of women aged 65–74 report being sexually active in the last 12 months, while 39% of men and 17% of women aged 75–84 did. These figures are from the recently fielded National Social Life, Health, and Aging Project (NSHAP), which provides detailed data on the relationship and sexual behaviors of Americans ages 57–84. The declining share of married older adults translates into rising proportions at risk of forming new sexual partnerships, which not only may have ramifications for access to social support but also for physical and mental health.

Older adults are a growing share of the U.S. population. In fact, the oldest old are the fastest growing age group today (National Center for Health Statistics 2009). The older adult population, which is diverse in terms of racial and ethnic composition, has witnessed significant changes in marriage and living arrangements since 1980. The decline in marriage coupled with increase in divorce and living alone have consequences for the well-being, care, and support of older adults. Shifts to more complex family living arrangements, including the emergence of unmarried partnerships, have led to more varied types of support networks. Mounting evidence suggests that men will pay a higher cost for less stable family life by having limited support networks in old age (Lin 2010). Theoretical perspectives on family change must pay attention to the shifting demographic foundations of families and households across the life course.

Family change has not been experienced in the same way by all Americans. We have shown differentials according to gender and race/ethnicity, but there are also likely socioeconomic differences in living arrangements and relationships among older Americans. Consistent with both the family change approach and a life course perspective, these social inequalities in family formation and stability have ripple effects and continue to exist among older Americans.

The demography of unions in older adulthood has important social policy implications. Institutional supports will be needed to serve a growing, heterogeneous population that will have fewer forms of

informal support to draw from. Lengthening life expectancies will only exacerbate these trends. Policymakers must be aware of the wider array of family situations characterizing older adulthood to ensure responsive policies are developed and maintained that reach across the range of relationship and living circumstances experienced by older adults. Close relationships play an integral role in the health and well-being of older adults, and formal institutional supports, particularly large government-sponsored initiatives, have the potential to greatly enhance the lives of the aged.

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Part V
Social Institutions and Aging

Chapter 14
Rethinking Retirement

Melissa Hardy

Because retirement is continuously being shaped by social policy, labor markets, economic systems, family dynamics, and personal predilections, retirement research has been the study of a changing social institution. Macro and micro level social processes have transformed what once was a status unavailable to the majority of older workers into a highly anticipated and often eagerly awaited stage of the life course. As the means of production shifted away from agriculture and the scale of enterprises grew, bureaucratic standardization of job entries and exits became a key component of labor force management. Defining the composition of that labor force relative to skill, speed, and compliance was linked with demographic traits such as age, gender, and education. Although the specifics have changed, retirement continues to be a key component of the social organization of work and the distribution of income. As categories of nonemployment, retirement, unemployment, disability, home production, and leisure are responsive to broader labor market conditions, prevailing economic policies, and social norms.

As a relatively new field, studies of retirement relied on prevailing theoretical perspectives adapted from the broader landscape of social science disciplines. As retirement research developed, interest in the personal and social consequences of allocating a growing proportion of the adult life course to "years spent in retirement" shifted from a primary focus on adjustment and adaptation to an emphasis on the social and monetary costs of assigning an expanding number of years to a stage of the life course that primarily involved consumption rather than production or accumulation. The political discourse has emphasized issues of distribution and equity relative to generational membership, social class, and demographic subgroups as points of contention, questioning the fairness and, in some cases, the basic morality of a redistributive regime that is both deliberate, hierarchical, and self-consciously productive of social relations in contrast to one that is market driven and indifferent to consequential inequalities.

During the last century, government retirement policies, industrial retirement programs, and personal retirement expectations were adapting to an age-structured approach to employment that moved retirement to younger ages, gained many twentieth century advocates, and now has many twenty-first century critics (Ekerdt and DeViney 1990). One issue at the core of retirement research has been the tension between human agency and social structure that is often framed in the terminology of voluntary decisions, personal preference, and individual behavior vs. unequally distributed opportunities and constraints, and the complex social relationships in which they are embedded. A basic division in the literature, therefore, is among studies that address what actors did, when the action occurred, and the circumstances and characteristics that influenced the likelihood and timing

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of these actions; studies that attempt to incorporate the voices of the actors, their explanations for their actions, how they viewed their options, how they evaluate different life domains, and how they see themselves; and studies that take a broader often comparative view of retirement (and retirement policy) as a symptom of labor market reorganization and industrial restructuring, reflective of culturally based perceptions of age, collective responsibility, governments, and markets.

Regardless of whether one thinks of retirement as a status, a transition, or a stage of the life course, classifying people as retired (or in the process of retiring) is a messy process. The use of labor force status has been a favored strategy, since it allows a consistent basis for historical and international comparisons of aggregate trends, but does not necessarily capture the complexities of individual transition behavior. Comparative researchers suggested employment status as a better indicator than labor force status, since a number of European countries (e.g., France, Germany, The Netherlands) had muddied the retirement transition by using unemployment or disability programs to replace wages for those too young for "early" retirement benefits, making the distinction programmatic rather than behavioral (Guillemard and Rein 1993). Add self-reports of transitions, sources of income, work history and identity to the mix, and possible operational definitions multiply (Szinovaca and DeViney 1999).

As retirement became more established as a distinct stage of the life course and the size of the retired population grew, retirement research was dominated by four sorts of questions. The first set of questions focused on the behavioral patterns: When do people retire? Why do they retire when they do? What do they do after retirement? The second set of questions tackled issues of inequality: Who were able to retire when they wanted to, and who worked longer or retired earlier than planned? How was the financial security of retirement affected by one's place in the occupational structure? By one's race, gender, marital status, health, or work history? To what extent did inequality increase, decrease, or remain the same after retirement? The third set of questions dealt with issues of adjustment: Were retirees happy with their lives? Did health (both mental and physical) improve or deteriorate because of retirement? How did retirement affect marriages and marital satis faction? A fourth set of questions addressed how retirement and retirement transitions differed across countries: How did the state respond to the challenges of industrial reorganization? What role did firms or unions play in orchestrating these transitions? How were different retirement regimes reflected in the security vs. vulnerability of the older population? In the remainder of this chapter, I will discuss our questions, our answers, and our approaches using an organizational heuristic – historical decades – to align for the reader the ongoing research process with changes in policy, politics, the economy, social attitudes, and societal expectations. Neither the prominence of the issues nor the appearance of the research can be neatly packaged into this framework. Changes in political leadership, presidential terms, economic conditions, and demographic shifts do not coincide with 10-year time spans. Even so, this approach invokes a broader context in which the reader can loosely situate the retirement research enterprise and appreciate the major themes of inquiry.

The 1970s: Building a Financially Secure Retirement

The 1970s ushered in a new era of retirement – perhaps what could be considered the modern era of retirement – as the early wave of baby boomers shifted from school to work and older workers moved into retirement with somewhat higher Social Security benefits and Medicare coverage. Retirement research was tracking these changes from the perspective of workers who had been born in the first part of the twentieth century and had fueled the postwar economic growth and the rising living standards the booming economy made possible. The research literature became more interdisciplinary, as many of the social sciences as well as some schools of business became more interested in the phenomenon. Although earlier studies had focused on mandatory retirement policies, passage of the American Discrimination in Employment Act in 1967 began the process of

largely eliminating mandatory ages. A branch of retirement research began to identify the "push" and "pull" factors that could move older workers into retirement, while a second branch of research noted insufficient institutional support for the new status. Researchers began to demonstrate how retirement behavior was responding to changes in policies, with ages of pension entitlement mirrored in how retirement was timed. As the circumstances of retirement improved, the public image of retirement was changing to that of an eagerly anticipated escape from the routine of work to the discretion of leisure.

Research studies were spurred by the development of several large longitudinal data collection projects, including the National Longitudinal Surveys (NLS) and the Retirement History Survey (RHS). This research concentrated largely on the retirement behavior of white men and in the RHS, unmarried women. Based on a prospective longitudinal design, these data sets allowed an observational window on "before" and "after" retirement characteristics, activities, and events. They included large national samples so that population estimates of this transition behavior could be developed, and their over-samples of African Americans allowed comparisons by race, although the concept of retirement did not fit minority experiences as well as those of white men.

A few studies focused on specific firms (Barfield and Morgan 1969; Rogers and Friedman 1980) to study retirement when modes of production were changing in the workplace. Transitions to new technologies that required new skills inspired a firm-based calculus that balanced the costs of retaining and retraining older workers against the costs of sweetening pensions and hiring younger replacement workers. Employers often assumed that older workers would be unable to make the transition to a new production technology. That many older workers lamented the demise of a labor process that involved skilled craftsmanship contributed to prevailing stereotypes of older workers – that they resisted change and were too rigid in their approaches to their work.

The general trend in research was toward developing reliable population estimates, which meant that the retirement research enterprise would increasingly shift to these large, secondary data sets and necessarily be limited by the information that was available in them. This period also marked disagreement over how to define retirement. Early reliance on self-reports was criticized as being too subjective. Whether these self-reports were used to sort people into workers vs. retirees or distinguish those with or without health impairments, or whether they described why the retirement occurred, such measures were viewed as inferior to behavior-based measures, such as labor force participation or labor supply, or functional measures, such as diagnosed disease, activity limitations, or formal disability status.

The 1980s: Understanding the Democratization of Retirement

In the early 1980s, we experienced the first modern crisis in social security; on the heels of legislation that improved the predictability and level of benefits, stabilized replacement rates, and secured the real value of benefits, the high levels of unemployment and inflation in the late 1970s produced a revenue shortfall, which required the temporary transfer of general funds. Putting Social Security back on sound fiscal footing led to another fundamental shift in funding strategy – preemptive tax increases in FICA, the reemergence of the trust fund, and scheduled delays in the full retirement age (FRA) to be staged in for the baby boom cohorts (Hardy and Hazelrigg 2007). The economic impact of retirement – on nations, firms, and households – was receiving negative attention and although ambivalence about financial support for early retirement was rising, workers still expected to retire before age 65.

As Sociologists tried to understand why some people retired earlier and others retired later, the general expectation was that virtually all workers would retire at some point. Some sociologists still emphasized social structure – opportunities available to older workers, the apparent lack of fit between those older workers who wanted to stay employed and the older workers whose employers

wanted to hire or retain, and the impact of an ever lengthening retirement period on couples, families, and communities; others focused more on person-level processes of anticipation, adjustment, and adaptation. Studies that addressed the relationship between health and retirement searched for better measures of health (compared to self-reported work limitations) as predictors of retirement, particularly early retirement, and noted that the health declines experienced in retirement could reflect the more negative health trajectories of those moving into retirement.

Viewing the attributes of the retirement status and the character and timing of the transition as an outcome of a career pattern also fit within the life course framework. Workers' location in the occupational structure correlated with a number of retirement-relevant characteristics. Job security, access to promotion ladders, coverage by employer-sponsored pensions and health insurance, total compensation packages, and the nature of job tasks were allocated through jobs rather than assigned to specific workers. Workers with secure jobs who engaged in substantively complex work tasks, exercised discretion over their work day, and engaged in positive social interactions tended to retire later than workers whose jobs were physically demanding and whose work days were highly structured (Hayward et al. 1989).

Researchers began to unfold retirement as an increasingly complicated and heterogeneous set of transitions and adjustments. Once viewed as a one-time, complete and permanent exit from paid employment, various retirement patterns started to emerge. Workers might end a career job through a "retirement" exit and then, within a year or two, reenter the labor force, sometime in an entirely different sort of job (Beck 1985; Hayward, Hardy, and Liu 1994). Older workers who were displaced from their jobs, spent some time looking for work, and then move into retirement; older workers who retired or were displaced from jobs moved into "bridge" jobs until they retired "completely," often working part-time schedules and at lower pay. Workers (primarily white-collar) claiming age discrimination – in hiring or retention decisions – went to court (Quadagno and Hardy 1991), and older workers caught up in a spiral of plant closings and downsizing took advantage of early retirement packages and either remained retired or shifted to different jobs. The extent to which older workers were "pushed" or "pulled" into retirement remained a point of debate, and whether differences in the nature of retirement transitions were linked to more fundamental inequalities was also explored, since different transitional processes were linked to different levels of satisfaction and financial security in retirement. "Discouraged" workers as a different category of labor force status resurfaced briefly (Hardy 1991), but "evidence" of this status relied on self-reported reasons for not actively searching for employment. Given that unemployment rates among older workers were quite low in relative and absolute terms, researchers continued to emphasize the supply of older workers rather than demand factors: what sorts of incentives could entice an older worker into early retirement or a retiree with desirable skills back into the labor force? The language of retirement also shifted from something that happened to people ("I was retired" or "it was time" for me to retire) to something they "took," a linguistic shift that suggested a change in agency and a focus on income replacement (taking the pension in lieu of wages or taking the retirement "package").

Recognition that women – married and unmarried – were also moving into retirement prompted researchers to question whether the transition, the process, and the status may differ for women and men (Hayward, Grady, and McLaughlin 1988). As the rising employment rates of women pushed the study of women and work (and gender differences in work) to the forefront, gendered responsibilities for housework and family care also received more attention. Whereas work was seen as central to the life course of men, family responsibilities occupied a central position for women. This assumption framed research on both the retirement transition and on retirement adjustment for women. Researchers started asking whether women's experiences should be viewed through a different lens (Calasanti 1993), or at least an expanded lens, that incorporated work and family roles as well as other life course dimensions on which men's and women's experiences and expectations differed.

Through cohort replacement, growing proportions of women had longer employment spells, so research began to focus on the impact of the gender gap in wages and the gendered composition of occupations and industries for women's financial security in retirement. Because of women's greater involvement in parenting, women's work histories were less continuous then men's; therefore, the study of women's retirement had to take family responsibilities and the joint trajectories of women's work and family roles into account (O'Rand and Henretta 1982; Henretta and O'Rand 1983). Compared to men, women generally had shorter work histories, lower annual and lifetime earnings, and lower rates of participation in employer-provided pensions (DeViney and O'Rand 1988). The discontinuity in women's work histories explained some of the gender gap in retirement income, but the underlying processes that sorted women into jobs that offered no pension plans reflected the gendered nature of occupational structure. Therefore, in retirement women were more reliant on spousal and survivor's benefits and particularly vulnerable to the policies that governed such benefits. That women faced higher risks of poverty in old age and that African American women faced much higher poverty risks reflected these life course patterns of gender and race inequalities.

The terrain of employer-sponsored pensions was also changing, as companies began to shift from defined benefit to defined contribution plans and 401(k)s. Put into effect on January 1, 1980, the amendment to the Internal Revenue Code provided tax exemptions to employees on income they chose to receive as deferred compensation rather than direct compensation. By 1983, almost half of large firms already offered or were considering a 401(k) plan (EBRI 2005), a retirement plan easier to administer and cheaper for employers, who paid only plan administration and support costs (in the absence of matching contributions) and were able to pass on much of that cost to plan participants.

But by the end of the 1980s, pension plan coverage had peaked and long-term liabilities in defined benefit pension plans were rising. The shift to defined contribution plans was, in part, attributed to employers' reactions to increases in reporting requirements, funding regulations, and attendant rising costs of administration, but it also signaled changes in institutional structure, the perceived advantages of long-term contracts, and employers' desire for additional "flexibility" in retention decisions. Loss of market share in the manufacturing industry was increasing the rate of plant closures, just-in-time production, and outsourcing. The vertically integrated enterprise offering long-term contracts for worker loyalty and the development of firm-specific skills was being replaced by more limited inventories of products and workers, shorter term contracts, and limited payroll liabilities – both current and deferred. In retrospect, we would see that the mid-1980s as the low point in labor force participation rates for older men and women. "Black Monday" (October 19, 1987), which marked the largest drop in the U.S. stock market up to that time, temporarily shook the confidence of U.S. investors, who had been experiencing long-term growth in equities; more and larger drops were to follow, but these events helped make the economy a major concern as we moved into the last decade of the millennium.

The 1990s: The Accelerating Process of Individuation

By the 1990s, the retirement research process had become increasingly politicized. Conservative think tanks emphasized intergenerational equity issues and the need to privatize Social Security. Counter arguments emphasized how fragile retirement was for many U.S. households, the importance of social insurance in combination with private investment, and the benefits of widely pooled risk. Frequent stories in the public media privileged the sound bite over more nuanced explanations, and researchers learned to parse their words carefully when talking about the topic.

Policy changes in both public and private spheres accelerated the process of greater individuation, manifested in greater within-cohort heterogeneity in when and how major life course transitions

occurred. Although the timing of retirement was still influenced by ages of Social Security entitlement, the early retirement incentives offered through private industry had shifted many retirement exits to younger ages. Pathways into retirement had also become more varied and more elaborate (Han and Moen 1999). Growing evidence of this heterogeneity challenged the concept of the "institutionalized life course" (Meyer 1986). Pathways to early retirement in seven industrialized nations illustrated the mix of public and private institutional arrangements that shaped the retirement process and revealed a wide range of age intersections (Kohli et al. 1991). Retirement as the entry point into "old age" was also being contested, as growing numbers of younger, healthier retirees rejected the label of "senior citizen," and an "anti-aging" industry offered a dizzying array of products to help buttress their claim.

Growth of defined contribution pensions further reduced the age-standardization of pension entitlement. Positive features of these plans included their portability, flexibility in when benefits could be claimed, and the possibility of "borrowing" funds if necessary. But these advantages were counterbalanced by the increased risk that was placed on workers and households. Different investment strategies, different economic conditions, different patterns of contributions could all produce different rates of accrual. When firms converted their DB plans to DC plans, the expected retirement age for older workers often changed substantially, since the rate of accumulation in DC plans could not produce the benefits promised by DB plans for workers nearing retirement age. What had been a clear connection between age, service, and benefits now depended on contributions, markets, returns, and annuities, an unfamiliar environment for many U.S. households.

Why people retired when they did was an important policy question, since reversing the pattern required an ability to manipulate the factors that prompted the behavior. Early in the decade, a new national survey was launched to provide longitudinal data to researchers interested in studying these issues. The Health and Retirement Study (HRS) fielded in 1992 became the primary U.S. data resource for studying retirement. Consistent with the view that retirement primarily involved the substitution of one income stream (earnings) for another (pension and savings income), HRS collected detailed information on income and assets as well as employment. Measures of "pension wealth," which were based on anticipated lifetime benefits, economic assumptions about inflation and discount rates, and demographic assumptions about longevity, convinced many households that early retirement was achievable even as studies demonstrated that median nonpension asset levels in U.S. households were primarily bound up in housing equity. Housing prices were rising, too; therefore accumulating higher levels of nonhousing, nonpension, and more liquid forms of savings seemed less important, especially when credit was so readily available. Although some threshold of retirement income was a prerequisite for voluntary retirement, understanding why people retired when they did also involved family considerations, social expectations, normative behaviors, and the organizational culture of the workplace. To the extent that firms aligned their pension plans with desired terms of labor force management, corporate downsizing could be handled through retirement rather than layoff, but the long-term costs of that strategy had been mounting. Employers routinely complained that ERISA regulations requiring them to offer ERIs to entire classes of workers eliminated their effectiveness in targeting reductions, with too many of the workers they hoped to "shed" or replace remaining on the job (Hardy, Hazelrigg, and Quadagno 1996). More skilled workers had better reemployment prospects and could retire and move to different jobs while simultaneously collecting their pension benefits. Accepting an ERI was therefore a reflection of household and employment trajectories that were more complicated than timing the generosity of the benefit package.

Older workers were not only retiring at earlier ages from career jobs. They faced growing risks of displacement, termination, and long-term unemployment. Previous studies of displaced workers had indicated that older workers faced lower risks of displacement than younger workers, but once out of work, they experienced longer spells of unemployment and larger wage reductions when they did find jobs. As a lengthening list of Supreme Court decisions narrowed the interpretation of the ADEA, involuntary job separation, which was more common among women and minorities

(Flippen and Tienda 2000), coupled with older workers' slightly higher rates of displacement compared to younger workers increased the volatility in late career employment behavior. Those factors highly correlated with age could be used to terminate employees made it much less risky for employers to focus layoffs and terminations on older workers. Using salary level or internal reorganization as criteria, employers could easily target more highly paid older workers for termination, inflicting disparate impact while avoiding disparate treatment.

Higher job exit rates, reductions in older men's job tenure, occupancy of short-term bridge jobs, and returns to work after exiting the labor force blurred work-to-retirement transitions. Beginning in the mid-1980s, the labor force participation rates for older men had stabilized at a historically low level, but in the 1990s rates for men had begun to rebound, even for men aged 65 and older. The labor force participation rates for older women also showed a small upward trend, as older workers continued in full-time or adopted part-time schedules and enacted transitional sequences reflecting opportunities and choices.

Disparate pathways to retirement had been more common in European countries, where public programs of retirement, disability, and unemployment provided wage replacement income to older workers who were considered "redundant." In countries such as Germany (Kohli 1987) and France (Guillemard and Rein 1993), the public sector financed early retirement as a method of easing unemployment. Although some researchers increasingly equated "early" retirement with voluntary retirement and viewed virtually all retirement exits as the behavioral manifestation of workers' preferences, sociologists continued to parse the difference between exits that were initiated through changing institutional demands, those prompted by poor health, and those that seemed to be proactively and prospectively planned by workers.

Within that framework, some retirements appeared to signal acceptance of one option among a choice set limited by protracted spells of illness or disability, by repeated failure to secure subsequent employment, because of ageism or skill obsolescence, or by increased family responsibilities (DeViney and O'Rand 1988). Were workers acting in accordance with their own timetables? Or were they adapting to changing circumstances, less secure jobs, or managers' signaling behavior? Earlier studies of how planned retirement ages matched (though perhaps not exactly) subsequent behavior had indicated a fairly high level of accuracy in such predictions, but that accuracy was arguably a function of the institutional predictability of retirement income and the security it offered. Even then, one third of the sample experienced either unfulfilled plans or unanticipated retirements (Ekerdt, Vinick, and Bosse 1989). Women's expected age of retirement reflected uncertainty as well. Initially responsive to when husbands would retire, women's expectations changed across time, becoming more or less certain, and more often shifting to older rather than younger ages (Wong and Hardy 2009).

Here again, the language mattered. Surveys differed in whether they asked about "expected" retirement age, "planned" retirement age, or when workers would "like" to retire; other questions were framed in terms of expectations of employment behavior, whether workers preferred full-time or part-time employment now of "after" they retired, and what kind of work they would do or would "like" to do. As U.S. researchers tried to grasp whether, when, and in what sorts of jobs people in this age group would continue to work for pay, European researchers were demonstrating the effectiveness of "partial pensions" and formal provisions for combining earnings and public pension income for keeping older workers in the labor force. Studies documented that earnings had become an increasingly important source of retirement income, a combination that to some was a contradiction. Pension benefits as wage replacement had been the conventional rationale; pension benefits as earnings supplements were something different. Even so, legislation modifying the earnings test in Social Security and employer attempts to circumvent regulations restricting in-service distributions supported phased retirement options.

As concerns about financial security in retirement increased, older workers' expectations about their retirement ages seemed to shift upward, as well. Whereas prior changes to pension benefits

made early retirement (before age 62) affordable, more recent changes encouraged retirement delays. Concerns about continued access to health insurance, uncertainty about the time horizon for benefits generated by defined contribution plans, reduction of work disincentives embedded in the benefit structure of Social Security, and ADEA amendments removing the upper age limit for protection coupled with relatively low unemployment rates during the 1990s correlated with rising rates of labor force participation that were, in part, due to a retirement process characterized by jobs shifts interspersed with multiple exits and reentries for a significant minority of workers. These blurred vs. crisp exits (Elder and Pavalko 1993; Mutchler et al. 1997), characterized by multiple jobs and switches in labor force status (Hirsch, MacPherson, and Hardy 2000), made the retirement process more difficult to define (Ekerdt and DeViney 1990). What was the difference between a "bridge" job and a routine job change? How was "partial" retirement different from part-time work? Although most workers still retired in one step, the ambiguities of characterizing late career employment behavior made post-hoc or age based-definitions more common and receipt of pension benefits more determinative. Framing it as a "bridge" process to retirement gave it a more positive spin, but whether older workers were easing themselves out of the labor force or trying to hang on was often unclear.

As cohorts of married women who had experienced higher labor force participation rates moved into older ages, studying how couples timed their retirements gained additional attention (Szinovacz, Ekerdt, and Vinick 1992). Sometimes approached as a problem of joint utility maximization, sociologists looked at how spouses linked their transitions, the quality of the marital relationship, the past family and career patterns of wives (Pienta 1999), and subsequent satisfaction with the experience of retirement. That husbands were often older than their wives, earned more than their wives, and were more likely to participate in an employment-based pension plan factored into the timing of retirement behavior. Retiring at the same time, despite differences in age, was a common pattern and the older the spouse, the more common this behavior. But a lack of pension coverage and the lower the wage of one spouse, the more likely couples retired at different times, with the lower wage, uncovered spouse working longer. Further study emphasized the importance of the early "family organizational economy" for the sequential synchronization of retirement. Although proximal work-related characteristics such as health, pension benefits, and work features constrain the timing of retirement for couples, these factors act in conjunction with longer-term patterns in the division of work and family roles (Henretta, O'Rand, and Chan 1993).

Whether couples act with equal influence or whether the timing of retirement displays an asymmetry in marital power continues to be explored as cohorts aging into retirement demonstrate different work and marital histories and different understandings of gender roles (Smith and Moen 1998). The inequity in responsibility for domestic labor also affects women's retirement. Women's disproportionate responsibility in this domain not only constrains their opportunities to build retirement income, but women are more likely than men to retire in response to caregiving obligations (Brubaker and Brubaker 1992; Dorfman 1992).

Not only should women's retirement be studied on its own merits, but the retirement process for race/ethnic minorities also arguably diverges from the model for white men. Among men, African Americans have lower labor force participation rates, less continuity in attachment, and higher unemployment (Gibson 1992). Rates of disability are also higher for African American men, suggesting that their lower levels of labor force participation are more a function of health limitations than early retirement. The retirement experience is therefore different for these men, since they spend a greater portion of their lives both working and disabled than white men, a difference that also reflects their higher mortality rates and shorter life expectancy (Hayward, Friedman, and Chen 1996).

That retirement as a transition and as a life course stage reflects substantial inequality also has been an important focus of sociological research. Acknowledgement that public programs such as Social Security redistributed income from high wage earners to low wage earners suggested that perhaps income inequality after retirement would narrow. But retirement income sources were

diversifying through the same sorts of market mechanisms that were increasing inequality in other areas of compensation. Stratified along several key dimensions that tended to be mutually reinforcing, the foundation for increasing inequality after retirement was being laid. The first layer of inequality involved access to employer provided pensions, health insurance, and relatively high wages that allowed substantial personal savings in pre-tax dollars, which was aligned with other favorable traits of "good" jobs. Among those with access, the level of benefits was further stratified along similar lines. Finally, those who expected or received relatively high benefits enjoyed different levels of reliability in the continuation of those benefits. For those not yet retired, plans for a particular retirement date could evaporate when employers froze existing defined benefit plans and replaced them with defined contribution plans based on benefits payable at that point in time rather than benefits promised by the typical back-loading of pension accrual. For those already retired, a bankruptcy could send the plan to the Pension Benefit Guaranty Corporation for administration. As dual-earner couples became the norm and the gender gap in pension participation narrowed, the retirement assets accumulated by couples rapidly outpaced those of the nonmarried.

Although defined benefit plans differed in benefit levels and eligibility rules, defined contribution pensions differed in both institutional and individual terms. Whether employers contributed, how much they contributed, and whether they matched employee contributions combined with whether employees chose to participate, whether and how much they contributed, how funds were invested, and whether pension assets were rolled over or cashed out when changing jobs. Women were increasing their participation, but they tended to invest more conservatively regardless of whether the market was rising or falling, and the frequency of job shifts made taking the relatively small balances in lump sum payments quite common (Hardy and Shuey 2000; O'Rand and Henretta 1999).

2000: Risk, Uncertainty, and Changing Expectations

The year 2000 started with a budget surplus that made the financial imbalance of Social Security seem easily solvable. But the surplus soon turned into steadily rising budget deficits under the priorities of a new administration. A changing economic and political environment fueled concerns about the future, and the discourse of privatizing Social Security was renewed. By the end of the decade, financial scandals, steep (though geographically uneven) declines in the housing market, rising unemployment, and a plunging stock market schooled a nation on the ephemeral nature of paper profits and job security. As the United States struggled to recover from what was likely its longest post-war recession (federal reserve), the elimination of old jobs and the failure to add new ones frayed public confidence. Pension wealth and housing equity plummeted, and though consumers were asked to buy to help reboot the economy, the mounting toll of earlier excesses was ushering in a new reality. Now, even for the average American, retirement had become a question of budget spreadsheets and disappointing quarterly reports, bound up with global financial markets, the strength of the dollar, and international banking. Expectations for early retirements were changing to delayed or partial retirements in an indefinite future. As the first wave of members of the baby boom cohorts turned 60, an event foreshadowed by apocalyptic predictions of bankrupt social programs and generational warfare, what had been a dire prediction – that wave after wave of baby boomers would flood into early retirement to "live off their children and grandchildren" – became a question: how will baby boomers change retirement?

Comparative studies of retirement indicated how European countries were struggling to shift from earlier to later retirement (and to manage the financial consequences of that trend within prevailing economic environments) by changing their public pension systems. Whereas employment rates among older workers had started moving upwards in the mid-1980s in the US, many European nations had continued to see erosion of labor force participation in older age groups. Some of the

early retirement trend could be attributed to the maturation of pension programs, but European governments had also provided generous support to those taking early retirement during times of high unemployment. Concern over the sustainability of social welfare programs had resulted in the European Union's setting ambitious goals for delaying retirement, calling for a near doubling (to 50%) of labor force participation rates among those aged 55–64 within a 10-year window (Taylor 2006). Although Finland, Sweden, and the UK reached this target in 2004, Austria, Belgium, and Italy still hovered at 30%.

An early developer of a universal public pension system, Sweden passed pension reform in the mid-1990s, replacing their defined benefit system with a combination pay-as-you-go notional defined contribution plan, an advance funded individual account system, and a guaranteed supplemental pension payable at age 65 for those with low lifetime earnings. Contribution rates were set at 18.5%, with earnings-replacement benefits (received during periods of illness, unemployment, disability, or work injury) and child-care credits factored into pension rights. An advantage of the Swedish system is that it easily accommodates partial retirement, allowing earnings and partial-pensions to be combined (Palmer 2000). On the other hand, the system is so closely tied to economic growth, that existing pensioners can see their pensions reduced during economic downturns, introducing unpredictability to retirees' future benefits (Simpson 2009).

Workplace "flexibility" has been promoted as one strategy to extend the working lives of older workers. Flexible work options can benefit workers of all ages, but the options for older workers differ because of their access to earnings replacement income, retirement health care, and asset income. For younger workers, particularly those raising children, health insurance coverage and accumulating vs. spending savings remain important, particularly where child care credits are not available. Questions about the advisability of pushing leisure to older ages rather than distributing it more gradually throughout adulthood is part of an "age integrated" life course that would considerably reduce the age limitations associated with adult behavior (Riley and Riley 1994). If we assume a given proportion of the average lifespan will be spent as "leisure," is it rational to allocate so little leisure time to midlife? The affordability of reallocating leisure across the lifespan poses a difficult societal dilemma. Earnings replacement for "family leave," childcare, or elder care was a European approach; in the US, these "leisure" activities had to be self-financed. Employers' reactions to increased workplace flexibility echoed their early responses to pensions and early retirement incentives. They preferred to have the discretion to offer these options sometimes but not always, to some but not all workers.

The future of phased retirement remains uncertain. Implemented as reduced hours per day, fewer days per week, fewer weeks per year, extended leave, job sharing, or the rehiring of retired workers, workers in government, and higher education are more likely to have these opportunities. Employers can exercise discretion when shifting an older worker into a "phased" schedule by being selective in the offer and setting a termination date. One of the major obstacles for employees, however, is maintaining access to employer-provided benefits, since cutting back on hours may compromise their eligibility for inclusion. In addition, the current law is silent on phased retirement, but provisions in ERISA and the tax code have limited the ability of workers (and employers) to use pension benefits as earnings supplements. To the extent that workplace flexibility is not available to all workers, but only to a subset of workers to whom employers choose to extend the option, it becomes another source of workplace inequality (Hardy 2008).

Whether delaying retirement through retention in career jobs, mobility to new jobs, hours reductions through phased retirement, or other aspects of workplace flexibility, much depends on whether employers want to rely on older workers. Industries can have different age profiles, depending on when they expand or contract. While government workers tend to be older, those in biotechnology are younger. The insurance, manufacturing, mining, public administration, real estate, transportation, wholesale trade, and utilities industries are highly dependent on baby boom workers, with education and health care services being particularly vulnerable. Within these industries, a high

percentage of baby boomers are in managerial or office and administrative support positions. The different age profiles of occupations and industries point to the types of positions that will open up when baby boomers retire from their career jobs. Assuming that productivity continues to increase, a significant number of retirements occur in declining or contracting industries, and sufficiently skilled workers from younger cohorts are available for promotion or hire, baby boom retirements should not lead to any labor shortage (Levine 2008).

At this point, however, it remains to be seen how and when baby boom workers will retire. Employers' decisions to eliminate health benefit coverage for retirees, the legislated increases in actuarial penalties for early Social Security benefits, and changes in the earnings test all encourage delayed retirement. Baby boomers' plans to postpone retirement beyond age 62 have been empirically linked to these factors as well as to higher levels of educational attainment and reduced entitlement to defined benefit pension plans compared to cohorts born earlier (Mermin, Johnson, and Murphy 2007). By the end of the decade, three-quarters of 51–61-year-old men, more than half 62–64-year-old men, and more than one third 65–69-year-old men were in the labor force, with rates of increased participation steepest at older ages (Johnson 2007). But a tight labor market and high unemployment for men and women aged 55 and older also produced a surge in early retirements, with a 20% jump in newly entitled Social Security beneficiaries in 2009 compared to 2008. Contributing to this increase in benefit claims was the leading edge of the baby boom cohorts, who celebrated their 62nd birthdays in 2009 and chose early benefits rather than wait for full benefits at age 66. Whether their earlier plans to work longer will motivate a return to employment once unemployment rates go down remains to be seen, but in tough economic times, even those who had planned later retirements may turn to retirement benefits to replace lost income (Johnson and Mommaerts 2010).

Future Prospects

Retirement is shaped less by aging than by institutional mechanisms that provide incentives and systematic procedures for workers' exits from the labor force. Historically linked to industrialization, by 1980, retirement was supported by a substantial infrastructure. Although the features of that infrastructure varied across nations and changed over time as social, demographic, and economic circumstances evolved, high income countries had been relying on retirement as a labor management tool. By reallocating long-term unemployment to older workers, renaming it retirement, and providing incentives through earnings replacement, a new life course stage was created. Decades of improved health, extended longevity, and declines in the median age of retirement had increased the duration of this stage. As the twentieth century drew to a close, however, early retirement was seen as unsustainable through federal programs. In the U.S., rates of employment among older workers had reversed course, showing significant increases. Policy revisions encouraged older workers to delay retirement, and the self-financing of retirement became a more prominent component of late life financial security. But by 2010, an extended global recession and high unemployment rates made even the sharper reductions in early Social Security benefits an attractive alternative to joblessness.

The high rates of early benefit entitlement have prompted some policy analysts to call for an increase in the entitlement age for receiving reduced benefits. Making such changes to entitlement age may or may not reduce program expenditures. Because OASI benefits are actuarially adjusted, the benefit formula as well as the entitlement age would have to be changed; otherwise, somewhat higher benefits would be paid out over fewer years. The portrait of those who claim actuarially reduced benefits at age 62 also suggests the picture is more complicated. Less well educated, in poorer health, more likely to be limited in the kind of work they can do, having stopped working

before age 62, and more likely to retire from physically demanding jobs, they may be candidates for disability benefits if denied access to early retirement benefits (Li, Hurd, and Loughran 2008).

Whether in private or government sector industries, the expansion of early retirement in the United States was funded primarily through provisions in employer-sponsored defined benefit plans, with some accommodating revisions in Social Security. Within the manufacturing industry, for example, many blue-collar workers were able to afford early retirement because of company plan incentives that provided higher benefits until age 62 when Social Security benefits could be claimed. Firms' abilities to meet their long-term commitments depend on their profitability and on the government's ability to enforce regulations designed to ensure the sound investment of pension funds. Complaints that ERISA required overly conservative investment strategies may be less compelling in light of recent investment scandals and market performance. But the factors that produced disappointing statements for 401(k) plan holders also produced sharp declines in DB pension funds, which means that a number of DB pensions are currently underfunded (i.e., hold assets insufficient to pay promised benefits in the long run, though able to maintain benefits in the short term). ERISA regulations prevent employers from breaking pension promises, and the Pension Benefit Guaranty Corporation, which is funded by premiums paid by firms offering DB plans, steps in when plans go bankrupt; but as more DB pension plans fail, the PBGC absorbs higher and higher long-term benefit commitments. Whether existing DB plans will be able to meet their obligations is unclear, but one prediction for an accelerated rate of plan conversions (from DB to DC) would have important negative financial consequences for baby boom retirees (Butrica et al. 2009).

Questions about how to distribute resources not only across people but also across generations – those currently living and those not yet born – should be an important focus of societal debates. Although the retirement of the baby boom cohorts has fueled talk of generational consequences, the baby boom cohorts may be a watershed cohort for retirement in another sense. While previous birth cohorts lived and worked much of their lives with one understanding of the "rules" of retirement, 1970s formulas for calculating Social Security benefits changed the rules in their favor, allowing them to collect higher benefits than they had expected. Baby boomers began working as these changes were being debated, passed, and implemented; but then the rules changed again, and they may change still more. After following the company "rules," their pension wealth may be redefined and responsibility for generating the benefits they expected placed in their hands.

Whereas the costs of DB pensions are necessarily pushed into the future, the value of DC plans is also pushed into the future: DB funding depends on the continuing ability to generate a revenue stream to pay benefits; DC accounts depend on an ongoing ability to build the asset and a future ability to exchange investment holdings for an expected benefit flow. Both involve risk and uncertainty, but while a DB approach can distribute risk widely across people and time, DC plans are individual and much more limited in timeframe. Balancing the two is an important element of societal variation, as is the extent of economic inequality, the impact of redistribution policies, the role of government, and the value of different sorts of activities.

The societal view of retirees as an "untapped resource" has introduced a new expectation for retirees. Although the "leisure lifestyle" of retirees has received considerable media play, for most retirees the reality has been more modest and less adventurous. Retirees are now called to "civic engagement," volunteerism, and other forms of unpaid labor. Older volunteers can reinvigorate our communities, staff our underfunded social programs, volunteer as mentors, and serve as the remedy for any number of nagging social problems. All societies rely on their citizens for various forms of productive behaviors. Where societies differ is in the sort of work (and workers) worth paying, and what sorts of work (and workers) are kept unpaid or underpaid. Much of the work in the service of home and family has been unpaid work, and as unpaid work, the responsibility has not been shared.

Labor force statuses are social constructs, designating salient distinctions among people vis-à-vis paid employment, as distinct from productive activity. Including "retired" as one of these categories recognized a distinction among those not employed that was primarily a function of age and receipt

of pension benefits. Statuses of "non-employment" have been the focus of legislative battles and court cases for the better part of a century, as women, people of color, older people, gays and lesbians, and those with disabilities fought for the right to work on equal terms. How to financially maintain subpopulations of adults with inadequate access to earnings, on the one hand, and dispensing accumulated claims to deferred income, on the other, raises fundamental issues of distribution. Negotiating the terms by which people become eligible for earnings replacement and claims to future income raises additional societal issues. How societies distribute the responsibilities of family, caregiving, programs for the poor, mentoring, tutoring, and the like speaks to value systems, patterns of exploitation and dependency, and the distribution of power. Before we can determine what sort of society we want to be, we must understand the interests served by the status quo and by the vectors of change being proposed and opposed.

What we know about retirement transitions is largely from the retrospective information and the prospective study of people as they approach and move into retirement. The perspective of employers is limited to a few firms, federally mandated reports, or interviews with human resource managers. Employer cooperation in these surveys is notoriously poor, and it is difficult to know what sort of work climate older employees face based on these data. However, organizational studies can produce important insights, and they provide a necessary balance to the person-based studies utilizing national samples of persons of households.

Survey instruments are central to the development of population estimates. If sociologists want to argue for a different understanding of retirement as a status or a process, they must move more aggressively on measurement issues. The concept of social context has been picked up by any number of disciplines, but the analytic treatment of this construct is often viewed as an exogenous factor that influences individual behavior. For sociologists to argue for endogeneity or system "embeddedness," we must develop testable theories with measures and techniques powerful enough to generate convincing empirical proof. Deciding how to define retirement likely will get more complicated. Rather than think in terms of categories, we should emphasize the joint patterns of employment, income sources, and health. If age is becoming a less reliable predictor of when people enter this stage of the life course, then we should move away from using it as our societal indicator of population subgroups. Does it matter what proportion of the population is aged 65 or older, or are we more concerned with the proportion of the population unable to be self-supporting and live independently?

Questions of timeframes, risk, redistribution, and equity should all be addressed by both macro and micro level research perspectives. Behaviors are an important focus of study, but so are meaning structures, social norms, distributional regimes, and cultural values. Much of retirement research has also become individualized. Responses to different systems of incentives, choices among alternatives, the correspondence between plans and actions, the use of information, and the decision-making process have received increased amounts of attention, especially by economists working from basic utility theory. Social psychological studies of satisfaction, adjustment, roles and relationships have also focused on individual behaviors and responses. This approach will continue to yield interesting and useful results, but a sociological perspective also has much to add to our understanding of retirement as a social institution.

Future decades of retirement research will need to track how changes in major life transitions intersect with shifts in demographic structure, cultural values, global markets, health, illness, and longevity. "Exceptionalism" in public policy on the part of any nation will have different implications in this new millennium. The mobility of labor and capital has already changed the terms of economic competition, and whether and how older workers will fit into the employment picture remains unclear. Changes in the family – the frequency of divorce, the growing numbers of gay and lesbian couples, and the extended period of adolescence and young adulthood – already demonstrate important inequities in our policy orientation. The interest of funding agencies for the quantification of behavioral responses to policy features or potential policy changes has become a dominant

component of retirement research. Research that implicitly offers a cultural critique of growing inequality, late life vulnerability, exploitation or abuse tells a different sort of story, and depending on the political climate, may have difficulty finding a receptive audience. Addressing social problems, in whatever guise, is as much about making society as describing it.

How changes in later life work patterns will shape the experience of aging depends not only on the pathways on which people have already embarked but also on how the terrain changes as they move on with their lives. Differences in education, first jobs, job changes, job losses, family structure, health, and social networks are just one layer of stratifications that will be reinforced, redirected, overcome, or underachieved. If education is the prelude to the career, then retirement is the conclusion. The conditions that determine how retirement will be experienced can change gradually or suddenly and, if the latter, allow little time for adjustment. Much of retirement behavior is therefore premised on trust, on confidence, on hope – trust that contracts, social or employment based or familial, will be honored; confidence that nest eggs will not shift overnight from goose to sparrow-sized, that the national economy will be strong, standards of living maintained, and services available; hope that good days are still ahead, that a good quality of life will be enjoyed, and that those we care about will enjoy it with us.

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Chapter 15
Learning and Aging

Emily Jovic and Julie McMullin

When we think about learning we often think about it in relation to formal education. Yet, education and learning are not necessarily the same things; one can go to school and not learn anything, while others learn without participating in formal schooling. Nonetheless, in sociology, the study of learning has largely centered on the study of education and its institutions and structural features, with an attendant focus on inequality and the individuals and groups most typically served by the system, namely, younger people. Although the adult educational complex has certainly expanded in recent years, 248% from the 1970s to 1990s in the United States (Hamil-Luker and Uhlenberg 2002:S324), there remains a considerable degree of age-based compartmentalization when it comes to learning, with an emphasis on training young people for the labor market. Hence, there continues to be an overall lack of scholarly attention to learning later in life.

A long tradition of research and theorizing affirm that industrialized societies and individual lives are largely organized around school and work relationships and that education is a significant determinant of the social and economic success of people and of nations (Comeau and McMullin 2010; Canada Council on Learning/CCL 2009a; Kohli 1986). Disparities in educational and occupational attainment based on class, gender, race, and ethnicity are a primary focus in research and policy; however, age is often treated as a constant or neglected altogether (McMullin 2010). The prevalence and duration of lifelong career jobs in many industrial sectors are being reduced, which has implications for patterns and experiences of learning and working over the life course. Yet, little is known about the extension of educational careers beyond adolescence and early adulthood. These matters are increasingly salient in the context of a changing economy, given the centrality of information and as people switch jobs or careers more frequently throughout their lives.

Lifelong learning (LLL) represents a recent and popular policy initiative that conceives of learning as an ongoing and voluntary pursuit having either personal or professional motivations. Ongoing learning is largely perceived as beneficial and can positively influence income, job satisfaction, political participation, and health and well-being as well as a nation's economic productivity and competitiveness (CCL 2008). Importantly, LLL recognizes learning over the entire life course and in many situations, not just early in life or in the classroom. The basic goals are appealing, to widen participation in learning activity and reduce inequalities (Morgan-Klein and Osborne 2007).

Although LLL is an attractive concept in theory, significant barriers and concerns emerge in its interpretation and application (e.g., Jackson 2003; Martin 2003; Schultz 2000). In some policy circles, it takes on the character of a buzzword and has been contested and criticized for its conflation with adult education (Morgan-Klein and Osborne 2007) and for the way in which it discursively masks certain social, economic, and political shifts (Martin 2003). Schultz (2000:72) points to an abundance of "lip service" but an overall lack of serious commitment to providing authentic learning

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opportunities over the life course. Similarly, Jackson (2003:367) argues that "a learning society that is 'grafted on' can only continue and replicate the structural inequalities of gender, class and other differences, where only certain types of knowledge, skills and work are valued."

While education and learning comprise a wide base, including, for example, personal growth, community development, social justice, and esthetic endeavors, LLL policy tends to be tied closely to skill development associated with the economy and labor market. In a new economy context in particular, there is a heightened emphasis on LLL insofar as it presumably enables workers to keep pace with technological and workplace changes and gain or maintain employability. Returning to school is one way people may "catch up" and better their economic and life circumstances. This is not always a choice, though; restructuring trends and the nature of work in knowledge-intensive fields often compel ongoing learning. To remain economically active, many workers are advised, and in some cases, obligated, to upgrade their skills and education (CCL 2008; Elman 1998).

In this chapter, we examine what it means to learn, work, and age under changing social and economic conditions. The inquiry begins with the new economy concept and the current context for learning over the life course. This is followed by an overview of sociological perspectives on learning, largely through the study of formal education, which is institutionally structured for the early part of the life course. In the third section, we address some ideas that generate promise for learning throughout life, including advancements in brain science and a better understanding of the social correlates and conditions for excellence in learning. The chapter closes with a consideration of policy implications and new directions for research and thinking.

Changing Contexts for Learning, Working, and Aging

Much of the learning that occurs beyond initial and compulsory schooling is job-related. Thus, work, employment, and larger economic forces are salient in considering later life learning. In the sociology of work, learning is often taken up in the context of an emergent "new" economy and a focus on the skills development of individuals and workforces. The new economy concept taps the idea that old ways of doing business are waning, attributable to technological advancement, the commodification of knowledge and the need to be globally competitive (McMullin and Marshall 2010; Ranson 2003). Under such circumstances, individuals are confronted with shifting labor markets and changing skill requirements, which can have ramifications that extend across the life course.

Technology is critical to the new social and economic context. Information and Communication technologies (ICTs) have essentially transformed life in many industrialized societies. They are now an integral part of everyday life, penetrating deeply into learning, work, and communication activities as well as culture and entertainment. One of the typical canons of the rate of technological change in recent years is its propensity to create new jobs (e.g., 20 years ago there were no web developers) and growth in certain employment sectors (e.g., information technology [IT]), fundamentally altering and even destroying old ones (e.g., manufacturing). The adoption of new technologies can thus render the knowledge and skills of some workers obsolete, making ongoing learning and the ability to reskill more important today than in the past.

The case of IT serves as an example. In this sector, knowledge and innovation are key sources of economic activity and jobs require increasingly higher order skills and a wider knowledge base. Workers need to be "self-programmable" in Castells' terms – flexible, adaptable, and quick to retrain (Adams and Demaiter 2010; Castells 2000). The rapid pace of technological change in this industry not only transforms types of jobs, work content, and skill requirements; it also drives the need for workers to stay current, especially if they wish to maintain or improve their labor market prospects. Thus, compulsory schooling and initial forays into postsecondary education, generally

concentrated in the earlier stages of life, no longer sustain an individual throughout his or her life (McMullin 2010). Returning to school and engaging in concentrated periods of learning in order to gain new or more relevant knowledge and skills are increasingly a requirement for many IT workers. As work continues to be transformed by technology, the likelihood is that this trend will emerge in other industries as well.

Another feature associated with a new economy is the reorganization of employment relationships (e.g., McMullin and Marshall 2010; Smith 2001). Among certain segments of the population, education and work careers have been quite stable and predictable, shaped by the bureaucratic tendencies of large organizations and a fairly linear understanding of time and achievement: "The sheer passage of time necessary to accumulate skill [gave] a person standing and rights – value in a material sense" (Sennett 1998:96). Within the current context, this seems to be somewhat unraveling and sustaining lifelong employment in one firm is increasingly rare (McMullin and Marshall 2010). Traditional industrial sectors like manufacturing are in decline and large corporations are restructuring, displacing many workers in the process. As a result, educational and employment trajectories may take on different, often more disjointed forms, even among formerly stable groups.

Transformation and trends in technology and the global economy have coincided with particular social and demographic changes. For example, there have been shifts in the incidence and frequency of marital and parental events over the life course, which influence educational and work trajectories (McMullin 2010). Related demographic patterns (e.g., smaller families) and increased life expectancies have led to population and workforce aging, which are occurring in industrialized nations at unprecedented rates. An aging population is not a crisis per se, but it can introduce potential challenges, including perceived threats to prosperity and the possibility of labor and skill shortages in certain industrial sectors (McMullin and Marshall 2010; Statistics Canada 2008a). The primary source of new skills and workers in the economy used to entail the integration of "new" people into the labor force, usually young adults, and sometimes immigrants; however, population aging is reducing the supply of workers. Retention and training of those already in the labor force emerges as a strategy for addressing workforce aging (McMullin and Marshall 2010). Thus, in order to remain employed and adapt to changing labor markets, workers of all ages may need to retrain or upgrade. Learning may no longer be a luxury (Eisen 2005) and learning throughout the life course is required of more and more people.

These shifting economic and social contexts generate new uncertainties and demands, which bring us to another significant trend, and the last one we address here: individualization and the resultant need for people to become more active in managing to safe-guard their own lives. Some thinkers argue that there is a loosening of traditional institutions and a decline in biographical continuity, which necessitates more life planning and self-monitoring (e.g., O'Rand 2003; Beck and Beck-Gernsheim 2002). The increasing diversity of the social milieu calls for openness to the ideas and beliefs of others, the ability to question institutional assumptions, and a greater capacity for self-reflection (Taylor and Lamoreaux 2008). People are expected to be flexible, to tolerate uncertainty, and to handle greater diversity, new ideas and new situations (Butler 2005:67).

Under such conditions, individuals are able to pursue a wider variety of life trajectories; however, they also face a large number and variety of choices, a great deal of instability, and few guidelines or roadmaps to help (Macmillan 2005; Beck and Beck-Gernsheim 2002). There is pressure to take *personal* control of one's life and *personal* responsibility for successes and, especially, failures. Individuals are therefore required to bear more of the risks in navigating the life course (Shuey and O'Rand 2004; O'Rand 2003; Smith 2001). This is particularly so given that social institutions are providing less protection. It is generally left up to individuals to alleviate personal risk via accessing, monitoring, and interpreting information and choosing among alternatives (O'Rand 2003:695). One way to mitigate risk may be to engage in ongoing learning but as the next section suggests, there can be significant challenges associated with doing so.

Education, Learning, and Life Course Structure

In this section, we draw on select insights from the sociology of education, which has primarily focused on formal schooling and the early stages of the life course. Indeed, McMullin and Marshall (2010:19) note that work and aging are interrelated, dynamic processes that influence personal development and well-being; yet, aging has been generally ignored in studies of paid work. This observation can be extended to learning, training, and education. Hence, after considering educational sociology, we turn to a discussion of learning and life course structure, followed by an overview of studies in the field of adult education.

The Sociology of Education

Learning is highly institutionalized and educational systems, through their age-graded and standardizing functions, contribute to the construction of normative life course trajectories. Schools are quintessential social institutions and systems of education are primary sites for youth-centric learning activity. They support processes of socialization and selection via mandated and hidden curricula and contribute to the organization and legitimation of knowledge (Comeau and McMullin 2010; Lehmann 2007; Davies and Guppy 2006). Theorizing about education draws from sociology's foundational thinkers, including Durkheim, Marx, and Weber, and ranges from the functional to the interpretive to the critical. While some lines of thought have fallen out of favor more generally (i.e., functionalism), all of these strands are present in contemporary theories and research.

Human capital theory, originating in the field of economics, is highly influential in education policy and holds currency in the popular imagination as well. It offers a perspective on why people invest in education and why education may provide differential returns. Human capital amounts to a stock of resources – skills, knowledge, abilities, etc. – embodied in people (Becker 1993). This approach is premised on a direct link between education, skills acquisition, and income. Education and training are thus seen as investments that will yield returns collectively (e.g., competitive advantage and economic growth) and personally (e.g., higher earnings and better labor market prospects). In this view, education primarily imparts skills and knowledge associated with productivity and employability and the role of learning is largely economic (Davies and Guppy 2006; Jackson 2003). Though important, job-related skills and instrumental value are not the sole motivators for learning (Pallas 2003). Nonetheless, most educational participation by adults tends to involve work-related training (e.g., Statistics Canada 2008a; Hamil-Luker and Uhlenberg 2002).

That workers almost invariably wish to optimize their labor market potential is a key assumption. Training and education are believed to equip people with the skills and knowledge required to do this. Yet, skill development is limited to the supply side, which places the onus on individuals to pursue appropriate training in order to realize personal returns. Employers and economies also stand to gain, even if they only minimally support participation in education. Human capital also helps justify and legitimate the allocation of people to various occupations and social standings, largely on the basis of their individual efforts and educational investments. This point ties into perceptions of accessibility and the presumption that everybody has a roughly equal chance of acquiring and leveraging education; however, critical perspectives point to differential experiences among social groups.

Reproduction theories of education, derived from Marxian lines of thinking, contend that dominant groups shape educational systems in self-interested ways (e.g., Bowles and Gintis 1976). Taking a conflictive stance rooted in Weber's work on power, monopoly, and social closure, educational attainment also conveys and maintains status (Davies and Guppy 2006). Education and

credentials may indeed serve as a rough measure of skill or ability (human capital); however, they are also found to tap attitude and potential (signaling) and status (credentialing) (Adams and Demaiter 2010; Arkes 1999; Collins 1979). Thus, educational systems are also places in which societal inequalities are reproduced and where already-privileged groups solidify and maintain their advantages (Comeau and McMullin 2010; Lehmann 2007).

A large body of literature points to connections between socioeconomic status (SES) and education. Put simply, those whose families have higher levels of education and greater financial security are more likely to participate in higher education (e.g., Comeau and McMullin 2010; Lehmann 2007; Davies and Guppy 2006; Jackson 2003). People with more education are also likely to enjoy better health and live longer, and those who are healthy are more likely to be in the workforce, further opening up opportunities to learn and achieve (McMullin 2010; Leighton 2007). SES is fundamental in understanding variation in educational attainment; however, critical perspectives have adopted a wider focus on inequality and structured social relations, including patterns and experiences that vary along gender, racial, and ethnic lines as well as according to time, place, and citizenship (e.g., McMullin 2010; Jackson 2003; Martin 2003; Elman and O'Rand 1998).

More recently, *intersections* among structured social relations and the application of other forms of capital have been leveraged to better understand disparities in educational achievement (e.g., McMullin 2010; Davies and Guppy 2006). There is a complex interplay between personal agency and structural factors; social background simultaneously structures the choices individuals make and shapes the structures in which they can exercise choice (McMullin 2010; Pallas 2003; Settersten and Lovegreen 1998). In addition to financial aspects, social, and family backgrounds also mediate social and cultural capital, such as the form and degree to which education is valued and supported in a household and exposure to people and experiences which enhance learning (Davies and Guppy 2006).

Age and historical period also shape one's chances in higher education, although these factors are less often the focus in educational research and theorizing (Comeau and McMullin 2010; Jovic 2009). Given current economic, social, and demographic changes and enduring patterns of inequality over time, issues of age, time, accumulation, and social change are particularly salient (McMullin 2010). Using logic akin to "the rich get richer while the poor get poorer," invoked sociologically by Robert Merton in 1968, Dannefer (2003) extends the "Matthew effect" to aging and the life course, noting the interaction of age and social structure in producing heterogeneity within cohorts. Referred to in life course studies as cumulative advantage/disadvantage (CAD), this perspective proposes a systemic tendency for initial inequalities in a given characteristic (e.g., education, health, money, status) to be magnified over time (McMullin 2010; Dannefer 2003; Elman and O'Rand 1998).

Cumulative (dis)advantage is highly relevant for educational participation. In fact, many later life outcomes can be traced back to early stratification processes in elementary and secondary schools, which have been amplified over the life course (Comeau and McMullin 2010; Davies and Guppy 2006; Elman and O'Rand 1998). Empirical studies are consistent with the presence of CAD in multiple life domains, including education. There are systemic and institutional barriers to later life learning and disproportionate access to higher education by more advantaged groups, including middle and upper classes and professionals (e.g., Comeau and McMullin 2010; Pallas 2003; Elman 1998; Elman and O'Rand 1998; Settersten and Lovegreen 1998; Quinnan 1997).

Although learning occurs throughout the life course, the timing, sequencing, and outcomes of educational participation, especially later in life, have been examined less frequently (Jovic 2009; Hamil-Luker and Uhlenberg 2002; Elman and O'Rand 1998; Jacobs and Stoner-Eby 1998). We know little about processes of human capital acquisition and the experience of education and learning beyond early adulthood (Elman and O'Rand 2007). And, as the next section shows, it seems age-graded structures in education may have increasingly less bearing on contemporary lives.

Learning, Earning, and Returning: The Institutionalized Life Course

In most societies, there is a rough outline of how lives are expected to unfold over time across interrelated life domains (e.g., education, family, work, health, etc.). Many life events, transitions and domains of activity are linked to socially constructed meanings of age, which can be quite strongly entrenched in institutions, organizations, and culture. Thus, the life course tends to be structured into stages based, at least loosely, on chronological age. Learning activity is highly institutionalized through systems of education and within the life course. Age has traditionally been a reliable determinant of educational participation and this holds to some degree. However, in the North American context in particular, there is a greater tolerance for educational "late blooming" (Levin and Levin 1991). Moreover, broader social and economic changes and associated shifts in institutional provisions and social policies are leading to declines in the uniformity and predictability of learning and work trajectories (O'Rand 2003). There is an increasing array of possible life course configurations, which has ramifications for learning over the life course.

State and economic institutions impose a considerable degree of order on lives, framing and indexing aging and life course patterns. In one influential view, the life course, at least in many industrialized countries, is divided into three periods of activity: education/preparation, work/activity, retirement/leisure (e.g., Kohli 1986; Cain 1964), or more colloquially, learning, earning, and returning (or serving). This tripartite or "three-box" model of life links age and life stage, with activity domains roughly corresponding with childhood/adolescence (and increasingly, young adulthood – Macmillan 2005), adulthood and old age, respectively. The three boxes are linked via their relationship to paid work and there is a presumed temporal lockstep between them (Kohli 1986), with learning largely confined to the early part of the life course. Certain achievements as well as cultural exemplars of lives are predicated on this model and the assumption that it is normatively, if not universally, experienced.

The tripartite view captures major stages and transitions in life as well as some of the institutionally-mediated relationships to the rhythms of chronological aging, presenting them as a familiar and relatively common life pattern. Yet, it also implies considerable homogeneity, a gendered demarcation of stages and a one-way linearity that does not correspond with many people's lives, especially in light of recent changes. Although there is no longer (and may never have been) a rigid order, pace, or sequence regarding participation in education and work, lives continue to be divided into a time and place to acquire knowledge and skills (youth, school) and a time and place to apply them (adulthood, the workplace). This model also fails to adequately capture the complexity of experiences of education and learning. Nonetheless, it continues to anchor social policy and institutions (Marshall and Mueller 2002; Settersten and Lovegreen 1998) and represents an influential timetable for how lives "should" unfold over time – neatly, steadily, and predictably.

In the three-box life course, education precedes work activity, particularly a person's first "real" job. Following high school, the typical options are to enter the labor force or to matriculate to postsecondary training. Increasingly, people are opting for higher education and there has been tremendous growth in college and university attendance (Comeau and McMullin 2010; Davies and Guppy 2006). Compulsory, early educational pathways are institutionalized, ensuring that young people between the ages of 18 and 24 comprise the bulk of the traditional postsecondary population (Comeau and McMullin 2010). There is a corresponding, intense concentration on education and learning processes in the first 20 or so years of life, and research and policy initiatives overwhelmingly address patterns, access, and outcomes among young people, usually not past age 30. This focus is not entirely misplaced; younger people indeed make up a substantial proportion of student populations and significant numbers of youth face difficulties with labor market integration and un- and underemployment (e.g., McMullin 2010). However, there has been a steady increase in the number and proportion of older students enrolled in postsecondary institutions (e.g., Hamil-Luker and Uhlenberg 2002; Elman 1998; Jacobs and Stoner-Eby 1998).

Clearly, age is not always a reliable indicator of involvement in learning and education (e.g., Levin and Levin 1991). It is increasingly important and necessary to consider multiple sequences of learning and educational participation and their consequences across the life course. Many adults follow varied and disjointed educational paths, returning to school to increase job security, improve current prospects, pursue new career possibilities, or prepare for future job changes (Jovic 2009; Elman 1998; Settersten and Lovegreen 1998). Sociological research has tended to focus on structural factors and patterns of participation (Jacobs and Stoner-Eby 1998), and in many cases, the experiences of women (e.g., Bradburn et al. 1995). Less is known about the personal and career-related experiences and outcomes of educational reentry and transitions back to the workforce later in life.

Corresponding shifts in patterns of educational consumption are often acknowledged; however, the tripartite view is the implicit life course structure. Learning efforts throughout life and the experiences of learners outside the youth demographic tend to be examined less frequently in research and surface less often in educational and workplace policy (Jovic 2009; Elman and O'Rand 2007; Settersten and Lovegreen 1998). That said, there has been some telling recent work in adult education, a topic to which we now turn.

Adult Education

More adults are engaging in postcompulsory education and learning endeavors, in part because of the imperatives of a shifting economy and labor market. In fact, educators are well aware that large numbers of people turn to education during times of change, as they seek opportunities to enhance skill sets and improve employment prospects (Butler 2005). The most prominent form of adult learning is workplace or job-related training (e.g., CCL 2009a; Hamil-Luker and Uhlenberg 2002). There is a rich tradition of research and theorizing in adult education (e.g., Morgan-Klein and Osborne 2007; Selwyn et al. 2006; Jarvis 2004), that is associated and sometimes conflated with aspects of LLL. Yet, in much educational research, adult learning is often treated as a separate chapter, a footnote or a specialist niche. Schultz (2000:80) reminds us that learning comes in various forms "with access never to be limited by age." Thus, there is thus a need to balance the unique needs and barriers faced by these learners (e.g., Settersten and Lovegreen 1998; Quinnan 1997) within a more integrated and inclusive framework for learning over the life course. In order to get a sense of the field of adult education, we distinguish three forms of learning and consider some of the challenges and barriers adult learners may confront.

Table 15.1 presents three categories of settings in which purposeful learning takes place (Statistics Canada 2008b; Hamil-Luker and Uhlenberg 2002). This distinction is salient for adult learners as they often do not have the same compulsory obligation and institutional attachment to education as youth and young adults.

Table 15.1 Types of learning

Type	Location	Credential[a]	Structured[b]	Intentional[c]
Formal	Educational/training institutions, schools	Yes	Yes	Yes
Nonformal	Workplaces, community settings, civic organizations, etc.	No	Yes	Yes
Informal	Daily life activities in work, family, leisure, etc.	No	No	Yes/no

[a]Leads to certification in the form of a degree or credential
[b]Structured in terms of learning objectives, learning time, or learning support
[c]Intentional from the learner's perspective
Source: Derived from Statistics Canada (2008b)

Formal learning covers the official, age-graded education system from elementary through postsecondary and comprises general academic study as well as specialized technical or professional training. Nonformal education has a much broader base, occurring in places like libraries and religious institutions or within community groups (Hamil-Luker and Uhlenberg 2002). Although informal modes of learning may impart relevant skills and knowledge, it is generally not recognized by governments and employers (CCL 2008).

About half of the adult population in the United States and Canada were enrolled in organized forms of adult learning and training in 2002 (Statistics Canada 2008a). As they age, people tend to engage in learning less frequently and become even less involved with career-related learning, speaking to the association of adult education with work-related training (Statistics Canada 2008b). Younger people are thus most likely to take advantage of opportunities for learning and training (CCL 2009a; Statistics Canada 2008b; Hamil-Luker and Uhlenberg 2002); in fact, in Canada, younger and single workers are more likely than older and married or divorced workers to participate in training and to obtain a credential (Zhang and Palameta 2006).

Vulnerable groups, including those with low literacy levels, low SES, older adults and less educated adults, are least likely to engage in formal education (Comeau and McMullin 2010; Rubenson et al. 2007). There is evidence of cumulative advantage; in short, learning begets more learning. Later educational participation reflects stratification processes that start early in life and initial levels of attainment, literacy, and skill are thus significant determinants of participation in adult education (Comeau and McMullin 2010; CCL 2009a; Statistics Canada 2008b). So, contrary to its purpose, adult education may actually amplify rather than attenuate inequalities in education and labor market outcomes (Rubenson et al. 2007:38; Morgan-Klein and Osborne 2007).

Marshall and Mueller (2002:11) suggest an effective model of lifelong education which entails a vaccination approach, "with repeated exposures over time needed to maintain an optimal level of functioning." However, unlike inoculation programs that promote public health more broadly, the cost, insecurity, and responsibility for postcompulsory learning are placed largely on individuals. A large proportion of adult learners thus pursue training on their own, without the financial assistance of employers (Statistics Canada 2008a). Firm size is a strong determinant of participation in employer-sponsored training, with workers in small firms less likely to be offered such opportunities (McMullin and Marshall 2010; CCL 2009a; Statistics Canada 2008a; Gorard and Selwyn 2005). Similarly, employer support for training tends to favor already high-skill workers in jobs with high skill requirements, keeping with the cumulative advantage hypothesis.

Assumptions and stereotypes about age and optimal learning and the perceived value of making later educational investments may present additional barriers to participation. Older learners tend to face more challenges in returning to school, personally and structurally (Comeau and McMullin 2010; Settersten and Lovegreen 1998; Quinnan 1997). This is in part due to time and financial costs and the fact that most adult learners take on learning activity on top of existing work and family responsibilities. Additional barriers include fiscal practices, such as rules relating to pensions, scholarships, and student financial aid (Settersten and Lovegreen 1998; Quinnan 1997). Institutional mechanisms are similarly implicated, as age biases and administrative imperatives in schools, such as class scheduling or admissions procedures, can discourage would-be learners (Jovic 2009; Elman and O'Rand 2007). Moreover, there are further challenges with "fit" and socialization with one's learning cohort as well as anxieties regarding academic performance, fear of failure, concerns about rusty academic skills, and a general sense that one may be "too old" to learn well or efficiently (Comeau and McMullin 2010; Jovic 2009; Leighton 2007; Butler 2005).

Although these latter concerns may weigh heavily on the minds of individual learners and run rampant in educational and employment systems, recent research suggests that they are unfounded or at least necessitate some qualification. In the next section, we consider emergent fields of inquiry and address how their development and application is expanding our understanding of learning and aging.

Learning and the Aging Brain

Thus far, this discussion has centered on some of the social structural factors that shape patterns and experiences of learning over the life course. We have established that adult participation in education is mostly work-related; however, learning certainly goes beyond the transmission of labor market skills and bodies of knowledge. It also encompasses the cultivation of identities, citizenship, and culture. As the previous section indicates, chronological age does not necessarily tell us much about an individual's capabilities or potential (McMullin 2010; Butler 2005). Although talents, abilities, and attitudes are distributed unevenly and can change over time, age-related declines are not inevitable (Corna 2009). Everybody can become a better learner (Leighton 2007). In this section, we address developments in brain science and metacognitive knowledge that can be integrated with sociological perspectives in order to better understand and potentially enhance learning throughout the life course.

Learning physically alters the brain, which lends credence to the edict of "use it or lose it" (Zull 2006). Advances in imaging technology and rapid growth in cognitive neuroscience are enabling researchers to observe the detailed architecture of the brain and its functions. For example, they can identify which areas of the brain are activated during different learning tasks (Zull 2002). This is useful for confirming and enhancing optimal strategies for learning. We are not going to delve further into physiological, cognitive, or neuroscientific detail here; suffice it to say that the brain changes as we age *and* as we learn.

Metacognition involves knowledge and awareness about learning, thinking, and problem-solving, generally and personally (Pintrich 2002). Educators and psychologists have made strides in understanding the practices and characteristics that promote excellence in learning. Many of the ideas and strategies target younger people, but they can be extended or adapted for all learners. As with educational attainment, SES is significant in promoting or thwarting conditions for optimal learning. For children, SES is thought to represent a rough measure of environmental stability and the degree to which basic human needs, such as food, shelter and love, are being met (Leighton 2007). Though this may appear self-evident, fundamental needs are sometimes easy for older learners to overlook – being tired or hungry or dehydrated, for example. Generally, less is known about this mechanism of SES in the case of adults; however, the situation is presumably complicated as many older learners participate in education precisely to improve their stability and security via income and labor market prospects.

Leighton (2007) offers a succinct overview of three elements that promote excellence in learning: deliberate practice, mentorship, and the nurturing of personal dispositions. Although these factors are articulated with young and exemplary learners in mind, they capture insights that, with some tweaking and recognition of barriers unique to older students, may apply to learning throughout life. As people become aware of metacognition and the conditions for optimal learning and enact them, they will tend to learn better (Leighton 2007; Pintrich 2002).

Deliberate practice refers to the fact that learning entails hard work as well as the motivation to engage in hard work (Leighton 2007). This is reflected in what is popularly known as the "10,000-hour rule" (e.g., Gladwell 2008). The most accomplished individuals in a given field have spent tremendous amounts of time – thousands of hours – engaging in intense and focused practice, whether in music, sport or computer programming. Obviously, the typical adult does not have that many free hours to sink into dedicated learning, nor do they necessarily need to in order to learn the new office accounting system. In most cases, they are not writing the software program. However, the principle of learning as labor applies here and it is important for older learners to recognize this, since they are often layering learning on top of other responsibilities, such as working and caring.

Mentorship is another condition for optimal learning. Good mentors inspire, motivate, and support, helping learners understand what they need to do and provide detailed feedback to direct and enhance learning (Leighton 2007). For adults, mentorship can be complicated by a tendency to engage in individualized learning (e.g., self-teaching) without mentors as well as what might be

termed a paradox of age and competence. There is an inherent assumption that mentorship typically flows one way, from older expert teacher to younger student. Moreover, learning has an emotional foundation and feelings of uncertainty or fear can impact thinking, decision-making, and ability to retain information (Zull 2006). In a culture that favors competence, dislikes failure, and often dismisses the value of experience, particularly in some new economy fields, older learners who find themselves as neophytes in a given subject may experience some discomfort (Butler 2005; Sennett 1998). Thus, it is useful for learners to seek out mentor relationships and for both mentors and learners to think through age-related presumptions and biases.

Personal dispositions also promote optimal learning. There are four characteristics at the core of metacognition (Leighton 2007): reflecting (thinking about learning goals and strategies for achieving them); leveraging (taking stock of abilities, identifying and using strengths and improving weaknesses); framing (thinking constructively about performance, learning from failure and mistakes, taking risks); and control (taking charge of one's learning). Settersten and Lovegreen (1998:526–528) identified a series of similar personal attributes, including planful competence, motivation, coping, and risk-taking as well as contextual ones related to resources and responsibilities. These orientations and habits permit learners to grasp the importance of deliberate practice and the benefit of constructive feedback and mentorship. They also provide strategies for approaching learning tasks and improving performance, and thus underpin transferable skills and critical "learning to learn" qualities (Leighton 2007). Like many habits, these dispositions are perhaps more easily instilled earlier in life, but can be acquired at any time.

Those who are aware of conditions and strategies that support optimal learning will be more likely to use them and Pintrich (2002:223) identifies a need to explicitly relate this knowledge to learners. Metacognition is particularly salient for adult learners, who may have been estranged from formal learning for some time (Leighton 2007). Older people may approach learning with strategies that are less efficient, outdated, or inappropriate. Further, internalized age stereotypes about trainability and attitudes toward change can also impact one's perceptions of one's abilities. Adult learners require current and accurate knowledge about different learning strategies (e.g., memorizing, extracting meaning from text) and cognitive tasks (e.g., solving general vs. specific problems), as well as knowledge about themselves and their dispositions (Pintrich 2002). Metacognitive knowledge tends to be directed at individual learners; however, mechanisms of cultural and social capital (e.g., Comeau and McMullin 2010) presumably shape tendencies in both individuals and groups. Sociological perspectives can thus provide additional insight regarding the social correlates of optimal learning. Policy-makers and providers of educational services can help maximize learning at all ages by recognizing barriers and taking them into account in activity design and program delivery.

As social and economic imperatives push and pull more people toward ongoing learning, concern about age-related declines emerge. Workers wonder about their capacity and desire to learn and ability to keep skills and knowledge current, especially when it comes to new technology (McMullin and Comeau 2011). For example, a reader poses the following question to a newspaper advice column: "Given the fact that memory and concentration skills tend to decline with age, how difficult would it be for a person in their 50s to work on a master's degree?" (Troyer 2009). The simple answer is not too difficult, given some basic metacognitive knowledge and appropriate compensatory strategies.

Cognitive ability can be understood as a combination of two types of intelligence: "*Crystallized intelligence*, or acculturated knowledge, is believed to accumulate over time through educational, occupational and cultural experiences and pursuits. It is reflected in tests of vocabulary, information accumulation and specific knowledge-based activities. *Fluid intelligence*, on the other hand, encompasses information processing, reasoning, short-term memory, abstract thinking, reaction time and regulatory processes" (Corna 2009:3). People can experience certain cognitive declines as they age, but this is not an inevitable aspect of aging (Corna 2009; Zull 2006). In fact, research is revealing that the human brain is "almost infinitely malleable" – even in adults (Carr 2008:2).

Windows for learning in select areas, such as visual development or language, may begin to close off in adulthood; however, research strongly indicates that "there is no age of finality for any learning" (Zull 2006:7). Moreover, there is presumably enough variation in baseline abilities related to learning, such as memory and recall, that difficulties are not necessarily linked to age. When age-related declines are observed, they tend to be associated with fluid intelligence – processing speed, ability to concentrate, and short-term memory (Corna 2009; Troyer 2009; Zull 2006). However, losses in these areas tend to occur slowly, allowing for gradual compensation (Corna 2009; Eisen 2005). Many people are thus able to maintain cognitive function as they age. Further, stereotype-driven self-doubts and the fast pace of a lot of educational programming are believed to be larger deterrents to later life learning than any changes in intellectual capacity (Eisen 2005).

While certain cognitive abilities may decline with age for some people, other capacities actually improve (Troyer 2009; Corna 2009; Zull 2006). Knowledge and experience help build neural networks, essential for thinking and decision-making, which become denser and more elaborate with age (Taylor and Lamoreaux 2008; Zull 2002). Learning entails continuous modification of what is already known and when faced with new information, the brain seeks patterned connections to existing information (Taylor and Lamoreaux 2008; Zull 2002, 2006). Over time, it becomes increasingly efficient at "cutting to the chase" when analyzing complex connections. With age, then, people have the capacity to gain wisdom via the ability to delineate the critical elements of complex knowledge, identifying what is important and discarding what is not (Zull 2006).

Keeping with the metacognitive perspective, adult learners can assess their strengths and weaknesses, including potential changes in cognitive ability, and adjust their learning practices accordingly. There are a range of techniques and strategies that will help people proactively compensate for abilities that do diminish as well as those they might lack in the first place (Troyer 2009; Leighton 2007; Zull 2006). Although there is evidence supporting the effectiveness of cognitive training, more research is needed to understand how these practices relate to learning (Corna 2009). Returning to would-be master's candidate, the expert respondent, a clinical neuroscientist, identifies three potential challenges for older learners: slower intake and processing of new information, increased vulnerability to distraction, and difficulty with short-term memory. The advice she provides is simple and highly practical: stay on top of the workload, allow extra time in new learning situations, focus on one task at a time, study in a quiet place, and employ repetition strategies to retain new information (Troyer 2009:L3). Insights from cognitive psychology and brain science indicate that learning may be enhanced if educators and learners align practice with how the brain functions (Zull 2002), particularly if social structural factors are also taken into account (Leighton 2007).

Discussion

Sociologists have often turned to the economy and the domain of paid work to understand patterns and experiences in education and learning. Links between educational systems and labor markets receive a lot of attention, in part because of their connection to social stratification and inequality. Put simply, education is a major conduit to occupational attainment, financial reward, and social advancement, as well as personal and social well-being (e.g., Comeau and McMullin 2010). People tend to look to education for solutions to many social problems and higher learning is perceived as one of the more accessible avenues for upward social mobility. Yet, the egalitarian and socially inclusive aspects of education and LLL directives often take a backseat to economic imperatives (e.g., Martin 2003).

Information is increasingly salient across life domains, and more and more people are expected to pilot complex, knowledge-intensive terrains, including employment, health, well-being, finance,

civic participation, entertainment, and culture. Informed and engaged citizens are better equipped to confront the critical issues of the day, such as poverty, conflict, and ecological responsibility. Education thus has important and lasting effects on future life chances and also on the shape and experience of social and individual lives. Economic opportunity and social engagement are increasingly linked to a person's ability to direct his or her own life (Beck and Beck-Gernsheim 2002). Learning may serve as a protective factor in this regard because it can enhance one's sense of control in managing one's life, creating opportunities, solving problems, and mitigating risks (Leighton 2007). Thus, the focus in education and learning cannot be confined to youth and employment preparation.

People of all ages are being advised to engage in ongoing learning in order to remain socially and economically active. Further, chronological age reveals increasingly less about one's capabilities, state of health, level of active engagement, or future potential (Butler 2005:63). It is troubling, then, that the sociological study of learning is so robustly associated with educational systems, labor market preparation, and the early part of the life course. There have been important economic and demographic shifts producing tighter links between learning and work in many employment sectors as well as unprecedented numbers of later life learners (Eisen 2005; Elman 1998; Jacobs and Stoner-Eby 1998; Levin and Levin 1991). The retention and retraining of workers over the life course is a significant issue in many industrialized countries (McMullin and Marshall 2010). This entails a complex set of challenges that require policies and programs which better attend to the changing learning needs and capacities of people over time and throughout their lives. In this regard, Settersten and Lovegreen (1998) suggest that despite a myriad of barriers to adult participation in education, there are opportunities for greater flexibility in the life course more generally.

Government policy tends to approach education and learning largely economically, with an emphasis on building a skilled, productive and flexible workforce, and a focus on the economically active and their competitiveness (CCL 2009a; Rubenson et al. 2007). Perhaps as a result, education is often analytically treated as fixed at the "highest" level of schooling. Although this approach is convenient and measurement-friendly, it does not adequately capture informal learning, upgrading, and retraining throughout life, learning pursued for nonwork-related goals, or circumstances in which general education (e.g., a bachelor's degree in sociology) may be sought at one type of institution, followed by occupationally-specific training at another (e.g., a certificate in database administration). Thus, we need more systematic examinations of understudied aspects related to learning, retraining, and requalification over the life course.

There are indications that returning to school and efforts to provide retraining may not be meeting the needs of many older learners (e.g., Jovic 2009; Settersten and Lovegreen 1998; Quinnan 1997). We need to work toward identifying and creating more favorable conditions for ongoing participation in learning, to allow people to better harness their capacities in order to meet everyday circumstance as well as life's challenges. In this regard, attention to the quality of programs, instruction, and learning, especially that which targeting adult students, is significant. Rising enrolment and higher levels of education inflate the value of credentials and additional educational investment does not guarantee improved or even similar prospects. There is a need to better understand how credentials and learning opportunities are evaluated and applied by employers and workers. In knowledge-intensive fields like IT, skills acquisition does not necessarily happen in formal settings; rather, alternative, leisure-based methods (e.g., hobby programming) can be more salient (Adams and Demaiter 2010; Jovic 2009).

Career management and development, including the acquisition and maintenance of relevant skills, are encouraged by governments and employers, yet responsibility is largely offloaded onto individuals. There are tax subsidies and programs to encourage retirement savings and investment for children's future educational needs, but fewer incentives for people to seek out the training they need over the life course (Schultz 2000:79) – to navigate changing labor markets as well as the increasingly complicated and information-heavy domains of health, finance, and culture. To help

people engage in the learning necessary to function in social life, more inclusive approaches to responsibility for learning are needed, ones that bridge employers, educational institutions and governments, as well as individuals and families. Optimal learning is predicated on social relationships and personal dispositions and we need to foster more favorable conditions for learning over the life course, including a solid foundation via the cultivation of basic skills and attitudes as well as guidance and support regarding how to direct one's learning efforts.

There remains a need to rethink so-called "normative" educational and career pathways (e.g., Marshall and Mueller 2002; Settersten and Lovegreen 1998) and provide more and better opportunities for learning and (re)training across the life course, "when people are young, before workers lose their jobs, when they lose their jobs" (Schultz 2000:79). This requires greater flexibility and responsiveness to needs that change over time, including the impact of events like parenthood, marital breakdown, and unemployment as well as provisions for smoother transitions between ages and stages. If this is not the case, then learning has the potential to become yet another demand stacked upon already-overburdened individuals. Research shows that employer support for training tends to favor those already at the higher end of the spectrum in terms of skills and skill requirements. There is a need to better balance the investments of government, employers, and individuals in learning and training.

At the same time, it is important to broaden the focus of learning beyond economic and labor market applications. Many people feel they do not have a pressing economic need for or interest in ongoing learning (Gorard and Selwyn 2005) and this is a valid position; however, given the ubiquity of information and technology, and especially, the internet, certain skill sets like literacy, numeracy, and critical thinking, are needed not only in the workplace but in most life domains. The increased flow of data tips heavily into social and cultural environments and people are left with little choice but to deal with it. This is especially the case in areas that become increasingly salient as we age, such as health, health care, and financial planning. People need to be able to take in, process, and evaluate large amounts of highly specialized information, or at least know where to seek out simplified yet reliable sources.

This leads to an emergent and highly interesting perspective on some profound changes in how we learn: "In becoming information-rich, we have become attention-poor." Technology commentator Peter Nicholson (2009:A21) cuts to the quick of a key contemporary challenge for learning – the tradeoff between the depth of what we know and how fast we can retrieve it. He employs an apt river-vs.-lake metaphor to capture the difference between a flow and a stock of knowledge. Similarly, Nicholas Carr (2008) wonders if *Google* is making us stupid, proposing that the internet and ICTs may be "reprogramming" us, shaping our brains to process information rather than understand or even remember it. Both commentators expound on the social and biological consequences of a glut of information, including scattered attention, diffused concentration, and potential impacts on deep thinking and the cultivation and application of expertise. The volume and flow of information is rapid, leaving less time to think and reflect. Thus, there may be an eroding of the "deep, integrative mode of knowing" associated with the 10,000-hour rule (Nicholson 2009:A21). Fostering the skills required to navigate information flows, particularly the ability to read, cut through, and access what is needed, will be an important challenge for learners of all ages and exploration of these themes is a significant future direction for researchers in science and social science.

The intersections of learning, work and technology, particularly ICTs, are drawing much academic and political interest (e.g., CCL 2009b; Selwyn et al. 2006). ICTs are believed to offer solutions to many barriers to learning, especially with respect to access and the provision of flexible, convenient and ongoing learning opportunities for people of all ages. However, as we have seen, determinants of participation in education and learning are deeply rooted in structured social relations and family background as well as matters of time and place (e.g., Comeau and McMullin 2010). Research indicates that these enduring patterns seem to hold, whether learning is aided by

technology, leading Gorard and Selwyn (2005:85) to observe that, so far, the "e-learning" society seems to be "remarkably similar to its nontechnological predecessor."

Aging and learning are biological, psychological, and social processes. As the knowledge base grows in each area and their various dimensions and intersections are fleshed out, we uncover new problems and questions. It is as necessary as ever to recognize and target enduring barriers to learning in the form of structured social relations and to take into account processes of time and cumulative (dis)advantage. Experiences with and orientations toward learning early in life shape later life learning. Similarly important is the attenuation and possibly reversal of individualizing trends with respect to learning, both in terms of cultural values (such as the personalization of success and achievement) and structural factors (educational institutions, workplaces, policies); otherwise, we will miss, in Gladwell's (2008:32) words, "opportunities to lift others up onto to the top rungs." Promoting optimal learning over the life course is not an end in itself; rather it is a means to an end, which is a better life (Leighton 2007) – a goal we ideally have for everybody.

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Chapter 16
The Midlife Years: Human Capital and Job Mobility

Cheryl Elman

What does midlife hold for today's U.S. working adults? Until recently, the modern life course was arranged around three distinct life stages: schooling in youth, work/family responsibilities over the middle adult years, and retirement in the later adult years. This tripartite division of the life course (Kohli 1986) was underpinned by normative expectations about role transitions due to age-grading (Mayer and Schoepflin 1989; Settersten 1998) and cohort socialization (Easterlin 1987). The timing and sequencing of role transitions within each life stage – although often gender-segregated into midlife work careers for men and family careers for women – then constituted, until recently, fairly predictable life course pathways, interwoven as the substance of individual lives (Elder 1975). However, the tripartite division, also rooted in state policies and industrial production methods of the mid-twentieth century, is becoming more blurred, associated with recent economic restructuring (Heinz 2003; Mayer and Schoepflin 1989; Myles 1990). A shift in work regimes, from mass production to flexible production, is reshaping midlife work arrangements and perhaps the conditions of employability itself (Myles 1990; Vallas 1999).

Although this transformation affects workers of all ages, it uniquely impacts middle-aged workers, about ages 40–59 who, well into their work careers, may find themselves newly "free" agents in a flexible economy (Heinz 2003). Midlife work careers no longer unfold under the institutional and contextual conditions from which they emerged and so adults may feel unprepared for new job searches or the need to cross educational or labor market boundaries for employment (Elman and O'Rand 2007; Johnson et al. 2009). But, as will be described in this chapter, these changes also carry promise. They may open up new pathways of flexible employment, human capital gains, increased work-engagement and phased retirement at the same time that they impose burdens, such as the reintroduction to roles and activities once thought to be relegated to one's personal past.

This chapter examines midlife human capital, work arrangements, and job mobility within and across two twentieth century periods marked by different methods of economic production: a mid-twentieth century period of mass production or Fordism and a post-1970s period of flexible production. It is important to study midlife work arrangements in the context of both the old period and the new period because macroeconomic transformations are slow and uneven. Some middle-aged workers remain employed under the rules of the old, even as many more traverse the divide to the new. The first two sections of this chapter are overviews of the older industrial and newer flexible production regimes, respectively. Each section describes key theories that sociologists and other social scientists use to understand adult human capital, job mobility, and work arrangements. A third section details current trends in midlife job displacement, reemployment, and work-to-retirement pathways, in the light of theoretical perspectives. A fourth section examines work-related human capital as adult education: a growing midlife response to today's transforming markets.

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Institutionalizing Employment: Mass Production Under Fordism

Fordist mass production in the United States emerged as a structured system of labor markets, product markets, and state policies by the mid-twentieth century (Meyer 1995; Mayer and Schoepflin 1989; Myles 1990). It is instructive to place Fordism in long-term perspective. By the early twentieth century nonagricultural workers were already employed in mid-to-large size – and growing – firms and state agencies (e.g., food service, department stores, railroads, financial institutions, government service) (Graebner 1980; Whitten 1983). Although large firm characteristics differed, early twentieth century employers faced similar problems in coordinating increasingly complex mass production and service delivery systems (Nelson 1975). They adopted Fordist techniques which restructured production processes and reallocated workers into newly redesigned jobs (Meyer 1995; Myles 1990). These included a core of managerial/administrative jobs to coordinate decision-making and a large base of "assembly-line" production or "shop-counter" service jobs with limited, repetitive job tasks or skills, subject to reorganization under managerial control (Gordon et al. 1982; Jacoby 1985). Additional firm-level jobs emerged over time, in human resources, marketing, clerical services, transportation, maintenance, and other areas of support.

Of course, many factors led to what became a mid-century U.S. Fordist accord, or social contract between employers and employees (Kalleberg 2000). For example, the early twentieth century reorganization of production might have tilted toward market or hierarchical form, but, perhaps because firm size was already large, Fordist expansion was hierarchical (Kalleberg 2000). Career ladders and labor contracts were adopted to regulate and rationalize hiring, promotion, and job turnover (Althauser 1989; Graebner 1980; Petersen et al. 1989); work rewards were adopted, based on wage formulas, job tenure, and age rules (O'Rand and Henretta 1999; Wise 1997). Fordist system growth also reflected industrial relations and the unionization of workers and mid-century geopolitical, often war-related, pressures that required national employer-employee cooperation, if not social cohesion (Myles 1990).

For workers, Fordism represented the potential of *lifetime work trajectories* of full-time employment until retirement, under a given employer's supervision and place of business, as long as performance expectations were met (Kalleberg 2000). As Davis (1988) noted, this was the Western "Standard Path of Retirement." Most adult workers – especially the leading edge of the baby boom cohort that entered labor markets at Fordism's height by the late 1960s – expected that these work arrangements would hold over their work lives. Indeed, women and ethnic minorities who were largely excluded from the Standard Path prior to the 1970s pushed for entry into these very arrangements (O'Rand and Henretta 1999).

Theoretical Approaches and Empirical Studies

This subsection highlights theoretical approaches used by sociologists and other social scientists to study human capital and work under the Fordist regime and summarizes key findings. As background, the United States has an open "market model" of job matching relative to the "institutional models" of other nations where school, apprenticeships, and work careers are more coordinated or tightly linked (Heinz 2003). It is in this open market model context that *human capital theories* arose by the 1960s (Becker 1964). Its tenets implicitly upheld the tripartite life course by differentiating lifetime streams of human capital, as education and work experience, across three life stages. Formal schooling was viewed as the occupation of youth, pursued to the point where it would be rewarded by employers. On-the-job training in firm-specific skills occurred over the work life stage (Becker 1993) and retirement, a reward for past productivity, occurred in old age.

Human capital theories apportioned the phases of work careers over the work life stage as well. School exit was followed by several years of job changes, testing "job matches." With a good job

match early-career workers self-subsidized training costs for another period of time (Becker 1964). They earned significantly lower wages and benefits than did experienced workers but expected to reap relatively larger wage returns to experience over mid-to-late career (Kotlikoff 1988). Employers provided firm-specific training for their early-career workers, then "locked-in" or vested these trained employees with contracted benefits such as pensions to reduce labor turnover costs (Hall and Lazear 1984; Petersen et al. 1989, for the organizational perspective). Employers also placed age and tenure clocks into contracts so relatively higher-paid older workers, as a group, would not overstay their welcome on-the-job (Graebner 1980). Workers' retirement decisions then reflected the relatively higher cost of continuing to work vs. retiring, also informed by tastes for leisure and cyclical conditions (Hall and Lazear 1984; Wise 1997).

To summarize, human capital models arose under the Fordist production regime and highlighted rational decision-making of employers and employees, expecting job changes to be more likely for the young, as market entrants, and less likely in later life, due to work experience with wage penalties for job exits (Lazear 1976). A classic study illustrating this distinguished job separations for men ages 45–59 as voluntary quits vs. involuntary layoffs (Bartel and Borjas 1977; NLS 1966–1971). Longer job tenures reduced layoffs, indicating that employers valued experienced employees. Yet about 22% of older men changed jobs over the period, half due to quits and half due to involuntary displacements. The quits predominated in good economic times, especially for high human capital men, but a 3 year job match pattern of higher turnover was still present for most of the older men who changed jobs. Whether because the older men were chronic movers or had selected into insecure jobs, a recent layoff or quit increased the likelihood of a subsequent layoff or quit. The time to reemployment, as now, was longer for older vs. younger men (also Rones 1983).

Sociological research around this time also found support for – or had theoretical parallels to – human capital hypotheses, including higher rates of early- vs. late-career job mobility (Tuma 1976), positive wage returns to job tenure (Hachen 1992), employer-limited turnover due to cost (Petersen et al. 1989) and retirement contracts with incentives to exit work (Hayward 1986; O'Rand and MacLean 1986). But sociologists also identified processes less consistent with human capital or Fordist principles, more generally. For example, studies found that hiring, on-the-job training, and promotions often reflected bureaucratic mechanisms or labor market divisions more than human capital theory would predict (Hachen 1992; Petersen et al. 1989; Rosenfeld 1992). Also, even though Fordist centralization of decision-making with the reorganization of other jobs into routine tasks was promoted on economic efficiency grounds, studies found that putative organizational efficiencies often were sacrificed for even greater managerial control (Gordon et al. 1982; Jacoby 1985; Myles 1990).

Market segmentation research studies soon focused on labor market divisions, finding that the social-demographic composition of work forces and structured work arrangements such as job entry opportunities, retention, and work rewards diverged across market sectors (e.g., firms, occupations, industries and/or cross-cutting domains) (Althauser 1989; Hachen 1992; Hodson 1984; Petersen et al. 1989). *Dual labor market* studies differentiated primary sectors from secondary sectors, finding that primary sector workers earned higher wages and had promotion opportunities – via career ladders with benefits – that most supported Fordist lifetime work trajectories (Althauser 1989). Secondary sector workers more often were women, ethnic minorities, very young or old workers and had lower-skilled, less-secure, lower-paid jobs with fewer benefits. Moreover, employers appeared to reward education and skill differently across sectors, even rationing access to primary sector jobs by setting up "job queues" or barriers to sector entry for secondary sector workers (Thurow 1975).

Occupational segmentation came to be of theoretic concern, with segments denoted by the occupational skills workers performed (Spenner 1990), the different rewards to skills (Althauser 1989; Rosenfeld 1992), the degree of occupational expansion or contraction (Hayward and Grady 1986) and occupational group control over work (O'Rand 1986). Studies found that occupational sector and skill effects explained much about mid-to-late-life job separation and retirement patterns, net of human capital hypotheses. For example, men in primary sector occupations or in self-employment

were less likely to retire if their job tasks engaged them, *net of* wealth or expected postretirement income (Elder and Pavalko 1993; Hayward and Hardy 1985). Middle-aged and older men in occupations marked by expansion, task complexity, and control over work also were less likely to experience involuntary job loss, net of education, and other human capital effects (Hayward and Grady 1986; Hayward et al. 1988a).

Also, where human capital theories proposed retirement patterns to mirror "benefit promises" in firm retirement packages and Social Security, this more likely occurred for primary segment employees (O'Rand and McLean 1986; O'Rand and Henretta 1999). For example, a relatively even proportion of 41% of women ages 55–64 worked over the 1965–1980 period (Purcell 2000, Table 2), will most ineligible for job-related pensions because pension-eligibility was unevenly allocated across industrial and occupational sectors and firms (O'Rand 1986; O'Rand and McLean 1986; Slevin and Wingrove 1995 for review of women and retirement). Women tended to work in low-wage service sector jobs or in firms with poor pension benefit coverage (O'Rand and McLean 1986). Therefore, women and minority elders – who also had less access to pension benefits because of sector of employment – often could not retire due to low income and so worked part-time into old age (Morrison 1983).

Job mobility and *life course* theories, which I treat here due to space concerns as interlocking perspectives, also fueled research on middle-aged and older workers by the 1980s. With regard to job mobility, the units of study include jobs with a given employer and/or the movement from one job to another (Hachen 1992; Petersen et al. 1989; Rosenfeld 1992). Studies also explore how adjacent jobs might differ, why job transitions occur, rates of change in job moves, and how jobs combine to form careers, in terms of directionality or coherence (Rosenfeld 1992). Life course research focuses on changes in state as well, but over the human life course more broadly (Elder 1975). Both perspectives are multilevel and dynamic and assume that decision-making is contingent on historical time, place, personal resources, and interpersonal linkages in life course studies (Elder 1975, 1994) or human capital and the opportunity structure that firms and labor markets present in mobility studies (Hachen 1992; Rosenfeld 1992).

Life course and job mobility studies uncovered gender segregation in occupations and work careers; the existence of wage penalties, net of human capital and productivity, due to family roles; and "glass ceilings" that limited hiring and promotions across firms, occupational and industrial sectors (O'Rand and Henretta 1999; Rosenfeld 1992). Life course studies also uncovered variability in job mobility and retirement timing due to nonwork influences, such as family or spousal circumstances (Henretta and O'Rand 1983; O'Rand and Henretta 1999; Slevin and Wingrove 1995) and cumulative life events (Szinovacz and Washo 1992). Human capital theorists Bartel and Borjas (1977) and later Ruhm (1990) noted that mature workers who were not securely attached to labor markets moved in and out of employment like young workers in a "job matching" process. Hayward et al. (1988b) also noted that older women in secondary sector jobs had high rates of *post-retirement* job mobility, while the patterns of older women retiring from primary sector jobs resembled men's Standard Path to retirement exits. Older African-American men under Fordism also had high rates of job mobility; life table analysis of work transitions found that they spent more time working and less time retired than European-American men, in both absolute and relative terms, due to higher rates of disability and mortality (Hayward et al. 1996). Older African-American workers also held different retirement expectations because they tended to be nonpension eligible. As Gibson (1986) noted, there was a third life stage of "unretired-retired" for workers who could not participate in the social institution of retirement.

Fordist Breakdown and the "Flexible" Turn

Economic restructuring captured sociological attention by the late 1970s (Bluestone and Harrison 1982; Piore and Sabel 1984). Economic stagnation (rising unemployment) with inflation was a concern during this period, initially attributed to exogenous market shocks (i.e., nonstructural

changes) such as increased energy prices, a labor market supply glut of baby boomers and/or rising numbers of career-oriented women (Thurow 1975). But a different employment pattern appeared by the late 1980s and 1990s, marked by the new types of workers at risk of unemployment and the types of jobs involved (DiPrete 1993; Farber 2003; Johnson et al. 2009). This second section discusses economic restructuring that has occurred in the last few decades with the transformation from Fordist to flexible production methods. The next (third) section of this chapter details recent trends in job mobility and work/nonwork transitions.

Recent labor market transformations reflect many factors such as global wage pressures with falling product pricing (Bills 1995; Smith 1997), declining union strength (Mayer and Schoepflin 1989; Myles 1990), corporate financial rewards for merging and downsizing (Morris and Western 1999; Hardy and Quadagno 1995), and new information systems that geographically decouple production from a managerial core (Prechel 1994). Also important is rising demand for niche and specialized products and services (Bills 1995; Vallas 1999), associated with technology shifts: in computerized hardware and software, the on-line production or delivery of goods and services and the like. Employers find it less necessary or feasible to maintain large, standing hierarchies of narrowly-trained Fordist production workers as a long-term labor force. They seek greater *numerical flexibility* in staffing (Kalleberg et al. 2003; Smith 1997) and so limit Fordist-style long-term employment contracts. They use retention and job separations as tools to gain numerical flexibility (Hachen 1992) with job separations occurring as layoffs or displacements. They also externalize employment obligations by outsourcing or subcontracting similar or new jobs to new workers or firms, or limit the duration of work contracts by hiring contingent or temp agency employees. Yet employers also seek greater *functional flexibility* in production and adopt new technologies, tools, reorganize shop-floor activity (Smith 1997), and/or reshape organizational networks to rapidly produce or modify specialized products for markets (Kalleberg et al. 2003; Smith 1997).

What this means for middle-aged workers is that jobs and work careers are being recast, from the *lifetime work trajectories* that kept job turnover low and anchored a tripartite life course division, to *flexible career trajectories* that accommodate short term or "just-in-time" staffing (Polivka 1996) and may override this division (Heinz 2003; Myles 1990). Even though many middle-aged and older workers continue to work under the old wage and benefit contracts of the Fordist regime, many more take new jobs at midlife, "flexible" jobs which increasingly proliferate under myriad "spot-market", or shorter-term work contracts (DiPrete et al. 2002; Kalleberg 2000; Smith 1997). In line with the change to flexible work arrangements, portable retirement contracts have emerged, such as 401Ks or defined contribution plans, less linked to specific employers or the age-scheduling of retirement (O'Rand and Henretta 1999).

Theoretical Approaches

This subsection describes new and evolving perspectives, introduced earlier, that are used to study work arrangements under flexible production. New *market flexibility perspectives* view the changing conditions of work as employer or market-rational responses to the macroeconomic challenges described above. Flexible hiring – rather than hiring workers into hierarchical internal labor markets with long training/vesting periods and career ladders – may better allocate worker productivity and human capital in the new economy. Also, the breakdown of rigidly structured Fordist production may foster more fluid organizational forms and career lines; this, in turn, may improve work conditions by supporting the creation of jobs that are less routine, more creative, and provide workers with more autonomy and decision-making power (DiPrete et al. 2002; Kalleberg et al. 2003; Smith 1997). Workers enter jobs: if jobs are more fulfilling then job satisfaction might offset the job insecurity that is inherent in flexible work (Smith 1997).

What is flexible work? Flexible work arrangements by one definition, take place outside of a workplace or at a time other than the standard workday (Rau 2003). This type of work can include

off-shift work, flextime, telecommuting or home-based work, part-time or contingent work (also see Fenwick 2009). In another definition of nonstandard work arrangements, the Bureau of Labor Statistics (BLS) categories include: independent contract work, on-call work, temp agency work, and contract company work (Kalleberg 2000 for overview). About 9.3% of U.S. workers in the late 1990s (DiNatale 2001; Polivka 1996) and about 10.7% in 2005 (BLS 2005) fell into one of these four categories. Also, in overlapping categories, the BLS reports contingent jobs (i.e., jobs not expected to last a year). About 4% of employees were contingent in 2005 but this group was diverse; members were more likely to be nonhigh school graduates but they were also more likely to have B.A. degrees than noncontingent workers (BLS 2005). Few "flexible work" studies as yet focus on older workers, but flexible work more generally can provide positive work conditions (DiNatale 2001; Johnson et al. 2009; Smith 1997), increase market rewards (DiPrete et al. 2002) and enhance skill sets (Spenner 1995). As described in a previous section, mature workers who are engaged in their jobs tend to delay retirement. Older workers also desire flexible work schedules and so might prefer nonstandard work as they near retirement (DiNatale 2001; Purcell 2000; Rau 2003). This suggests that recent restructuring, despite uncertainties felt by current older workers, might increase working life expectancy in the *long* run.

However, many adult workers in BLS nonstandard arrangements, with the exception perhaps of independent contract workers, prefer the longer, more durable employer–employee contracts that predominated earlier in their careers (BLS 2005; DiNatale 2001; Polivka 1996). The Fordist regime promoted a significant measure of job security, culminating in the Standard Path of retirement, especially for primary sector workers. As noted by McCall (2000) many employees define the new, flexible employment as insecure employment. *Market accumulation perspectives* view changed conditions, under the "flexible turn," as a change in the relative Fordist balance of employer vs. worker power. Fordism was anchored in durable employment agreements over the mid-twentieth century, and if it conferred job ladders and retirement benefits for workers it benefitted employers as well, reducing turnover and training costs. In this view, deinstitutionalization of Fordist arrangements may represent a continued shift of relative power back to employers' structured advantage. As Fordist arrangements fade, even advantaged sector workers may lose previously gained wage rewards, workplace power or even skills – if employers redesign jobs or allocate mass job losses relative to their particular skill sets (Bluestone and Harrison 1982; Prechel 1994; Spenner 1995).

In this critical vein, recent *market segmentation* studies find that some market divisions have grown in scope with the decades-long shedding of Fordist-style work contracts, especially among midlevel employees and union workers (Hudson 2007). *Dual market* studies now highlight a polarized "good-jobs" vs. "bad-jobs" divide (Hudson 2007; Kalleberg 2000) with significant differences in job security, wages, and control over work across this divide. Of concern is that stratification resulting from flexible staffing can develop, including structures of "insider and outsider" employees (Kalleberg et al. 2003) where insiders populating the organizational core are better-trained with relative autonomy in work, higher wages, and job benefits. In contrast, workers at the organizational periphery, as "outsiders," tend to have less control over work, be contingent, and do less skilled work with weaker occupational ties even if highly skilled (Brand 2006; Kalleberg et al. 2003). The share of middle-aged and older workers as "outsiders" in nonstandard work arrangements has grown (Hudson 2007; Kalleberg et al. 2003).

Critical studies also highlight forms of *flexible work trajectories* - vs. organizational careers that have emerged. A "*knowledge worker*" perspective identifies polarization in flexible careers which also may be associated with a growing educational divide in wages and employability (Morris and Western 1999). Middle-aged workers with some limits to education or skills – although many have considerable work experience or postsecondary degrees – follow disadvantaged flexible career pathways marked by high rates of job mobility without advancement in low-wage market sectors. Many of these workers are women (Han and Moen 1999) or men displaced from blue-collar and midlevel jobs (Farber 2003). In contrast, middle-age workers with higher levels – or different mixes – of education

or skills form more advantaged protean careers, such as "portfolio workers" who build careers across work settings and jobs (Kalleberg 2000; also see DiPrete et al. 2002; Han and Moen 1999; Kleinman and Vallas 2001; Uchitelle 2006). Protean work trajectories can encompass job-hopping across managerial, employee, and self-employment roles and across education, government, and other industry segments. Employers loosen managerial control due to the creative nature of their production and seek to retain them (DiPrete et al. 2002). In turn, protean careers allow knowledge workers to develop skills, improve task-based skill performance, and align themselves to projects in their areas of expertise rather than to organizational boundaries.

Empirical Studies of Mid- to Later-Life Job Mobility

How do middle-aged workers fare given such changes? A rapidly expanding social science literature finds that, with the "flexible turn," job tenure or career job length has declined (Munnell et al. 2006) and job mobility rates and work/nonwork transitions have markedly increased and grown more blurred (Elder and Pavalko 1993; Han and Moen 1999; Hayward et al. 1988a, b; Giandrea et al. 2009; Sterns and Chang 2009). Given the growing heterogeneity in work patterns at midlife, this section and the next section on adult education provide overviews of fields of study in flux. I first define types of job mobility and work-retirement status changes that are addressed in this review, including the limitations of these definitions.

Excluding firing for cause, nonretired older workers might exit jobs due to quits or involuntary separations. The reasons for quits at midlife are diverse and understudied (Bartel and Borjas 1977; Hachen 1992). Involuntary separations can be defined as job displacements or exits from jobs due to the elimination of positions or shifts, plant closings, employers going out of business, layoffs, and/or reductions in force due to slack work for workers older than age 20. Job loss is an event that results in a state of unemployment. This state traditionally penalizes older more than younger workers, due to longer times to reemployment. As will be shown, involuntary job loss is not uncommon, yet excellent databases still underestimate its incidence and prevalence. This is because the line between quits and involuntary separations is often invisible. Employers can keep wages low, reduce hours, limit benefits, and make work conditions difficult in order to induce – or at least not discourage – quits (Farber 2003).

It is as difficult to estimate final retirements. According to Purcell (2000) retirement reflects two characteristics, nonparticipation in paid labor and income receipt from Social Security or another form of pension plan. Final retirement takes place when nonparticipation and pension receipt occur together as a stable state. But middle-aged workers seek or reenter employment while collecting Social Security or pensions (Johnson et al. 2009). They also are economically inactive in the absence of pension or other income (Burr et al. 1996). Also important, then, is the perception, planning and/or the intention to retire (Ekerdt et al. 1996; Han and Moen 1999; Szinovacz and Davey 2005) or stages of retirement, such as from self-reported partial to complete work exits (Ruhm 1990, 1991). Yet, beyond this, studies distinguish voluntary vs. involuntary retirements because even pre-retirement age workers (well under age 62) retire in response to economic inducements, poor health or disability, threat of layoff, or actual job displacement (Han and Moen 1999; Hardy and Quadagno 1995; Szinovacz and Davey 2005). A career job is a worker's longest spell of employment with a single firm (Ruhm 1990).

Because middle-aged workers enter postcareer jobs with pensions or after spells of inactivity, the jobs taken between a career job exit and a final retirement are often termed "bridge jobs" (Ruhm 1990). "Re-careering jobs" involving change in occupation and employer are also studied (Johnson et al. 2009). Unfortunately few, if any, studies of job displacement or bridge jobs incorporate the BLS definitions of nonstandard work so cross-classification of the prevalence of "flexible"

postcareer jobs is unknown. But postcareer activities constitute (often blurred) pathways to a final retirement. The next two subsections describe job displacement and work-retirement status changes, respectively. I focus as much as possible on midlife. My separation of these processes is not entirely by choice, but, beyond definitional differences, treatment of each process markedly differs across the social sciences.

Job Displacement

Recent studies largely come from labor economics and use panel data such as the Displaced Worker Supplements (DWS); the Wisconsin Longitudinal Survey (WLS); or the prospective longitudinal Health and Retirement Survey (HRS). Most study samples are adults with 3–5 years of job tenure or in a baseline career job, a point beyond human capital theory's critical "job-match" period. How common is displacement? Couch (1998, HRS) found 2-year displacement rates of 4.7 for men aged 51–60, similar to BLS data of the period (Gardner 1995). Chan and Stevens (2001, HRS) found that 17.2% of workers aged 50 and over were displaced at least once due to layoffs or firm closings between 1984 and 1996; about 14% of the WLS cohort experienced a job displacement between 1972 and 1992 (Brand 2006). In a sample of retirees aged 51 and over, 13% of men and 15% of women were displaced prior to retirement (Szinovacz and Davey 2005, HRS). Finally, 25% of full-time workers, ages 51–55 in 1992, had been displaced by 2006 (Johnson et al. 2009, HRS).

Of importance is whether displacement reflects cyclical economic conditions (recessions), more deeply-rooted or structural change, or both. Also important is whether displacement risk differs by age. Studies show that displacement [incidence] rates rose in the early 1980s and quickly returned to baseline, for workers of all ages, when recession-related conditions improved. In contrast, displacement rates for all workers jumped over the early 1990s recession but then remained elevated for older workers to about middecade (Farber 2003, ten DWS waves; Gardner 1995), especially men and women aged 45–59 in blue-collar, and less educated men aged 45–59 in white-collar jobs (Siegal et al. 2000, DWS). Siegal et al.'s (2000) examination of relative displacement rates of younger (age 25–39) vs. older (age 45–59) workers found that older men had lower rates than younger men until the early 1990s when rates then converged (also Gardner 1995). Farber (2003) concludes that, beyond the cyclical job losses due to layoffs and plant closings over the early 1980s, early 1990s and early 2000s, older workers, and especially educated older workers became subject to secular increases in job displacement over the mid-1990s and beyond, largely due to "shifts/positions abolished."

To be sure, the high unemployment rates of youth and declining labor force participation of young adults – under age 40 – are of great concern (Gendell 2008; Uchitelle 2006). But, as Munnell et al. (2006, DSW and HRS) note, a positive and significant relationship between age and the incidence of job displacement, has emerged, holding job tenure constant. If job tenure continues to decline at midlife, job displacement will become more common (DiPrete et al. 2002; Munnell et al. 2006).

Consistent with "good jobs, bad jobs" labor market models, part-time workers – who are more likely to be in poor quality jobs – have relatively high displacement rates, as do semiskilled blue-collar workers (Chan and Stevens 2001; Couch 1998). Yet men have a higher risk of displacement than women (Brand 2006; Munnell et al. 2006). And, although relatively high 1980s displacement rates in blue-collar jobs continued into the 1990s (Siegal et al. 2000), job loss by the 1990s strongly impacted white-collar, primary sector jobs (DiPrete 1993). Human capital effects on displacement also became less protective over time: college degrees reduced the probability of job displacement by 5% points in the 1984 DSW wave but were not significant by the 2002 wave (Munnell et al. 2006). These latter findings, especially with regard to the weakening protective effects of seniority,

male gender, human capital, and primary sector location on involuntary job loss are consistent with waning of the Fordist labor regime, and market accumulation processes of work-reward retrenchment for formerly advantaged employees.

Displacement results in unemployment; unemployment at midlife is associated with relatively longer times to reemployment and entry into lower-quality jobs (Couch 1998). In a simulation with HRS data, Chan and Stevens (2001) estimate that, if displaced at aged 55, only 50% of men and 45% of women find work 1 year out (also Johnson et al. 2009). Munnell et al. (2006, HRS) find that non-Whites are 13% less likely than Whites and women 7% less likely than men to become reemployed or else may enter a series of low-wage jobs (also Couch 1998; Mutchler et al. 1997). Postdisplacement jobs then tend to be of short duration (Chan and Stevens 2001) and pay significantly less than lost jobs, with wages reduced for 6 years out or more (Chan and Stevens 2002). However, consistent with the market flexibility perspective, many older workers enter flexible work arrangements by choice; if independent contractors, they often are self-employed or employers of others (DiNatale 2001). Job quality can be high with control over the tempo and organization of work (Kalleberg 2000; Polivka 1996); job satisfaction can be high in new flexible jobs, even if older workers earn less than they did in a prior job (Johnson et al. 2009; Sterns and Chang 2009). Finally, although displacement might lead to final retirement (Szinovacz and Davey 2005) most displaced workers do become reemployed, about 75%, with one-third of these new jobs being career-changes (Johnson et al. 2009). And, with reemployment, displaced workers enter more blurred pathways to final retirement.

Pathways to Final Retirement

Relatively few workers aged 50 and over move directly from career jobs into final retirement, however modeled. More than 50% move from full-time career jobs into self-reported partial retirement (e.g., at least part-time work) (Ruhm 1990, RHS) and more than 60% from full-time career into bridge jobs (Cahill et al. 2006, HRS). Also, about 44% of workers (age 51–55) who had retired from full-time career jobs in 1992 took new jobs by 2006 (Johnson et al. 2009, HRS). The variability in retirement timing has increased over time, measured across cohorts (Elder and Pavalko 1993; Han and Moen 1999; Giandrea et al. 2009). And, although critical human capital influences such as health, wealth, and pension availability remain important predictors of work vs. retirement (Cahill et al. 2006; Wise 1997), complex mixes of social characteristics, past job mobility, market segmentation, and life course influences also explain pathways to retirement.

As under Fordism, social heterogeneity in worker characteristics allocates workers across divergent market segments that then shape work-to-retirement pathways (Couch 1998; Flippen and Tienda 2000; Han and Moen 1999; Mutchler et al. 1997; Quinn and Kozy 1996). For example, careers – marked by employment continuity, direction (e.g., upward mobility) and work rewards – shape postcareer job pathways, although gender and ethnicity play a role in these work trajectories (Flippen and Tienda 2000; Han and Moen 1999; Quinn and Kozy 1996). For example, men in "high geared" careers tend to end their careers in "crisp" final retirements of the Standard Path while women in "intermittent" careers tend to enter postretirement work (Han and Moen 1999). More generally, relatively advantaged workers, with higher education, greater past earnings and pension benefits and generally European American men, tend to still retire in a "crisp" pattern of the Standard Path (Johnson et al. 2009; Mutchler et al. 1997); they are less likely to change careers or change employers if they do become reemployed (Johnson et al. 2009). In contrast, women, ethnic minorities, workers with less wealth or pension access or workers with more midlevel (12–16 years) education are more likely to "re-career" or change employers and occupations after career job exits, although these jobs often have lower status and wages (Johnson et al. 2009). The least advantaged

group, often women with delayed work experience, former blue-collar males, secondary sector or part-time workers, (Han and Moen 1999; Mutchler et al. 1997; Quinn and Kozy 1996) and a large subset of ethnic minorities has the least secure market attachment (Burr et al. 1996; Flippen and Tienda 2000). Then, as poorly attached older workers, depending on economic need and health, they are either more likely to withdraw from activity in midlife as economic nonparticipation becomes an absorbing state (Burr et al. 1996; Hayward et al. 1996) or have sporadic work spells over later life (Han and Moen 1999; Mutchler et al. 1997). Work-to-retirement patterns remain influenced by spousal and family events and relations (Cahill et al. 2006; Han and Moen 1999).

Retirement is examined well elsewhere in the handbook, so I highlight two changing midlife patterns, across displacement and retirement pathways studies, relevant to the "flexible turn." A first pattern is a changing of directions in the traditional correlations between human capital and work/retirement. As noted, job tenure, or firm-based work experience, once valued by employers (Bartel and Borjas 1977) is becoming less so (Munnell et al. 2006), as also tracked by displacement rate trends. Also, age until recently was negatively correlated with job displacement and positively correlated with final retirement. But, at some point in the 1990s, the relative risk [incidence] of displacement changed for older vs. younger workers (Farber 2003; Siegal et al. 2000) while, at the aggregate level, older workers (age 60+) began to delay final retirement or reattach to markets postretirement (Gendell 2008) as employment, especially among men ages 45–59, remained stagnant or declined (Gendell 2008; Uchitelle 2006). Although rising old age participation reflects growing economic need with recent (post 2000s) market volatility, changing pension types/rules and perhaps better health, middle-aged workers have similar, if not greater, economic need to work and greater exposure to defined contribution pensions. Finally, human capital as education and work experience, once associated with stable and lengthy work careers, also appears to be a changing indicator as it is often a nonsignificant predictor of job retention vs. displacement (Couch 1998; Munnell et al. 2006) or of retirement or nonparticipation (Burr et al. 1996; Flippen and Tienda 2000; Han and Moen 1999), especially for men (Giandrea et al. 2009). Known correlations have weakened if not reversed.

A second pattern is one of growing inequality in work outcomes of employability and wages. Middle-aged men have long had more orderly, upwardly mobile careers than middle-aged women (Flippen and Tienda 2000; Han and Moen 1999), including institutional supports for retirement. But, well before the recent economic downturn in 2007, adult men had growing problems with labor force attachment and employability, especially if under age 60 (Uchitelle 2006). In contrast, women's labor force attachment has increased more than men's, especially at older ages (Gendell 2008) but women continue to earn lower wages and benefits than men (O'Rand and Henretta 1999). In addition, within – gender inequalities may be growing, in terms of complex race/ethnicity and labor market structure effects. Men of color have shorter career job durations and higher rates of persistent nonparticipation than European American men (Burr et al. 1996; Mutchler et al. 1997; Flippen and Tienda 2000). Among women, although middle-aged and older Hispanic women work less than other women, (Flippen and Tienda 2000), marked differentials in wages, more than employability, are present. And, wage differences reflect differences in quality of nonstandard work arrangements more than in level of education or skill (McCall 2000).

Both the patterns of changing human capital effects and rising inequality and what they portend needs study; policy recommendations for middle-aged workers will differ, depending on findings. With regard to changing human capital effects, or the loss of employability for workers of once-advantaged status, employers do not likely disvalue work experience, education, or skill – indeed, recent growing wage inequality reflects growing education and skills-gaps (Elman and O'Rand 2004; Morris and Western 1999). But educated, skilled and, especially, experienced older workers have much *firm-specific training* and employers may value firm-specific skills less. Market flexibility perspectives suggest that employers seek to add innovation and value in production; if so, they may gravitate toward workers with a wider range of cross-sector or transferable skill, for functional flexibility ends (DiPrete et al. 2002; Kalleberg et al. 2003; Smith 1997). This is what Fordist-trained middle-aged workers may lack and so adult education and general skills training (discussed in the

next section) may allow better job matches (Sterns and Chang 2009). Beyond retraining, midlife workers may also has to reconceptualize "work": as employers seek numerical flexibility and employability in the new century, "work" may refer less to new career jobs and more to gaining entry into any job, including nonstandard arrangements.

But, to the degree that market accumulation forces are dominant, employers may reap much of the rewards from flexible employment, limiting employment opportunities, as middle-aged, often skilled employees become subject to displacement, lower wages in reemployment, and less engaging, "outsider" work. If so, then mature workers, especially women, minorities, and those with few resources might work sporadically into old age because of economic need and an inability to retire (Burr et al. 1996; Hayward et al. 1988b; Gibson 1986; Johnson et al. 2009). But, in the meantime, workers with more education and skill – if able to exit economic activity via the "Standard Path" – will do so rather than find reemployment, given the option of taking *low quality* flexible jobs (Cahill et al. 2006; Johnson et al. 2009). Notwithstanding the societal, aggregate losses of human capital and contractions in working life expectancy (Davis 1988; Wise 1997), this outcome is not ideal for middle-aged workers because they potentially constitute a leading edge of employees that might benefit from high-quality nonstandard jobs.

In summary, a mix of policies is needed that can benefit heterogeneous mixes of midlife workers. In general and especially for those weakly attached to markets, job creation, and targeted (re)training is important; for workers who seek a broader educational foundation or new skills for recareering, formal education programs might facilitate employment. To encourage extended working life expectancy for the more advantaged, skilled workers whose relatively early retirements tend to be final, policies that support work-engagement, job-sharing, phased retirement or other high-quality flexible job redesigns might be as or more important than retraining. This said, many middle aged workers, especially women, seek retraining to increase employability. I turn to this below.

Adult Education New Human Capital Streams in the Flexible Economy

The U.S. educational system grew rapidly over the twentieth century. The early twentieth century "nontraditional" students, children of immigrant families, used education to enter the semiskilled blue-collar and white-collar Fordist jobs that were emerging (Nasaw 1979). And, by mid-century the educational system had become a "licensing agency for Americans who wanted to enter professions" (Lazerson 1998: 64), mostly European-American men. Then, between mid-century and the late 1970s a different type of educational expansion occurred as the number of baccalaureate, community college, and vocational institutions of higher education doubled in the United States (Lazerson 1998). This post-World War 2 school expansion or "educational massification" (Zemsky 1998) represented a U.S. public commitment to schooling and contributed to the education-to-work life stage division that arose over the mid-century.

But, another group of students appeared in the 1970s: young to middle-aged, largely female, often of ethnic minority background, as the new "nontraditional" students. Members of the baby boom cohort (Jacobs and Stoner-Aby 1998), they sought professions and other good jobs, too. Postsecondary education would help them enter the economic mainstream, including the white-collar or service, albeit less-secure, non-Fordist jobs emerging by century's end. Although both men and women entered 2- and 4-year colleges at higher rates after the 1970s, women's enrollment rates, then degree completion rates, rapidly accelerated across all educational settings, surpassing men's rates by the late twentieth century (Buchmann et al. 2008).

By the end of the twentieth century, the U.S. educational system had changed from being a licensing system for professional jobs into a gateway for many jobs – or sometimes any job (Bills 2003). Moreover, adult demand for education continues to grow even as demassification occurs: an erosion of state financial support for higher education amidst rising tuitions (Zemsky 1998).

Adult students absorb most of the cost of schooling and so adult educational participation needs to be explored in the context of future employability, job availability, job quality, and wage rewards. Under the mid-twentieth century Fordist accord, educated and less educated workers could be matched to jobs, even if not always "good jobs." But, with a growing share of post-Fordist jobs as flexible or nonstandard low-wage and low-skilled jobs, facilitating employment for newly skilled adults will become critically important.

Theoretical Perspectives and Empirical Studies

As noted in the previous section, human capital and employment relationships have changed, singly and in the context of each other, but these new relationships have yet to be fully understood or theoretically integrated. Adult education is not well addressed in human capital theory, other than in variants such as *screening* or *signaling* theories. These theories propose that employers notice degrees [credentials] and who holds them more than educational content or learning, when assessing the productivity of potential hires (Bills 2003). At issue is whether an older age of graduation sends neutral or negative signals to employers that affect hiring and wages (Monks 1997). In contrast, *cumulative dis/advantage theory* makes variability in the life course timing of education the central problem, in broader social, historical, and institutional context (Pallas 1993). It highlights educational stratification processes by exploring institutionalized tracks of advantage and how life course timing differences in the access to such structural resources produces growing intragroup inequalities over time (Dannefer 1987).

Consistent with a process of cumulative disadvantage/advantage, most adults who graduate with baccalaureate and higher degrees "on time" – in a trajectory of postsecondary persistence – had, as youth, advantaged social backgrounds (Bozick and DeLuca 2005; Elman and O'Rand 2004; O'Rand et al. 2009). Adult schooling, if education occurs, is then likely to be episodic with entries and exits across different semesters, years and/or schools (Goldrick-Rab 2006; Zemsky 1998). While most adult postsecondary school entrants do not complete degrees (Jacobs and King 2002), about 6% of B.A. degrees and 20% of Associate degrees are obtained after age 40 (O'Rand et al. 2009). Adult postsecondary completion rates are low because most adults go to school part-time (Jacobs and King 2002) and have high intensity co-occurring economic activities (Jacobs and King 2002; Kane and Rouse 1999; NCES 2002). Most adult community college students report that work is their primary activity (Kane and Rouse 1999).

Program-of-entry patterns resemble those found in *market segmentation* studies: differential selections by race/ethnicity, class, and/or gender into postsecondary 2- vs. 4-year degree programs (Elman and O'Rand 2007; Karen 2002; Kane and Rouse 1999). Adult women and minorities tend to enter non-baccalaureate programs, partly because they appear to cost less. However, when the opportunity costs of paid work and time are added to total costs, tuition is a relatively small part of the total cost (Kane and Rouse 1999). As *life course* theory would predict, the timing of education and the type of program entered is constrained by family roles (Astone et al. 2000; Bozick and DeLuca 2005; Jacobs and King 2002). And, as signaling theory suggests, adults may earn less for equivalent degrees earned at older ages (Elman and O'Rand 2004; Monks 1997).

Yet adult educational participation has rapidly increased over the last few decades. Cross-sectional National Household Education Surveys (NHES) highlight the range of adult educational activities, including basic skills training, apprenticeships, work-related courses, and part-time college or university degree programs. About 37% of adults ages 45–54 and 27% ages 55–64 took a *work-related course* in 2005 (Levesque et al. 2008). Considering only economically active adults, about 40–45% of adults ages 45–49, 50–54, 55–59, and 60–64 took a work-related course in 2005. Comparable percentages by age group were lower in 1995 than in 2005, but comparable percentages in *both* 1995 and 2005 were lower than in 2003, when participation jumped near the 2001

recession (Snyder et al. 2009). Also, NHES adults entered school to do more than "brush up" on a single skill: working adults aged 45–64 were more likely to take two to four courses than working younger adults (Levesque et al. 2008).

In summary, adult educational participation is growing as adult career job length declines, as flexible replacement jobs proliferate and as the greatest wage gains and employability accrue to workers with baccalaureate and higher degrees (McCall 2000; Morris and Western 1999). But adult students find educational completion to be a difficult accomplishment; for completion rates to increase, research and programmatic change will be needed to address ways in which school settings and practices are not tailored to adult student needs. Also, financing is costly, whether in community or baccalaureate settings (Kane and Rouse 1999). Given the cost, research is needed to understand the type(s) of education that enhance employability and earnings for middle-aged workers – and for what subgroups or under what circumstances – and whether working life expectancy is extended (Davis 1988).

Concluding Remarks

Transformative change in the social organization of work has occurred. This has uniquely impacted middle-aged adults, who bridge changing production regimes. Some subgroups will do well post-career: in self-employment, reemployment in similar economic sectors, or in flexible work arrangements, including in the nonstandard arrangements that can provide job satisfaction (DiNatale 2001; Johnson et al. 2009). Other subgroups will experience midlife downward mobility, into lower-wage or less engaging jobs or will experience reduced employability with inactivity for long spells and early economic withdrawal (Burr et al. 1996; Flippen and Tienda 2000; Uchitelle 2006). What middle-aged adults now need is information about "what works" for job matching at midlife. Many will and can retrain (Sterns and Chang 2009), partly motivated by the perceived job insecurity associated with flexible or contingent jobs (Elman and O'Rand 2002). But what should the content of adult human capital be under flexible production regimes? Should adults pursue general education and cross-training? Or renew or update the narrower firm-or skill-specific types of training that, under Fordist production, was mostly provided by employers?

Overall, middle-aged adults have higher levels of human capital, work experience, and computer skills than past midlife cohorts, even perhaps comparable levels to current young market entrants (Munnell et al. 2006). They want to work longer than they actually do (Hardy and Quadagno 1995; Han and Moen 1999), to at least age 65 (Munnell et al. 2006), but face barriers to employment. How can midlife employment, job satisfaction and working life expectancy best be facilitated? Overall, we need to explore jobs, job matching, and employability in the context of cyclical *and* transformational changes. This will require refinement of human capital, labor market, and life course theories to fit new conditions. This will also require the implementation of policies, including the development of mechanisms – given our open "market system" vs. an "institutional system" of employment – that facilitate job matches in the hiring process for older workers who (re)enter labor markets. This will also require longitudinal databases, to track midlife education and work trajectories in the context of each other, and to map these long-term trajectories to later-life wealth, health, and work-related outcomes.

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Chapter 17
The Changing Worlds of Family and Work

Madonna Harrington Meyer and Wendy M. Parker

In the United States, the worlds of family and work are often incongruent. Much has changed since the *Leave It to Beaver* era of the 1950s, when men worked primarily outside the home and women worked primarily inside the home. In the past several decades, aging and life course scholars have documented and analyzed unprecedented increases in single mothers raising children; widespread entry of women, particularly mothers of young children, into the labor force; and modest increases in men's contributions to the unpaid house work and child care at home (Glass 2000). In some respects, these trends have narrowed gender gaps, but in other respects these trends have collided, leaving many women, and a growing share of men, feeling mounting pressures at home and at the office. Moreover, the efforts to juggle work and family responsibilities with few supports from the welfare state or employers leaves many ill prepared for the financial challenges of their own old age. This chapter explores these changing trends and their impact on the ways in which families balance paid and unpaid work over the life course. We pay special attention to differences between women and men and to differences among women by race, class, and marital status. We focus on how the presence of certain US policies, and the absence of others, shapes both the ways that families balance work and family obligations and the implications of that balance on economic security in later life.

Theoretical Approaches

Aging and life course scholars tend to highlight the extent to which social structures and institutions constrain individual actions across the life course, generating inequality in old age. The *life course perspective*, which emphasizes the long-term implications of factors such as historical events, cohort differences, timing and sequencing of personal decisions, and structural opportunities, is widely deployed among aging and life course scholars (Elder 2006). An emphasis on life course ramifications highlights the ongoing impact of various choices, opportunities, policies, and programs at different stages of life (Settersten 2003; Moen and Spencer 2006). For example, when women take time out from work to raise children, the immediate consequence is loss of salary, but the long-term consequence is reduced access to public pensions, private pensions, and savings. People traverse different pathways throughout their lives. The *cumulative (dis)advantage perspective* points out that along those pathways, they may accumulate advantages and disadvantages. Multiple layers of accumulating advantage and disadvantage across the life course lead to inequality

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in old age and those trajectories are not randomly distributed. Persistent organizing features of social life in the U.S., notably gender, race, class, and marital status, generate significant income and health inequality across the life course (Acker 2006; Lorber 2005; Padavic and Reskin 2002; Estes 2001; Harrington Meyer and Pavalko 1996; Settersten 2003; Baca Zinn and Thornton Dill 2005).

Aging and life course scholars analyze how best to use social policies and programs to reduce inequality in old age. *Feminist scholars*, who are united in their attention to gender inequality in old age, are divided in their views of how best to minimize that inequality. *Liberal, or gender-equity, feminists* focus on the continued gender gap in wages and support equal opportunity and comparable worth in the labor market. This focus has helped to shrink the wage gap and launch more women into positions of authority in a wider array of fields (Acker 1989). Because their aim is for women to compete fairly with men on the current playing field, liberal feminists have typically not supported policies like paid maternity or family leaves, flexible scheduling, or universal child care (Jacobs and Gerson 1998). They argue that the development of benefits specifically for women or those that women are much more likely than men to take undermines efforts toward gender equity by further entrenching the gendered division of labor at home and by concentrating women in part time and lower paying traditionally female occupations (Mandel and Semyonov 2005, 2006; Morgan and Zippel 2003; Hewlett 1986; Padavic and Reskin 2002). By contrast, *socialist, or gender-accommodative feminists,* support welfare policies that help women and men balance work and family across the life course, arguing that policies such as paid parental leave, flexible scheduling, and universal child care are needed to offset the unequal amounts of unpaid work that most women, and some men, continue to perform (Hewlett 1986; Pascall 1986; Herd and Harrington Meyer 2002). Moreover, they suggest that these programs are needed for the growing legions of single mothers raising children on their own. Their aim is to rewrite the rules at work and at home to reward women and men for both the paid and unpaid work they are doing (O'Rand and Henretta 1999; Lorber 2005; Mandel and Semyonov 2006).

Evidence from Norway suggests that neither of these approaches may be sufficient to entice the majority of men to take a leave from work to stay home with their newly born children. In the 1990s, Norway introduced a gender neutral policy that offers cash-for-care, and working parents may choose which of them will stay home to care for the children (Brandth and Kvande 2009). This policy has not increased fathers' participation in child care. Norway also introduced a policy known as the fathers' quota policy, which provides up to 6 weeks of paid leave only to fathers (Brandth and Kvande 2009). The gendered quota policy has increased fathers' participation in child care and helped offset the otherwise highly gendered practice of child care. Only the use-it-or-lose-it nature of the paternity leave provided sufficient impetus to encourage a substantial portion of men to take time at home with their children.

The *political economic* perspective, which emphasizes the structural influences that shape peoples' lives, points out that both the old age polices we do have, and those we do not have, are often shaped more by the business interests of those who lobby effectively to shape the legislation rather than the day-to-day interests of older people and their families. Indeed, supporters of *market-friendly policies* suggest that the government should bow out of the retirement business altogether and allow consumer needs for income security, health care, and long-term care to be addressed via the market in ways that maximize business interests (Harrington Meyer and Herd 2007; Hacker 2002; Pauly et al. 1991;Yergin and Stanislaw 1998; Gilbert 2002). Supporters of *family-friendly policies* favor a full slate of policies that help families juggle work and family at all ages and enable people to enter old age with sufficient economic resources (Korpi and Palme 1998; Korpi 2000). They caution that the political and economic power of business interests are evident both in the unequal distribution of employer-based benefits and in the quick dismissal of efforts to develop policies for paid family leave, universal day care, or universal long-term care programs, with little regard for those in need of such assistance, who are disproportionately women (Katz Olson 2003).

Changing Social and Demographic Trends

In recent decades, aging and life course scholars have written extensively about sweeping changes in our patterns of marriage, parenting, paid work, and unpaid care work. In many instances, gender gaps have grown smaller, but economic insecurity has remained persistent for some, particularly single mothers and Blacks and Hispanics.

Changing Family Patterns

Families have changed remarkably during the past 30 years with implications at all stages of the life course (Goldstein and Kenney 2001). Most notably, the U.S. has experienced a retreat from marriage coupled with an increase in cohabitation and a dramatic increase in single parent families. These trends vary significantly by race and ethnicity. Between 1960 and 2008, the percent of women married dropped from 66 to 53%, the percent of women divorced rose from 3 to 11% (U.S. Census Bureau 2008a, b, c). These trends are more pronounced among Blacks. The percent of married White women dropped from 67 in 1960 to 55 in 2008, while the percent of married Black women dropped from 60 to 34% (U.S. Census Bureau 2008a, b, c). The retreat from marriage is linked to an increase in single parenting. As Fig. 17.1 shows, between 1960 and 2008, among families with children under age 18, the percent of married couple families dropped from 91 to70%, while the percent of single mother families rose from 8 to 23%.

As Fig. 17.2 shows, in 2005, fully 39% of all U.S. births were to unmarried women. The rate varied dramatically by race. Asians had the lowest rate of births to single mothers, 17%, compared to Whites with 28%, Latinos with 51%, and Blacks with 72% of births to single mothers (Hamilton et al. 2009; U.S. Census Bureau 2008a, b, c).

The rise in single parenting is particularly problematic for women, with implications across the life course. In 2005, 80% of single parents were women (U.S. Census Bureau 2008a, b, c). Single parenting is linked to poverty, especially for women, because it often impedes advanced education or working the number of hours needed for many career advancements. Moreover, many single mothers raise children on a single income when noncustodial fathers provide little or no child support

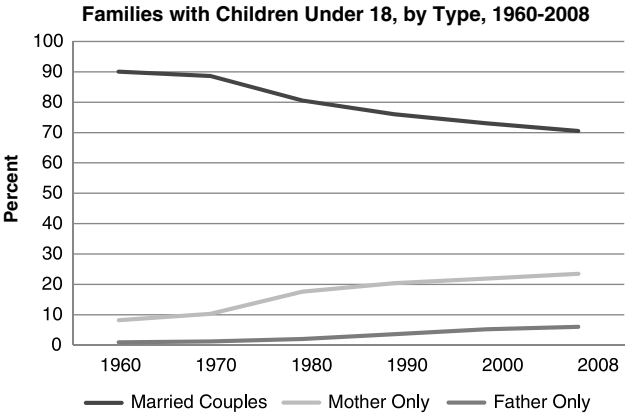

Fig. 17.1 Families with children under 18, by Type, 1960–2008. U.S. Census Bureau 2008. Table FM-1. Families by Presence of Own Children Under 18: 1950 to Present

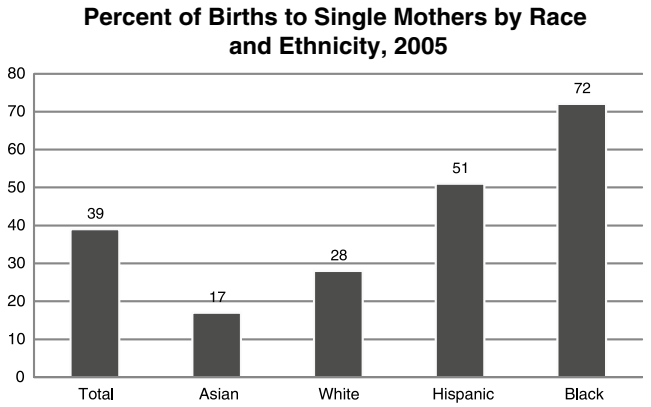

Fig. 17.2 Percent of birth to single mothers by race, 2005. Source: U.S. Census Bureau 2008

(Sorensen and Zibman 2000; Carlson 2006). About one-quarter of single mothers are not receiving child support payments to which they are legally entitled, and another one-third are not receiving the full award (Sorensen and Zibman 2000; Sorensen and Hill 2004). Among families with a child under 18, 7% of all married couples, compared to 36% of female-headed households, are poor (U.S. Census Bureau 2006). Single parenting is especially difficult for Black and Hispanic mothers; 45% of Hispanic and 42% of Black single mothers live in poverty (U.S. Census Bureau 2006). Many of these single mothers continue to be poor throughout the life course and as they reach old age.

At all ages, women are more likely to be single and the gender gap grows with age, often with adverse effects on economic security. Among those aged 65 and older, 72% of the men and only 42% of the women are married (U.S. Census Bureau 2008a, b, c). Among those 85 and older, 54% of the men and only 14% of the women are married. There is a strong link between marriage and poverty in old age. Older people who live alone do not enjoy the economies of scale afforded to those who live together, such as sharing the rent, heating, and grocery bills. Figure 17.3 shows that among those aged 65 and older, married couples have poverty rates of 5% while 40% of single Black and Hispanic women are poor (He et al. 2005).

Several aspects of the retreat from marriage have led to more complex family trees. Divorce rates rose throughout the 1960s and 1970s and then leveled off at a fairly high rate. One half of all those aged 65 and older have been divorced, and many of them, particularly men, have remarried (Bengtson et al. 1990; Cherlin 1996). The impact of divorce and remarriage on various generations is somewhat mixed. While some blended families fare quite well, some research shows that blended families report lower well-being and weaker family ties than nonblended families (Goldscheider and Goldscheider 1993). Following divorce, children are more likely to move between parents, have no significant father role model, or live in blended families where nonfamily or extended family play a sizeable role in their upbringing (McLanahan and Sandefur 1994; Rainwater and Smeeding 2004). Following a divorce or remarriage, some grandparents find their roles severed, while others play a central role in helping grandchildren adjust (Cooney and Smith 1996). During particularly difficult times, including parental drug abuse or incarceration, some grandparents become legal guardians and raise their grandchildren. The percent of children being raised by grandparents rose from 3% in 1970 to 6% in 2004 (He et al. 2005). Blacks are more likely than other groups to be custodial grandparents – they make up 12% of the elderly but account for 29% of custodial grandparents (He et al. 2005). The job can be rewarding, leading to very close relationships and a better quality of life for the grandchildren. But it can be daunting as well, particularly if the children have special needs or are struggling in school. Many grandparents report that while they are glad they are

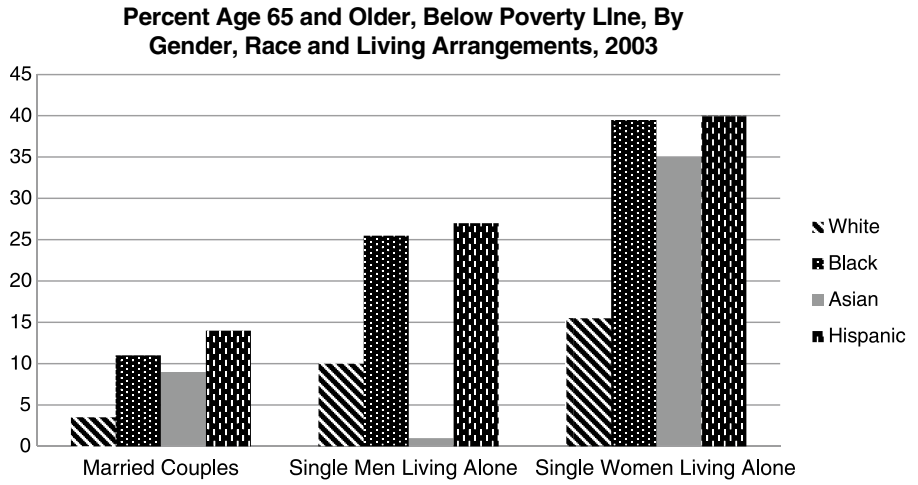

Fig. 17.3 Percent of age 65 and older, below poverty line, by gender, race, and living arrangements, 2003. Source: U.S. Census Bureau 2005. Civilian non-institutionalized persons

contributing, they experienced declining physical or emotional well-being, and rising economic concerns, after taking on the responsibility (Burton and deVries 1993).

Changing Work Patterns

Over the past several decades the gender gap in employment and in wages has narrowed. Nonetheless women continue to work fewer hours, in part because of their disproportionate responsibility for care work, and for lower pay, in part because they continue to be concentrated in traditionally female and lower paying jobs (Glass 2000). Despite a sizable increase in women's labor force participation, women remain more likely than men to work part time, less likely to work year-round, and more likely to have entire years out of the labor force (Rose and Hartmann 2004). Nearly 60% of all adult women work in the U.S., but only 75% of them work full time and the remainder work part time (U.S. Department of Labor 2008). By comparison, 90% of employed men work full time. While men's labor force participation has dropped from 76% in 1970 to 69% in 2004, women's overall participation has risen from 40 to 56%. Figure 17.4 tracks the changes in labor force participation over the decades for women with children. Women with children ages 6–17 are the most likely to work, with the percent employed rising from 55% in 1975 to 78% in 2004. Note that the percent of women with children under age 3 working rose from 34 to 57% between 1975 and 2004.

As family and work patterns changed, there has been a decline in the traditional breadwinner family. Historically, marriage was an event that led many women to leave the labor force. Over time, marriage lost that impact, but childbirth prompted many women to exit. Today, neither transition has much impact on employment. Among married couples, the percent with only the husband working has dropped from 29% in 1986 to 22% in 2008 (U.S. Census Bureau 2008a, b, c). Among married couples with children under age 18, 60% of the wives were working in 2008, and among married couples with children under age 6, 62% of the wives were working in 2008. With the exception of

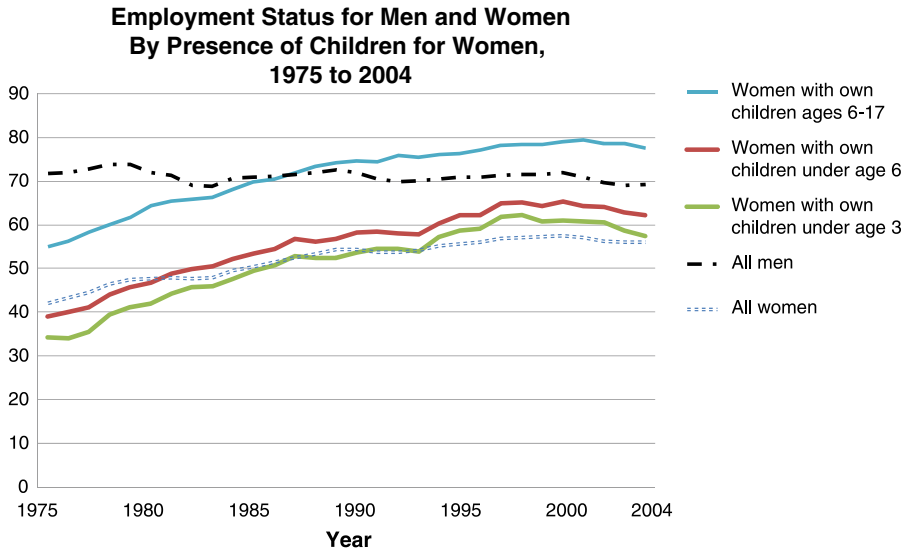

Fig. 17.4 Employment status for men and women by presence of children for women, 1975–2004. Source: U.S. Bureau of Labor Statistics. (2005). "Women in the Labor Force: A Databook. Report 985." Table 7. Employment status of women by presence and age of youngest child, 1975–2004."

widowed women, married and unmarried women are now equally likely to be employed, though those with younger children work fewer hours (U.S. Bureau of Labor Statistics 2006a, b).

Historic race differences in work patterns have also narrowed. In the early 1900s, Black women were nearly three times more likely than White women to be employed; currently 62% of Black and 59% of White women work (Goldin 1992; U.S. Department of Labor 2008; U.S. Bureau of Labor Statistics 2005a, b). Black women remain, however, significantly more likely than Whites to work full time, to be unemployed, and to receive smaller wages. Race differences in wages are pronounced. In 2004, median weekly earnings for Black women were 14% less, and for Latino women were 28% less, than for White women (U.S. Bureau of Labor Statistics 2005a, b).

The gender gap in wages among full time year round workers has shrunk from 62% in 1979 to nearly 80% in 2008, marking important gains in some women's economic security (U.S. Department of Labor 2008; Institute for Women's Policy Research 2006). But the cumulative wage gap may be more telling of the life course consequences of juggling work and family responsibilities for women. Hartmann et al. (2006) traced the cumulative wage gap, which captures both fewer hours of employment and lower wages. They analyzed PSID data from 1983 to 1998 and found that for all women of ages 26–59 with at least 1 year of earnings, women earn just 38% of what men earn. They then traced a cohort of college educated women and men who were of ages 25–29 in 1984. By 2004, the women were $440,000 behind the men in cumulative wages. The gender gap in wages increased over these 20 years. When they were in their 20s, women's average annual full-time year-round earnings were about 75% of men's; by their late 40s, 62%. These data, which exclude women who are not working full time, year-round, suggest that as they try to juggle work and family responsibilities, women fall further behind men. Lower wages during the younger years translate into smaller savings and investments, smaller private pensions, and smaller public pensions in old age.

The gender gap in wages continues into old age. Relatively few older people are employed; among those aged 65 and older in 2007, just 20% of men and 12% of women were employed (U.S. Department of Labor 2008). Because most have retired, earnings account for only 22% of all old age income. Employment is highest among those who are younger. Among people aged 65–69, 33% of men and 23% of women are employed (He et al. 2005). Though the gap has narrowed in recent decades, older women are still only 57% as likely as older men to be employed. When

employed, they work fewer hours and accrue smaller earnings (He et al. 2005; Wu 2005; SSA 2009). Generally, single older people plan their retirement based on individual income and health concerns, but married older couples often try to plan to retire jointly, rather than sequentially, if they can afford to do so (Pienta and Hayward 2002; Elder and Pavalko 1993; Henretta et al. 1993). Because women tend to marry men 2–3 years older, they tend to retire at younger ages so that they can spend their retirement years with their husbands and this tendency toward earlier retirement undermines their financial security when they are older. When the economy and the stock markets are in a downturn, however, many older persons may strive to continue working. They may find it hard to obtain or retain employment, which is particularly troubling for those who are aware that their nest egg will not be big enough (Gendell 2008).

These changing demographic trends increase the need for high-quality and readily available child care, parental leave, flexible work hours, and early childhood education and other programs that will help families juggle work and care work responsibilities. Thus far, however, many of the responses to these growing demands, both through employment-based and welfare state programs, have been aimed at either the very poor or the upper middle class leaving the majority in the middle with little support. For example, because the US Family and Medical Leave Act (FMLA) offers only unpaid leave, few in the middle and lower income brackets are able to take advantage of the benefit (Rudd 2004). The overall impact of the rise in single mothers, and in middle-aged and older single women, is increased financial insecurity across the life course for many women, particularly those who are Black and Hispanic.

Changing Care Work Patterns

No matter how demanding the work schedule, every family has to find ways to take care of the day-to-day unpaid care work of dishes and laundry, raising children, and caring for disabled or frail older adults. At every point in the life course, women are more likely than men to provide that care for family members. Indeed, though the gender gap in care work has shrunk, women still perform the majority of unpaid work within families for children, people with disabilities, and the elderly. And the work itself remains devalued (Hochschild 1989; Hooyman and Gonyea 1995; Cancian and Oliker 2000). The gendered division of labor among younger families is not as pronounced as it was in the 1960s and 1970s, men are spending significantly more time with children than their fathers did, but women continue to spend about twice as much time as men caring for children and performing household chores like cooking and cleaning (Krants-Kent 2009; Bianchi et al. 2006). Moreover, the nature of parenting has changed considerably, especially for middle and upper class families. In contrast to her mother 30 years earlier, a good mother now is expected to provide a very intensive type of mothering that involves hands on help with activities such as homework, sports, music, languages, and summer camps (Stone 2007). Childcare and homemaking responsibilities lead many women to reduce or eliminate employment and education, with lifelong implications for financial security. Even though there has been some closing of the care work gap, Stone (2007) shows just how firmly held traditional expectations about women's responsibilities for raising children and running the household continue to be for many. She describes how women with very high status and high paying jobs tend to cut back or eliminate paid work following the birth of children in part because their husbands increase paid work and stop performing most house and child care work altogether. Single mothers face a different set of obstacles: there is no division of labor for the growing numbers of women who are heading households on their own.

The gender gap in providing care to frail older relatives has also eased, but women continue to perform about twice as much care work and face greater consequences for their own well-being (Chesley and Moen 2006). Overall, families are providing close to 80% of all long-term care and

many of caregivers are on call 7 days a week for at least 3 hours a day (Brody 2004; National Alliance for Caregiving and AARP 2004; Navaie-Waliser et al. 2002). Care work may include cooking, cleaning, helping with finances, running errands, providing medical care, and assisting with eating, bathing, dressing, and mobility. Women are more likely to provide care both because of long held perceptions that they are natural caregivers, and because they tend to have more tenuous and lower paying relationships to the labor force (Stoller 1994; Stone et al. 1987; Moen et al. 1994). Nearly 70% of spousal caregivers are wives and 60–80% of children who care for their older parents are daughters. Compared to sons, daughters do an additional 10–18 hours a month of care work (National Alliance for Caregiving and AARP 2004; Navaie-Waliser et al. 2002). Compared to White women, Black and Hispanic women perform carework more often, for longer periods, and at more medically intense levels, to relatives that are in worse health. Given that they have lower incomes and worse health, these additional duties add up to an even greater burden (Wolf et al. 1997).

The nature and scope of carework for the frail elderly changed dramatically in 1984 when Medicare and later Medicaid altered the reimbursement structures in ways that caused hospitals to shorten stays and export unprofitable care out of the hospital (Estes 2001). Hospitals discharged patients quicker and sicker and with little training, families, mainly wives and daughters, were expected to take on highly technical work including chemotherapy, apnea monitoring, phototherapy, oxygen tents, tubal feedings, dressing changes, and more. Estes (1989) calculated that in the first 5 years of the prospective payment system, more than 21 million days of care work had been transferred from hospitals to families. In recent decades, Medicare and Medicaid coverage of community based long-term care has shrunk considerably. Since 1997, the percent of the Medicare budget devoted to home care has dropped by 50% and the number of recipients and the number of home visits have dropped significantly (Harrington Meyer and Herd 2007). The net effect is that more, and more intensive, care work is pushed on to families. Stone (2000) estimated that there are 40 unpaid informal care workers for every paid formal care worker. The total value of annual care work is now estimated to be between $50 and $103 billion (Holtz-Eakin 2005; National Alliance for Caregiving and AARP 2004; Stone 2000).

While carework for frail older relatives can be rewarding, it can also lead to caregiver burden and stress (Pearlin et al. 1995). Caregivers report adverse effects on physical and mental health, marriages and other relationships, and employment and earnings (Cantor 1989; Brody 1990, 2004; Hooyman and Gonyea 1995; Stone 2000). Caregivers, particularly those who report doing more than their share, have higher rates of physical and psychological distress, anxiety, depression, loneliness, family tension, sleeplessness, exhaustion, inadequate exercise, increases in chronic conditions, and drug misuse (Bird 1999; National Alliance for Caregiving and AARP 2004; Pavalko and Woodbury 2000). Despite poorer health, caregivers are twice as likely to lack the time, energy, or resources to obtain care or fill a prescription for themselves (Commonwealth Fund 2005). Prolonged carework may lead to a weakened immune system, increased psychological distress, and accelerated aging at the cellular level (Pavalko and Woodbury 2000; Epel et al. 2004). Chesley and Moen (2006) found that carework is associated with diminished mental health for dual earner women but improved mental health for dual earner men. That gender difference appears to be due, at least in part, to gender differences in the number of hours, and years, spent providing care. The impact of carework on women's work and wages is mixed. Some women add unpaid carework to their paid responsibilities without taking any cut in pay, while others tend to reduce or eliminate paid work (Pienta et al. 1994; Scharlach 1994). Pavalko and Henderson (2006), found that women whose jobs have less flexible hours, unpaid family leave, and paid sick leave are more likely to reduce or end employment, which reduces not only current income but old age income from public and private pensions and savings. Employers can do a lot to help employees balance work and family commitments, but for the most part such benefits are available only to higher paid and better educated workers.

Aging and the life course scholars note that to the extent that it impedes paid work, unpaid care work across the life course contributes to many women's, and some men's, economic hardship in

old age. Moreover, given that it remains devalued, and that single motherhood continues to be on the rise, carework is likely to continue to be disproportionately the responsibility of women.

Changing Policies at Work and Home

Aging and the life course scholars have explored various policy proposals that might help younger families by increasing their ability to balance work and family with minimal economic penalties and decreasing the likelihood that they will arrive at old age with meager economic resources. These policies, including paid leave, flexible scheduling, and universal day care, are particularly important for women because even when they are not actually providing the care, they are often responsible for arranging that care. And their importance for single mothers can hardly be overstated because the range of affordable alternatives available to them is slim indeed.

Paid Leave

Under the provisions of the FMLA male and female employees in the US are eligible to take up to 12 weeks of unpaid leave each year for either the birth or care of their newborn or adopted child – or to care for immediate family with serious health problems – if they work in a company with more than 50 employees, have been employed for at least 12 months with that employer, and average at least 24 hours of work per week (U.S. Department of Labor 2000; Dorman 2001). Though the policy was developed to help families balance the needs of work and family and to encourage economic stability and security for families, most studies have shown relatively little impact for women or men (Waldfogel 2001). The act covers just about 60% of private sector workers, and just fewer than 50% are both covered and eligible. Among those who were eligible but did not take the leave, most reported that they could not afford time off without pay (Baum 2006; Armenia and Gerstel 2006; U.S. Department of Labor 2000). Though FMLA policies in the US are gender neutral in design, women are significantly more likely than men to take the unpaid leave (Rudd 2004). Additionally, those with lower incomes and who are single parents, who are least likely to be able to afford time off without pay, are least likely to take leave (Rudd 2004; Levine Sheriff 2007; Han et al. 2009).

Critics suggest that the unpaid family leave does not provide meaningful choices for single mothers and those at the lower end of the socioeconomic spectrum (Baum 2006; Harrington Meyer and Herd 2007). Several states now offer 6 weeks of partial wage replacement through their disability insurance programs and studies show the take-up rates are relatively high (Levine Sheriff 2007). California offers 55% wage replacement, up to a maximum of $728 per week, for up to 6 weeks. The benefit is paid for by a 0.08% tax on the first $70,000 in earnings, with a maximum cost of $55 per worker per year (Appelbaum and Milkman 2004).

In the absence of federal or state mandates, many workers rely on employment-based leave policies. But workers with higher levels of education and salaries are more likely than those of lower socioeconomic status to be offered such benefits. Reliance on employment-based paid leaves creates greater inequality among workers because those with lower incomes are both less likely to be offered paid leave through their jobs, and less likely to be able to take unpaid leave through the FMLA. Proposals to expand unemployment insurance to cover paid parental leave estimate that costs would range from $11 to $28 per worker per year (Institute for Women's Policy Research 2000).

Most European countries have long offered paid time off for the birth or adoption of a child. Most EU countries offer 3–12 months at full or partial pay. Norway offers 42 weeks at full pay or 52 weeks at 80% pay (Gornick and Meyers 2003). In addition to more generous paid leaves,

European nations also establish a more regulated and structured work schedule that allows more time for family (Bosch et al. 1994). Europeans average more than a month of paid vacation time per year and enjoy fairly broad coverage of sick days. Lower income and less educated workers in the US often have just 2 weeks of paid vacation and no coverage whatsoever of sick days. For example, Bond and Galinsky (2006) found that 79% of middle and higher waged women had some paid sick time, compared to just 39% of lower earners.

Many aging and life course scholars have concluded that workplaces in the US are often incompatible with family life and called for paid time off that would permit women and men to juggle, rather than chose between, work and family. Neither US employers nor welfare state policies have made much progress in providing meaningful family leave supports for those who are unable to take time off without pay (Chesley and Moen 2006). In the years ahead, aging and life course scholars will likely focus more sharply on gender, race, class, and marital status differences in taking paid and unpaid leaves in both the short run and in the long run, as well as models for providing more supports for parents with the greatest needs for those supports.

Flexible Scheduling

During the past few decades, some employers have introduced family-friendly forms of flexible scheduling into the workplace to help families accommodate work and family lives. As methods of communication have multiplied, including e-mail, texting, and cell phone calls, so have methods of conducting business. Flexible scheduling includes compressed work weeks such as working four 10 hours days or working from home on some days (Weber and Curlew 2009). Employees often have to pursue such flexibility through their own initiative, and some find that it hampers career advancement, but those with children or frail older relatives in need of care may find the flexibility worth the trouble (Stone 2007). Flexible schedules are not available to all; those in manufacturing and service sectors are often excluded. Employees who are Black or Hispanic, have less education, or earn lower wages, are less likely to be in positions that are offered or allowed to arrange flexible scheduling. Indeed, middle and higher earners are significantly more likely than lower earners to be able to set their start and end times through traditional or daily flex time benefits (Weber and Curlew 2009; Bond and Galinsky 2006). But those who can get them appreciate the flexible schedules. The National Study of the Changing Workforce indicates that employees who have more control over their schedule or access to flexible schedules typically report greater involvement in their workplace, commitment to their jobs, and well-being (Galinsky et al. 2008).

Another flexible option that permits families to juggle work and family involves working part time or job sharing. But these options tend to be combined with lower pay and fewer fringe benefits. They also tend to be combined with less meaningful work, slower advancements, and less recognition (Stone 2007). Moreover, in the current throes of economic downturn, conversion to part time work is being used as an alternative to lay-offs, often with negative short and long-term economic consequences, which include less pay now and less Social Security and private pensions later (Hewlett 2009 interview; Weber and Curlew 2009; Goldin 2006).

Child Care

More women with young children are in the labor market than at any other time in history, hence there is an increasing demand for flexible, affordable, and high-quality child care (U.S. Census Bureau 2006; Presser 2003). In 2005, about one-fourth of children of employed mothers were in

organized child care facilities, and one-fifth was cared for regularly by a grandparent (Federal Interagency Forum on Child and Family Statistics 2006). Child care is often difficult to find, expensive, and of variable quality. Those with irregular work patterns, requiring child care during late afternoons, evenings, or on a part time or rotational basis often find that there are few organized child care options for them (Presser 2003). Moreover, when children are sick, they are not permitted at day care and working parents have to make other arrangements or stay home from work. The costs for child care can add up, eroding family earnings. According to an Urban Institute report (2000), families with children under the age of 13 averaged nearly $300 a month for child care accounting for the second largest household expensive, after the house mortgage (Giannarelli and Barsimantov 2000). Concerns about the quality of child care are persistent. Studies show that care is variable and often only fair to poor in quality (Vandell and Wolfe 2000). Aging and life course scholars have shown that when child care is difficult to arrange, costly, and poor in quality, women are more likely than are men to reduce hours or leave the labor force altogether (Crittenden 2001; Presser 2003).

The state provides some supports for families. Middle-income families may be eligible for tax subsidies through the dependent care tax credit. Low-income families may be eligible for tax credits and subsidized child care, but finding openings in quality settings especially for young children may be problematic. Programs including Head Start and universal pre-K have garnered attention in recent years as a way to bridge families, and particularly moms, back into the labor force and to offer a better start for children from low-income households. Head Start has demonstrated success, but budgetary constraints that have reduced its reach and waiting lists are often long. Universal pre-K programs have also demonstrated cost effectiveness and academic benefits for children in some states, but there has been little movement toward a national pre-K program to date. Most of these programs are targeted to nearly school age children and families living below the poverty line, leaving a number of critical child development years and families behind (Zigler and Muenchow 1992).

Despite evidence that universal day care throughout Western Europe fosters early childhood development, and despite evidence that readily available good child care prompts mothers and fathers to remain employed, there has been little movement by the US toward universal or expanded subsidized child care (Crittenden 2001; Gornick et al. 1997). Over the decades, aging and life course scholars have concluded that providing accessible and affordable child care is one of the most important strategies for improving income security, particularly for women, both in the short run as they are raising their children and in the long run as they reach old age and rely on their Social Security, private pensions, and private savings.

Discussion

As aging and life course scholars continue to analyze changing trends, and somewhat unresponsive social policies, they will work to place gender, race, class, and marital status inequality at the center of those analyses. While some gender differences have narrowed, they have not disappeared and show no signs of doing so. Moreover, many differences due to other factors such as race and marital status are increasing. Our social policies have not kept pace with key demographic changes, particularly the increase in single mothers and in employment among mothers. Though policy solutions are discussed, few are acted upon, in part because there is debate about the best way to minimize inequality in old age and in part because business interests play a central role in the development of contemporary policies (Crittenden 2001; Moon with Herd 2002; Harrington Meyer and Herd 2007). Americans tend to avoid wholesale policy shifts in favor of more incremental changes. Expanded social policies for younger family, particularly paid family leave, increased flexibility options, and

flexible, affordable, and high-quality day care would go a long way toward assuring that vulnerable people were less likely to arrive at old age with relatively few resources. But such proposals are rarely considered seriously and are often preemptively silenced by powerful business interests, those who favor the traditionally gendered division of labor, and those who prefer gender neutral welfare state policies. If house work and care work for the young and old alike were sufficiently revalued, encouraging men and women to do their share, it would help married and cohabitating women. But even then, many families, and nearly all single women, who continue to bear the economic burden of providing care work, would benefit from stronger social supports across the life course.

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Chapter 18
Developing Age-Friendly Communities: New Approaches to Growing Old in Urban Environments

Chris Phillipson

Developing what has been termed "age-friendly" communities has become a significant issue for social policy, embracing questions ranging across urban as well as rural environments. The reasons for such attention are not hard to discern and will be assessed in some detail in this chapter. In brief, however, they include: first, the complexity of demographic change, with the emergence of a wide spectrum of housing and community needs among those in the 50 plus age group. Second, the pressures affecting different types of localities, with the impact of accelerated urbanization for some and deindustrialization for others. Third, is acceptance of the importance of the physical and social environment as a factor influential in maintaining the quality of life of older people (Wahl and Oswald 2010). Fourth, is the policy debate about what constitutes "good" or "optimal" places to age, as reflected in the work of the World Health Organization (WHO) around "age-friendly" cities, these defined as encouraging: "…active ageing by optimizing opportunities for health, participation and security in order to enhance the quality of life as people age" (WHO 2007:1).

Despite the importance attached to building age-friendly communities the approach itself requires better understanding and elaboration at conceptual and operational levels. Some important and critical questions that might be raised include:

- How does the age-friendly theme link to research covering environmental issues and aging?
- What are the origins of the age-friendly approach within social and public policy?
- How viable is the idea given the extent of change operating within communities?
- What needs to be done to make age-friendly communities a realistic option for older people?
- What are some of the barriers that might be encountered in attempting to implement the policy?

The above questions will be examined in the context of the process of urbanization affecting communities across the world. Population aging and urbanization have in their different ways become the dominant social trends of the twenty-first century, with their interaction raising issues for all types of communities – from the most isolated to the most densely populated. By 2030, two-thirds of the world's population will be residing in cities; by that time the major urban areas of the developed world will have 25% or more of their population people aged 60 and over. Cities and the metropolitan regions of which they are a part are themselves changing. Soja and Kanai (2008:58) use the term "global city region" to refer to a: "…new metropolitan form characterized by sprawling polycentric networks of urban centres clustered around one or more 'historic' urban cores". Such networks vary in size from one million at the lower level to ten million and beyond at the upper, covering well over a billion of the world's residents.

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Accelerated urbanization brings advantages and opportunities of different kinds. Soja and Kanai (2008:68) note the extent to which: "Dense and heterogeneous cities and city regions have become the driving forces of the global economy, generating enormous wealth as well as technological innovation and cultural creativity". Cities are regarded as central to economic development, attracting waves of migrants and supporting new knowledge-based industries (Savage et al. 2003). The rebuilding of many cities – notwithstanding economic recession – provides opportunities for innovations in housing and services suitable for a range of age and income groups (Rogers and Power 2000). However, the extent to which the "new urban age" will produce "age-friendly" communities remains uncertain. Cities produce advantages for older people in respect of easy access to medical services, provision of cultural and leisure facilities, shopping and general necessities for daily living (Katz et al. 2008). However, they are also seen as threatening environments, often creating insecurity and feelings of vulnerability arising from changes to neighborhoods and communities. Assessing the challenge of creating age-friendly communities within urban environments is the central aim of this chapter. The discussion is organized under the following headings:

- What have been the main approaches used by sociologists to understand the impact of physical and social environments on older people?
- What have been the main factors driving the debate on creating age-friendly cities?
- How age-friendly is the urban environment?
- What are the options for improving urban environments for older people?
- What are the restrictions and barriers likely to be encountered implementing an age-friendly policy?

The chapter will conclude with a brief summary of the arguments and provide an assessment of the next stage in the research and policy debate.

Environmental Issues and Aging

The environmental context of aging – and issues relating to place and location in particular – has resurfaced as a major theme within the sociology of aging. Drawing on classic studies from Rosow (1967), Rowles (1978), Lawton (1980), and others, environmental gerontology is presented as developing a systematic approach to understanding the physical and spatial contexts influencing people through the life course (Wahl and Weisman 2003). The theoretical questions examined in this body of work include: the influence of the physical environment on the aging self (Wahl and Lang 2006); the impact of neighborhood characteristics on health and well-being (Krause 2004; Smith 2009); the relationship between place and identity (Rowles 1978; Laws 1997); and the impact of urban change on social networks in later life (Deeg and Thomése 2005; Phillipson et al. 2000). These and related questions have emerged as influential themes within social gerontology, and have stimulated diverse empirical projects with a comparative as well as single-country focus (Phillips et al. 2005; Rodwin and Gusmano 2006). Interest in the effects of the physical and spatial environment has been a long-standing feature of research into aging with studies covering:

- "Integration" vs. "segregation" debates in the field of housing.
- Theoretical models examining person–environment interactions.
- Research on attachment to place and the construction of identity.
- The impact of community and neighborhood change.

The field of housing provided the initial focus for research, with studies in the 1950s and 1960s using this topic to explore arguments around "age integrated" vs. "age segregated" communities (Kleemier 1956; Webber and Osterbind 1960). Such debates reflected competing theories in social

gerontology during this period – notably activity and disengagement theory (see Marshall and Bengtson this volume) – which presented contrasting hypotheses about the degree to which older people wished to remain part of mainstream society (Friis et al. 1968). An additional factor influencing this work, however, was the rapid development of retirement communities – from the 1950s onwards – in Florida, California, and beyond. Such communities raised issues about the advantages of "age dense environments" for older people, especially regarding security, recreational facilities, and access to specialist support (Streib et al. 1986). This work was subsequently extended with researchers, such as (Rosow 1967) and Teaff et al. (1973), examining the benefits for friendship formation and reduced isolation arising from different types of age-mix within public and private housing.

By the 1970s researchers had moved on from focusing on the advantages and advantages of specific housing arrangements or types, to modeling the way in which older people might be influenced by their physical environment. In particular, the Lawton and Nahemow (1973) "press-competence" (PC) model was widely adopted as an approach to understanding person–environment relationships (Schiedt and Norris-Baker 2004; Oswald et al. 2005). The approach taken by the model is that individual behavior and satisfaction are contingent upon the dynamic balance between the demand character of the environment (press) and the individual's ability to deal with that demand (competence). With this approach, those with low competence encountering strong environmental press are more likely to have maladaptive behavior compared with those having high competence encountering weak environmental press where behavior is likely to be positive (Lawton 1980). The PC model, along with its variants (see, for example, Carp and Carp 1984), has been especially influential in examining the extent to which a mismatch between environments and basic needs can undermine emotional well-being and mental health (Kahana 1982). Peace et al. (2007) highlight the extent to which this work has been dominated by studies of age segregated settings (such as in residential homes), with a particular focus on the impact of lack of privacy and control in creating stress-inducing environments.

The person–environment tradition became the dominant paradigm in environmental gerontology in the 1970s and 1980s, and has retained its influence (Wahl and Oswald 2010). Through the 1980s and 1990s, however, further approaches emerged, drawing on perspectives from cultural and human geography and urban sociology (Rowles 1983; Laws 1997; Peace et al. 2007). These raised issues both about the meanings individuals attach to their environment as well as the structural forces affecting communities and neighborhoods. Rowles (e.g. 1978, 1993) has been especially influential on the first of these, applying phenomenological perspectives to an understanding of the impact of environment on self-identity. His work has drawn attention to the way in which attachment to particular places – such as home and neighborhood – accumulate over time, creating what he views as an inherent "body awareness" of the physical configuration of the environment. According to Rowles (1978:163), this has important implications for aging in place as the "lessons learned through repeatedly traversing familiar space facilitate… continued participation in environments which might otherwise have been almost impossible to negotiate". Rowles (1978, 1983) developed the term "insideness" to refer to the different types of attachment that people maintain to their environment. These include the "*physical insideness*" already referred to but also *social insideness* arising from everyday social exchange over long periods and *autobiographical insideness* reflecting the way in which place can become "a landscape of memories" which can assist in the maintenance of identity in old age (Rowles 1983:114).

At the same time, attachment to the environment may itself be compromised by structural changes affecting communities, these undermining the strategies identified by Rowles for maintaining identity in old age. This may be especially the case in urban environments marked by a rapid turnover of people and buildings, and in unpopular urban neighborhoods characterized by low housing demand and abandonment by all but the poorest and least mobile residents (Wacquant 2008). Here, urban sociology drawing on the Chicago School has provided an important intellectual

framework with a range of studies examining problems of aging within inner-city contexts (e.g. Townsend 1957; Birren 1969; Cantor 1975; Stephens 1978; Phillipson et al. 2000; Smith 2009). This work has been extended over recent years, with studies examining the impact of economic recession on inner-city areas (Ogg 2005; Scharf et al. 2002). Such research has been further linked to issues of inequality and racial discrimination affecting minority groups in metropolitan districts (Smith 2009).

The various strands of research identified above have been especially important in highlighting the influence of environmental change at meso- and microlevels. However, the narrow focus of research within most of the approaches raises problems given the larger-scale forces affecting urban communities. Much of the "integration/segregation" debate was itself applied to a limited range of housing-related issues, drawing on theoretical models now largely discredited within the field. The person–environment perspective remains important but its testing has been confined to institutional or domestic settings and, as with phenomenological approaches, this approach is poorly equipped to deal with change at a macrosociological level. Even research examining problems of older people in urban areas such as inner-cities, while exploring issues about the impact of global change, has yet to incorporate findings into a coherent theoretical model.

At the same time, the need for an approach linking different levels of environmental change is especially urgent given the pressures affecting many of the communities in which older people live. In this chapter, the idea of "age friendly" communities is used as way of exploring macro-, meso- and microlevels of change affecting older people. The next section examines some of the main factors behind the development of this approach.

Developing Age-Friendly Communities

Debates about securing optimum community environments for aging populations emerged from a number of organizations during the 1990s (Evans 2009). The theme of age-friendly communities arose from policy initiatives launched by the WHO. A precursor was the notion of "active ageing" developed during the United Nations' Year of Older People in 1999 and elaborated by the European Union (1999) and the WHO (2002). The idea of maintaining "active ageing" referred to the notion of older people's "continuing participation in social, economic, cultural, spiritual and civic affairs, not just the ability to be physically active or to participate in the labour market" (WHO 2002:12). Achieving this was seen as requiring interventions at a number of levels, including maintaining effective supports within the physical and built environment. Here, the WHO (2002) acknowledged that:

Physical environments that are age-friendly can make the difference between independence and dependence for all individuals but are of particular importance for those growing older. For example, older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness, and increased mobility problems (P. 27).

The theme of age-friendly environments was subsequently applied to urban contexts, with work beginning in 2005 around the theme of "Global Age-friendly Cities". Subsequent work by the WHO, based upon focus groups with older people, caregivers, and service providers, produced a guide and checklist of action points focused on producing an "ideal" city relevant to all age groups. This work concluded that: "It should be normal in an age-friendly city for the natural and built environment to anticipate users with different capacities instead of designing for the mythical 'average' (i.e. young) person. An age-friendly city emphasizes enablement rather than disablement; it is friendly for all ages and not just 'elder-friendly' (WHO 2007:72)."

Such ideas were consistent with new perspectives influencing urban development over the course of the 1990s and early 2000s, notably ideas around "sustainable" (Satterthwaite 1999) and "harmonious cities" (UN-Habitat 2008). The former raised questions about managing urban growth in a manner able to meet the needs of future as well as current generations. The idea of "harmonious" development emphasized values such as "tolerance, fairness, social justice and good governance" (UN-Habitat 2008), these regarded as essential in achieving sustainable development in urban planning. These themes were also influential in the elaboration of ideas associated with "lifetime homes" and "lifetime neighbourhoods" (Department of Community and Local Government 2008; Atlanta Regional Commission 2009), which emerged alongside recognition of the need for more systematic interventions to support population aging at a community level. An additional influence was recognition of the development in many localities of what has been termed "naturally occurring retirement communities" (NORCS), i.e. neighborhoods that, with the migration of younger people, have effectively evolved into communities of older people. The key issue behind the "lifetime" concept was an understanding that effective support for older people within neighborhoods would require a range of interventions linking different parts of the urban system – from housing and the design of streets to transportation and improved accessibility to shops and services (see further below).

Finally, the extent to which environments are "age-friendly" or "hostile" to groups such as older people has been raised in theoretical debates around globalization and its influence on the routines and structures influencing everyday life (Phillipson 2007). One view of the impact of globalization, identified in the research literature, is that it has fragmented and distorted the experience of community and place for older people and other social groups. Rather than the mutual solidarities presented as typical of locality ties in the 1950s and 1960s, community life is now regarded, in the words of Beck (2000), as "unsettled [and] friable". In Bauman's view (2001:47), the present period is best characterized as "times of disengagement": "Gone are most of the steady and solidly dug-in orientation points which suggested a social setting that was more durable, more secure and more reliable than the time-span of an individual life". More generally, some commentators have presented such changes as reflecting the decline of "social capital" or the "disembeddness" of individuals and families from a stable community existence (Putnam 2000; Blokland 2003; Charles et al. 2008).

The link between globalization and themes associated with rootlessness, mobility, and impermanence have become familiar and might be judged as a factor undermining the development of age-friendly communities. An alternative view, however, would be that many of the changes associated with globalization, and its consequences for urban environments in particular, reinforce the need to rethink the way communities provide support through the life course. This is especially important given evidence about the significance of the physical environment in the lives of older people, as well as evidence from research about its influence on the quality of life in old age. A review of this aspect follows below, together with a survey of research findings on the impact of urbanism on older people.

How Age-Friendly is the Urban Environment?

Pressures and Constraints of Urban Living

Physical environments are significant influences for all age groups, but may be especially important for the old and young with the former becoming increasingly reliant on their immediate community. Wight et al. (2009) suggest that there are good reasons to expect that with increased age there is increased vulnerability to the "press" (see above) of the neighborhood environment. Glass and

Balfour highlight four mechanisms that may be at work: "longer duration of exposure; increased biological, psychological, and cognitive vulnerability; changing patterns of spatial use; and reliance on community sources of integration" (cited in Wight et al. 2009:247). Older people may in fact be especially sensitive to changes to the physical and built environment, given its significance for the maintenance of identity, and because of the length of time spent at home – 80% of the time of those 70 and above according to one study (Horgas et al. 1998).

Older people may experience urban areas as "unfriendly" for a variety of reasons – many of these shared with other age groups but in some cases experienced in a more intense form because of the vulnerabilities associated with age. Brown et al. (2009:235) highlight a number of research findings demonstrating that older adults residing "in physically deteriorated neighborhoods [are more likely] to perceive that social support is less available to them…[in comparison with] elders who reside in better-maintained neighbourhoods". The authors also note the extent to which problems associated with the built environment (such as poor maintenance of buildings, limited access to shops and facilities within the neighborhood) have been shown to increase levels of psychological distress even after controlling for variables such as age, gender, and financial strain. Neighborhoods characterized by high levels of economic and social deprivation may present a particular challenge to older people. This can in part be attributed to the relatively high rates of both personal and property crime that characterize such neighborhoods (Smith 2009). The experience of crime and the fear of being a victim of crime can act as direct barriers to the maintenance of a "normal" daily life for many older people. As a consequence, older people may be less likely – especially in inner-city areas – to leave their homes after dark (Phillipson et al. 2000; Scharf et al. 2002). There may even be some parts of neighborhoods, such as parks and cemeteries, which are effectively out of bounds to older people even during daylight hours (Smith 2009).

Older people may be especially susceptible to problems arising from poor-quality housing (Hunt and McKenna 1992; Department for Communities and Local Government 2008; Brown et al. 2009). In England, 33% of homes occupied by older people fail the official "decent homes standard" (Evans 2009). Particular types of urban housing have been linked to mental health problems in later life. Research in the USA found that elderly residents living in high-rise dwellings were more depressed, had higher rates of psychiatric disorder, and were more socially isolated than those living in detached homes in the community (Husaini et al. 1991). Evandrou (2003) highlights housing problems faced by older people living in Inner London where high density terraced housing damaged during the Second World War was replaced with high-rise flats:

Many of these were erected during (the 1950s) and the 1960s and their tenants have aged with them. Flats that were suitable for people earlier in their life course are no longer suitable for them in later life. Poor communal infrastructure, with lifts that frequently break down, entry phones subject to vandalism and graffiti-ridden communal landings all serve to heighten older people's sense of isolation and exclusion (P. 3).

Studies of older people in inner-city areas have identified the ways in which they can be affected by the side effects of population turnover and pressures on public space (Hannan Foundation 2001; Scharf et al. 2002; Newman 2003; Smith 2009). At the same time, we might also consider the extent to which contemporary urbanization creates extreme pressures on everyday living for certain groups. Klinenberg (2002) examined the 1995 heat wave in Chicago that over 1 month alone killed around 600 people, of whom three-quarters were aged 65 and over. As well as the acute factors that caused such high rates of mortality among the old, the author noted chronic attributes of the urban environment that reduced the quality of life of elderly residents:

In recent years, a number of studies have shown that older people living in violent and deteriorated urban areas tend to be more isolated and afraid of crime than those in more robust regions. Among the mechanisms producing this concentrated fear and isolation in ecologically depleted and politically underserved places are the lack of local commercial venues and service providers to draw people into the streets; barriers to physical mobility, such as broken stairs, crumbling sidewalks, and poor lighting;

the psychological impact of living among signs of disorder; indifferent government agencies who neglect the local infrastructure; and the decrease of trusting and reciprocal relationships in areas with high levels of crime.

Restrictions on daily living, as detailed in the research, were reinforced by degraded public space, a product of abandoned buildings, poor-quality infrastructure, and the loss of local businesses – "institutional disengagement" in the words of Herbert Gans (1972). Such conditions became especially perilous for older people when matched by declines in health and social support networks. Newman (2003) illustrated this in her research on older people in inner-city New York, where she argues that, unlike younger people and families who move in and out of neighborhoods, for older people "the home place sets the tone for their daily lives" (Newman 2003:198).

The structure of the modern city also raises issues for groups such as older people. Mike Davis (2002) highlights the development of a "post-urban metropolis" where traditional central-place functions (culture and sports, government, shopping and administration) are radically dispersed among different locations. Along with this, he points to the emergence of "dead cities" stripped of the functions and activities that contribute to the maintenance of lively and diverse public spaces, or what Jane Jacobs (1961) referred to as the "daily ballet" of city sidewalks safe from "barbarism and fear". In Davis's world, by contrast, pedestrian expeditions become an ordeal for young and old alike in cities dominated by cars. Geographical disparities within urban areas may lead to age-and class-segregated neighborhoods, with significant tensions between the needs of groups at different stages of the life course (Rogers and Power 2000).

Sassen (2001) has identified the way in which large cities concentrate both the leading sectors of global capital, along with a growing share of disadvantaged populations (see also Rodwin and Gusmano 2006). Cities, she argues, have become a strategic terrain for a series of conflicts and contradictions – among which the management and support of vulnerable populations is one of the most acute. In like vein, Wacquant (2008:257) refers to what he terms the appearance of "advanced marginality" within urban areas, with the multiplication of "unstable social positions [with] vulnerable populations at an increasing remove from the middle and upper tiers of the structure of classes and places".

An important question concerns the extent to which the construction of the modern (or late-modern) city as the "site for the new consumerism" (Savage et al. 2003:149) results in social exclusion for groups such as older people. Rodwin, Gusmano, and Butler (2006:7) make the point that while world cities offer extensive cultural and entertainment opportunities, they are expensive places in which to live. They illustrate this point by citing a study of New York City that found that only 1-in-20 older households had sufficient money to take full advantage of the quality of life offered by the city. Comparable data is unavailable for British cities, although a relevant finding from the English Longitudinal Study of Ageing (ELSA) for the Social Exclusion Unit was that a larger percentage of older people living in London than in the rest of the country experienced multiple types of poverty and deprivation (ODPM 2006). This is consistent with an analysis of global cities that emphasizes the increasing divergence of the lifestyles and opportunities of wealthy and poor residents, itself a manifestation of growing inequalities linked to social class, ethnicity and, in some respects, age (Gordon and Townsend 2000).

The Benefits of Urban Environments

The pressures associated with urban environments appear to be well documented, and would seem to pose a considerable challenge for implementing an age-friendly approach. On the other hand, the advantages – both existing and potential – of urban areas for supporting aging populations must also be highlighted: First, the resources characteristic of urban economies suggests major opportunities for developing policies of relevance to a more diverse population of older people. Mike Davis

(2002), despite emphasizing the crisis affecting many urban environments, reminds us nonetheless of the facilities they provide, notably in respect of libraries, museums, parks, and communal spaces. He contrasts the "public affluence" of cities with the limits of "privatized consumerism", viewing the former as able to challenge some of the worst excesses associated with the latter. In similar fashion, Smith (2009) points to the cultural and social diversity associated with urban living, with cities able to develop spaces and places associated with different lifestyle choices. Cities can thus present a supportive environment to groups with specialist needs and interests, an aspect that may be especially valued by groups in later life.

Second, even in areas of high economic and social deprivation (such as those in the study by Scharf et al. 2002), older people may report a strong sense of identification with their community. In the Scharf et al. (2002) study of three districts in major cities of the United Kingdom (Liverpool, London and Manchester), three out of four respondents identified positive features about their neighborhood, with most of these commenting on the presence of good neighbors, friends, and family. More than three-quarters of respondents indicated that they had at least one friend in their neighborhood. Of those people with local friends, almost half had a chat or did something with a friend every day.

Third, rather than providing limited social support, urban environments may, as the above would indicate, offer assistance from a wider range of networks as compared with rural areas. Friendship networks, for example, appear to be especially robust in urban communities and may offer an important support mechanism for those who are single or widowed (Phillipson et al. 2000). Urban settings are of particular importance to migrant groups, especially in respect of access to special forms of cultural, social, religious and economic support.

Fourth, although much of the discussion thus far has emphasized the problems associated with urban living, this environment may also represent advantages for those moving into retirement. Ogg and Bonvalet (2007) make this point when examining residential preferences among the baby-boom generation (those born between 1945 and 1955) living in inner-city London and Paris. They highlight in particular the experience of those who chose to move to the city when starting their careers. Among this group are the "pioneers" of gentrification (i.e. house improvements) within inner-cities who benefited from the rise in property values associated with urban regeneration. Some in this group may well have "second homes" in the county, with dividing their time between the "the city" and "the country" becoming a preferred strategy to leaving the urban environment altogether. The city may thus retain its appeal for those who moved earlier in their lives from provincial towns or rural areas. Conversely, "local inhabitants", who were born in and who have spent most of their life living in and around a particular urban area, may be more divided about the changes affecting their locality. Nonetheless, even among this group, despite concern with changes in the population and the apparent loss of social cohesion, attachment to life in an urban environment appears strong (Ogg and Bonvalet 2007).

Constructing Age-Friendly Communities

Creating a better "fit" between urban environments on the one side and aging populations on the other is assuming some urgency within social policy. The WHO (2007:4) develops the point that "making cities more age-friendly is a necessary and logical response to promote the well-being and contributions of older urban residents and keep cities thriving". Equally, measures to support the inclusion of elderly people within cities must be viewed as a key part of the agenda for creating sustainable and harmonious urban environments. Implementing this agenda will, however, demand radical interventions across urban areas. A number of themes can be identified here:

- First, developing new forms of "urban citizenship" which recognize and support changing social needs across the life course.
- Second, understanding the dilemmas of the urban environment in terms of the changing needs of the body.
- Third, developing an age-friendly approach within the context of lifelong/lifetime communities.
- Fourth, ensuring the engagement of older people in the replanning and regeneration of neighborhoods.

The first argument concerns the need to link the discussion about age-friendly cities to ideas about urban citizenship and rights to the benefits which living in a city brings. Painter (2005), for example, cites the work of Henri Lefebvre, who explored issues relating to citizenship and rights in an urban context (see also Holston 1999; Soja 2010). Lefebvre stressed:

The use-value of the city over its exchange value, emphasizing that citizens have a right to make use of the city, and that it is not just a collection of resources to enable economic activity. The uses of the city by citizens should be seen as valid ends in themselves, not merely as a means to produce economic growth. The right to the city is the right to live a fully urban life, with all the liberating benefits it brings. [Lefebvre] believed the majority of city residents are denied this right because their lives are subordinated to economic pressures – despite being *in* the city, they are not fully *of* the city (P. 9).

This last point applies especially well to older people, who may find that despite having contributed to an urban world in which they have spent most of their life, it may present major obstacles to achieving a fulfilling existence in old age. On the one hand, cities are increasingly viewed as key drivers of a nation's economic and cultural success. On the other hand, the reconstruction of cities is often to the detriment of those outside the labor market, especially those on low incomes (see further below). Achieving recognition of the needs of different generations within cities, and exploiting the potential of the city for groups of whatever age, will be central to implementing an age-friendly approach.

Second, linking "age-friendliness" with "urban citizenship" also draws attention to changing needs associated with age, and in particular recognition of the frailty of the human body. Geographical perspectives on cities assert that "all urban dwellers have to negotiate the city *practically* [author's emphasis], and work through the dilemmas, problems, and possibilities of 'getting by' in the city" (Hubbard 2006:113). And feminist perspectives on the use of urban space highlight the way in which "women's spatial practice is constrained by geographies of violence and fear" (Tonkiss 2005:94–95). Such ideas, and the extent to which older people are to some degree "prisoners of space" (Rowles 1978), are especially relevant to aging in the city – both in global cities undergoing accelerated change and those cities facing deindustrialization. Both contexts raise dilemmas in the context of mental and physical vulnerabilities. Elderly men and women may experience difficulties "creating" space within cities. Global cities raise tensions between a "hypermobile" minority and those aging in place; deindustrializing cities (with shrinking populations) create problems arising from the withdrawal of an economic base which can maintain sustainable networks for different social groups. The challenge here then is creating an urban environment that supports the autonomy of the aging body and the equal rights of older people with others to a "share" of urban space. This issue will be especially important to implement at a local level, with a particular focus on improving the quality of urban design and promoting safety and inclusion as key features of urban living.

Third, some of the issues associated with the above are being developed through the ideas associated with lifetime communities and neighborhoods. In planning for lifetime neighborhoods Harding (2007:8) suggests the need to consider:

- Accessibility of the built environment.
- Appropriateness of available housing.

- Fostering social capital.
- Location and accessibility of services.
- Creating esthetically pleasing public spaces which promote a sense of place and social cohesion.
- Cross-sectoral integration and planning of services.
- Building intergenerational relationships by shared site usage.
- Better use of information technology.

Work by the Atlanta Regional Commission (ARC) (2009:7) made the point that although mobility begins inside the individual unit or house, it must carry on throughout the entire built environment ". . . from inside the dwelling, down the street, and into the restaurant, theatre or store . . . continuously across the entire urban environment". This argument applies equally to all types of communities – suburban as well as inner and outer city. In relation to suburbs, for example, these have frequently been designed with families and commuters in mind, rather than the specific needs of older people and/or smaller households. There is scope here to explore the urban design implications of a different population mix together with neighborhoods that explicitly have a longer lifespan. Strategic guidance on urban design might be developed further to indicate how "lifelong" adaptability for an aging population can be built into communities from the start (Brook Lyndhurst 2004).

Fourth, a critical issue for an "age-friendly" approach concerns ensuring the involvement of older people in urban regeneration policies. A study in the United Kingdom by Riseborough and Sribjilanin (2000) found that older people were often "invisible" in regeneration policies. The problem here was less the absence of older people in consultations around policies, more an underlying "ageism" which viewed them only as "victims" of neighborhood change. Again, this goes back to the argument from Rowles (1978:216) of the "need to break free from prevailing social attitudes, which have served to alienate the elderly and to install within us a view of their lives as one of inevitable spatial withdrawal". Riseborough and Sribjilanin (2000) make the point that regeneration practice could benefit from the experience of older people, their attachment to their neighborhoods, and their involvement in community organizations. At the same time, there is also a need to develop urban regeneration strategies targeted at different groups within the older population, with awareness, for example, of contrasting issues faced by different ethnic groups, people with particular physical/mental health needs, and those living in areas with poor housing alongside high population turnover.

Obstacles to an Age-Friendly Perspective

Despite the benefits of applying an age-friendly approach, some critical questions also need to be faced to ensure effective implementation of such a policy. At the present time, discussions around age-friendliness have been largely disconnected from the pressures on urban environments in the Global North, where private developers remain the dominant influence on urban planning (Solnit and Schwartzenburg 2003; Minton 2009). The result, according to Harvey (2008:31), is that the "quality of urban life has become a commodity, as has the city itself, in a world where consumerism, tourism, cultural and knowledge-based industries have become major aspects of the urban political economy". Blokland and Savage (2008:38) argue that such processes are leading to a different type of urbanism, one that is "confirming rather than challenging inequalities within cities". The tension here is between the social needs of older people, as an increasingly important constituent of urban populations, and the pressures on public space arising from private ownership. This may lead to a distortion in provision in terms of meeting the needs of competing groups within the urban system (Tonkiss 2005; Minton 2009).

A second important issue concerns applying "age-friendliness" in a way that recognizes the complexity of the urban environment. The techniques for ensuring an age-friendly approach will vary considerably depending on the characteristics of urban change and development. While the trend towards urban living is world-wide, the pattern of urban growth demonstrates huge variation: shrinking city populations in the developed world (Europe especially); and accelerating urbanization in Africa and Asia, with both continents demonstrating a mix of rapidly expanding cities in some cases, declining ones in others (UN-Habitat 2008). "Age-friendliness" will also need to reflect the size of a city: The approach might, for example, be different in Europe where small cities with fewer than 500,000 residents are the norm, as compared with the USA where large urban agglomerations (with populations of between two and five million) are much more common. Securing "age-friendliness" in the context of the rise of "mega-cities" and "hyper-cities" (the latter with populations of 20 million or more) provide another variation. At the same time, processes for developing "age-friendliness" will need radical adaptation given the "slum cities" prevalent in Southern Asia and sub-Saharan Africa (UN-Habitat 2008). The bulk of population growth in these continents has taken place largely through the rise of slums, many of these located on the periphery of capital cities (Davis 2006). The problem of reaching older people and migrants who are "ageing in place" and housed in temporary accommodation bereft of basic facilities, underlines the need for new models of intervention which can respond to the highly unequal contexts experienced by the urban elderly across the world.

A third issue concerns linking the debate around environmental change with that concerned with urbanization and population aging. The vulnerability of older people in periods when urban environments are challenged through extremes of temperature has already been highlighted. But other problems may also be cited. Air pollution is a major hazard, especially in newly industrializing countries in the Global South. WHO estimates that more than one billion people in Asia alone are exposed to outdoor air pollutant levels that exceed WHO guidelines, leading to the premature death of half a million people annually. Older people, especially those with chronic health conditions – these exacerbated or caused by environmental degradation – will be among the worst affected in terms of their quality of life. Looking ahead, rising sea levels associated with climate change may bring particular risks for older people living in cities. Fourteen of the world's 19 largest cities are port cities located along a coastline or river delta. In Asia, the dominance of port cities is even greater; 17 of the region's 20 largest cities are coastal or on a river bank or in a delta. Many of the world's most prominent global cities (e.g. Mumbai, Shanghai, New York City) will be among the most exposed to surge-induced flooding in the event of sea level rise (UN-HABITAT 2008:141). The consequences for their substantial populations of elderly and very elderly people are immense, and will require detailed planning and assessment. Older people are especially vulnerable in periods of environmental crisis, with the potential for displacement from their home, from relatives, and services and support (Rodwin and Gusmano 2006). These aspects were clearly demonstrated in crises such as Hurricane Katrina in the USA (Bytheway 2006) and the 2003 heat wave in France (Ogg 2005). In both cases, elderly people were disproportionately affected compared with other age groups, but failed to receive the special help and assistance required. In these instances, environmental disaster undermined the ability of urban areas to respond quickly and effectively to the needs of their elderly habitants.

Conclusion

Securing age-friendly cities remains an important goal for economic and social policy. The future of communities across the world will in large part be determined by the response made to achieving a higher quality of life for their older citizens. A crucial part of this response must lie in creating

supportive environments providing access to a range of facilities and services. However, the research and policy agenda will need to change in at least three ways if this is to be realized: First, the issues raised by developing age-friendly communities within complex urban environments will require a more coherent link between research and policy than has thus far been achieved. Research on environmental aspects of aging has an impressive literature to its name, yet it remains detached from analyzing the impact of powerful global and economic forces transforming the physical and social context of cities. As remedy, this will require closer integration with developments in disciplines such as urban sociology, urban economics, and human geography. Understanding optimum environments for aging must be seen as an interdisciplinary enterprise requiring understanding of the impact on older people of developments such as the changing dynamics of urban poverty; the impact of urban renewal and regeneration; the influence of transnational networks; and changing relations between different class, gender, ethnic, and age-based groups.

Second, in keeping with the approach taken in this chapter, given the rapid changes affecting many urban areas, new approaches to understanding older people's relationship to urban change – and city development in particular – is urgently required. In particular, there is a strong case for more research in "urban ethnography" to capture the disparate experiences of those living in cities that are now experiencing intense global change and that are strongly influenced by complex patterns of migration on the one side and population aging on the other. Sassen (2000:146) pointed to the need for detailed fieldwork as a "necessary step in capturing many aspects of the urban condition" (see also Wacquant 2008); such work will be especially important for understanding the impact of urban growth on groups such as migrants aging in place, single people, and those on low incomes. Urban sociology was founded (through the work of the Chicago School from the 1920s) upon detailed studies of experiences of urban life, particular of disadvantaged and insecure people from different migrant populations. Ethnographies would bring to the surface the attitudes, motivations, and experiences of older people who are "ageing in place" and will deepen our understanding about the way in which cities are changing, and about the positive and negative contributions that the changes have on the quality of daily life in old age.

Thirdly, it might be argued that the benefit of thinking about age-friendliness lies more in its challenge to reassessing the values (and ideals) that might be nurtured within urban communities. From the 1960s onwards, writers such as Jane Jacobs (1961) and Richard Sennett (1970) argued the case for celebrating the diversity of city life. Giradet (1999:424) put forward his vision of the city "as a place of culture and creativity, of conviviality and above all else of sedentary living". In the United Kingdom, Richard Rogers and Anne Power (2000) developed a new approach to urban planning, one calling for a sharing of spaces for the collective good and for a reversal of the drift towards suburbanization. All of these – and similar ideas – are relevant to developing age-friendly cities and arguably need closer integration to the sociology of aging. Thus, despite the many obstacles to implementing this approach, its potential for reminding us of the values to be nurtured for harmonious city living are important and certainly relevant for building communities fit for populations of older people.

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Part VI
Economies, Government, and Aging

Chapter 19
Crises and Old Age Policy

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The theme of crisis is a central motif resonating throughout the contemporary U.S. welfare state that is particularly salient for old age politics and policy. To understand these issues, analysis must attend to crisis construction and crisis management by the state and the role of other interests and actors in the economic, political, and civil sectors of society.

During the past three decades, much has been written about crises related to old age and aging. Perspectives on crises surrounding aging span the topics of individual human development, the family, demographic and population aging, health, health disparities, health costs, social inequalities, and national and global economics, among others.

The perspective in this chapter draws from the framework of critical theory as incorporated and reflected in critical gerontology and the political economy of aging. Critical theory is "designed with a practical intent to criticize and subvert domination in all its forms" (Bottomore 1983:183). For critical gerontology, "the overall project … has been to provide alternative theoretical frameworks and emancipatory knowledge, address[ed] toward concerns of social inequalities and social justice" (Estes and Phillipson 2007:330–1). The political economy of aging is employed to understand the stakes of the state, capital, and democracy (citizens and the public) in the constructions of old age policy and politics in crisis.

Working within variants of this critical approach, the processes of aging and societal aging may be analyzed as a crisis, a problem, a triumph, or some version of all three. The study of beliefs, values, and ideology is central to understanding competing constructions of reality regarding old age and societal and global aging. These constructions signal whether and how old age and aging are defined as issues, problems, and crises (or not) as well as whether or which lines of public or private action are considered appropriate or even feasible.

Critical gerontology draws from a *conflict perspective* that posits that the social order is held together by the dominance of certain interests and groups over others (Weber 1946; Estes, Swan, and Gerard 1982; Collins 1988). Power struggles and their outcomes shape how society is organized, its key institutions, institutional functions, and resource allocations. The social order (the status quo) is held together by constraint rather than by consensus. The most powerful impose their ideas, material interests, and actions on the less powerful. The state and its key agents in their multiple institutional forms (e.g., legislative, executive, judicial, military, and educational) also actively participate in these power struggles (Skocpol 1992). Key actors and interests that comprise the economic system of capitalism and its multiple sectors (e.g., the medical industrial complex, the military industrial complex, and the prison industrial complex), political parties and organizations, and the public (including communities of color, gender, and disability) are major forces in combat.

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Crisis Defined

As "turning points" in which preexisting relationships and meanings can no longer be assumed, crises are "moments of truth" that signify "the restructuring of social relationships that occurs when new power centers confront existing structures of domination; the outcome is generally unknown and existing institutions and social practices can no longer be taken for granted" (O'Connor 1987:54–5).

Critical theorists weave together individual and system level crisis theories in ways that implicate the political, economic, and socio-cultural realms (Habermas 1975; Offe and Keane 1984; O'Connor 1987). O'Connor posits "that modern economic, social, political, and cultural crises interpenetrate one another in ways which transform them into different dimensions of the same historical process … [and] the modern crisis becomes one 'general crisis'" (pp. 11, 54). Habermas explores crisis tendencies specific to advanced capitalism that originate in the political and socio-cultural as well as the economic system. Offe and Keane posit the centrality of state political and administrative power for understanding crisis tendencies in light of the state's coordination and "steering" problems (see below).

Ideology and Crisis

Power struggles over beliefs and ideology reflect, reproduce, challenge, and/or alter the dominant social relations that frame the nation's treatment of old age and aging via its societal institutions, especially as advanced through state policy. As belief systems, ideologies are competing world-views that reflect the social position and structural advantages of their adherents. All political, cultural, and economic regimes use ideology as the discourse with which to communicate and impose their reflection of the dominant social relations. The contest for *ideological hegemony* (Gramsci 1971) is about achieving acquiescence and maintaining power through the means of the production and inculcation of ideas in the broader public rather than through overt violent coercion or revolution. When a dominant group achieves widespread support for its priorities, the dominant group attains hegemony (Sassoon 2001). For example, "When older people are perceived by other, dominant groups, to be irrelevant to social stability, or a threat to economic viability, they may be coerced into certain roles and institutions" (Estes, Biggs, and Phillipson 2003:64).

Ideology is integral to three processes by which dominant views of social policy and aging are produced and sustained (Estes 1991a, b): (1) the successful creation of cultural images by policy-makers, experts, and the media, for example, that the elderly are "greedy geezers" who steal our children's futures and unfairly enrich themselves through Social Security; (2) the appeal to the necessities of the economic system, for example, claims that the elderly are responsible for the nation's economic problems and "busting the budget"; and (3) the implementation of policy and the application of expertise in ways that transform conflicts over goals and means into systems of rational problem-solving. The processes of "rational problem resolution by technical experts" (e.g., commissions) obfuscate the substance of class, gender, racial/ethnic, religious, and other conflicts (George and Wilding as cited in Manning 1985) that are codified and reified through crisis definitions and solutions.

Ideologies shape and delimit public understanding of what is, what is good, and what is possible (Therborn 1980). A crucial dimension of ideology formation is how it shapes what is seen as conceivable in terms of the root problem and the solutions deemed as appropriate. Two challenges arise: (1) to locate the systems of beliefs and values within specific social formations (such as old age policy) and examine how these systems articulate with the economic system of capitalism, the state, and social class, gender, race/ethnic, and other struggles; and (2) to investigate ideological

communities that exist within specific, organized collectivities (e.g., nation states, economic and cultural sectors) and how these communities relate to and mask past social and class struggles and contradictory norms and values (Thompson 1986:14).

Several ideologies are particularly relevant to old age crisis politics and policy in the United States policy. First in relevance is the hegemonic *market ideology*, which some call *neo-liberalism* or *market fundamentalism* (Soros 1998; Stiglitz 2010). Neoliberalism, attributed to Adam Smith and neoclassical economics, is hostile to anything that may impede the (assumed) natural superiority of the market (Levitas 1986). O'Connor (1984) observes that *American individualism* is:

> capital's most powerful weapon of ideological domination of labor [with its]…myths of the 'self,' private property and natural rights [that] 'mediate back' [i.e., obfuscate] ethnicity, race, and sex with a fateful and unconscious power which subverts … ethnic and sexual identities. 'Free market laissez faire' and 'individual responsibility' reinforce the two great pillars of social domination, 'blame the victim' and 'scapegoating.' (P. 14)

Both the laissez faire free market and individual responsibility stand in direct opposition to the alternative, inherently social and collective framework that values and acknowledges the commons, interdependence, social solidarity, and the intergenerational chains of exchange and care over many lifetimes that make possible individual opportunity and success at any one time and place.

Gender ideology supports the separate public and private spheres in which women's work in the home is seen as separate, hence private (off limits to state policy but subject to traditional patriarchal and religious family values). In contrast, men's work is seen in the public sphere, an issue that Gita Sen (1980:77) affirms in observing the existence of "patriarchal ideology."

Classical neoliberal economists fail "to accurately analyze (or even recognize) the role of the market in creating intractable inequalities in power relations within the family" (Bergmann as cited in Ciscel and Heath 2001:408). Folbre (2001) further emphasizes the unrecognized imbalance of familial forces by describing an *invisible heart of care*:

> The invisible hand of the market depends upon the invisible heart of care. Markets cannot function effectively outside the framework of families and communities built on values of love, obligation, and reciprocity … The invisible hand [of Adam Smith] is about achievement. The invisible heart is about care for others. The hand and the heart are interdependent, but they are also in conflict. The only way to balance them successfully is to find fair ways of rewarding those who care for other people. This is not a problem that economists or business people take seriously. (P. 4)

Neoconservative ideology complements gender ideology in advancing the religious right's cause of recapturing traditional patriarchal family structure and norms. The resurgence of efforts to reinstate women's subjugation is manifested not only in conflicts over reproductive choice, but also in increased demands for more unpaid reproductive labor of caregiving from women of all generations. The *family responsibility* (i.e., women's caring work and sacrifice attendant thereto) is deeply inscribed in the U.S. nation state's long-term care policy (Estes, Swan, and Associates 1993). Well-documented consequences are unequal, sex-based work opportunities; wage discrimination; grinding poverty; and negative health effects, with the most deleterious disadvantages accumulated by women of color, unmarried women, and women not living in the Ozzie and Harriet type nuclear family.

Racial ideology, according to Feagin (2006), is a white racial frame in which "the dominant discourse denies racism" (p. 259), as it fosters and rationalizes "racial injustice and social institutions that privilege one racial group over another" (p. 310). From neocolonial days of the United States, this ideology defended "white privilege as meritorious and accenting" (Feagin 2006:230) the alleged superiority of whites and the inferiority of those who are racially oppressed. This "elite color-coded ideology … permeated the legitimating discourse of the whites who were dominant in major social institutions including the economy, law, politics, education, and religion" (Feagin 2006:28). Economic domination by white males is imposed via processes of discrimination, exclusion, and marginalization. The *racial state* (Omi and Winant 1986, 1994) is a structural manifestation of the ideological hegemony of the white racial frame that has enormous consequences for the meaning and experience of race in the daily lives of people of color and ethnic minorities across the

life course as well as profound inequalities. *Racial formation* is "the process by which social, economic, and political forces determine the content and importance of racial categories, and by which they are … shaped by racial meanings" (Omi and Winant 1986:61).

Ageism as Ideology

In 1975, Butler coined the term, *ageism*. Both he and Maggie Kuhn recognized ageism and its commonality with racism and sexism as a highly negative attribution that provide the basis for discrimination. Ageism is manifested both structurally and ideologically. Structurally, ageism influences the agenda setting, formation, and implementation processes surrounding public policy. Ideologically, ageism bolsters images of elders as undeserving persons who do not merit the benefits (e.g., Social Security) that they have earned and paid into for decades (Estes et al. 2009b). Maggie Kuhn campaigned against ageism through the Gray Panthers (Estes and Portacolone 2009), showing that "[a]geism afflicts … institutions serving older people with a deep, insidious paternalism … Ageism infects us when we reject ourselves and despair our own powerlessness, wrinkled skin and physical limitations" (Kuhn 1974).

In its contemporary form and at the collective structural level, ageism is the denial of basic and civil rights of elders (Anti-Ageism Taskforce 2006). As evidenced by more than three decades of attacks on American elders as greedy geezers, the slander against older persons has garnered such media acceptance and promotion that it qualifies as an ideology.

Crisis Construction and Impact

Subjective and Objective Crisis Construction

The subjective and objective dimensions of crisis formation have both a symbolic and material impact. *Crises* are socially constructed in relation to the capacity and power of strategically located agents and interests to define particular issues as problems and to press their views into public consciousness and law (Estes 1979). The manufacture of crises (objective and subjective) and crisis recognition occurs at all levels, the individual (micro), the organizational and institutional (meso), and the systemic (macro).

Subjectively, crises are socially constructed through social perception and definition. Crisis ideation is influenced by dominant ways of conceptually ordering the world, especially and by ideologies. In a sense, a crisis may be said to exist *if it is perceived to exist*. Conversely, a crisis does not exist if the condition or situation is not perceived as a crisis and if people do not act as though a crisis exists. This is not to assert that the elderly face no problems independent of those that are perceived as real. Demographic aging and structural conditions (e.g., stock market crash and global warming) may be said to be objectively real, regardless of how they are perceived. Social action, however, is indivisible from the socially constructed ideas that define and provide images of (or deny) these phenomena (Estes 1979:14).

Objectively, crisis and crisis tendencies are an integral part of the workings of the economy according to both classical and critical economists. Crisis tendencies occur with the slowdown or breakdown in profit-making, bad economic times, massive unemployment, and threats to financial institutions, as with the recession-depression unfolding from 2007 to the present. Most critical theorists argue that there is a "'logic of crisis' in crisis ridden growth and unstable accumulation"

(Bottomore 1983:102). Significantly, crises are potential avenues leading to societal transformation insofar as they "undermin[e] core organizational principles of society" (Bottomore 1983:102). This is the case, regardless of how crises are generated.

Symbolic and Material Impact of Crisis Construction

Crises are flashpoints for conflicts over the allocation and control of symbolic and material resources. *The symbolic impact* of the labeling of crises and other social problems is in the designation of cause and effect. Crisis construction with a negative symbolic and material impact is exemplified by portrayals of old people as unproductive drains on society. Linking the symbol of crisis to the perception of old people as *the problem* is a central dimension of age-related versions of crisis. As research on labeling theory illustrates, negative labels, when applied to any group, have consequences. The empirical case for lasting individual and psychological damage of racial and sexual stereotyping is well demonstrated. For older persons to be stereotyped as weak, sexless, toothless, worthless, and senile is similarly damaging (Estes 1979:12–14). In each case, personal self-esteem, efficacy, and individual performance are likely to be impaired. *Learned helplessness* (Seligman 1975) and the *looking-glass self* (Thomas [1923] 1969) describe the fact that negative perceptions, labels, and attributes ascribed to individuals in certain population groupings (and to the group at a systemic institutional level) not only provide for discrimination that is structured into our way of life, but also may teach the labeled parties to think and act as they are labeled (Mead 1934; Blumer 1969). A large body of literature on ageism and low self-efficacy attests to the destructive effects of such labeling.

The material impact of socially manufactured crises is lodged in the disparate societal and human consequences as crises: (1) generate a climate of uncertainty that legitimates the rejection of old and familiar assumptions, opening the way for previously unaccepted (even radical) solutions; (2) provide a sense of urgency to *do something* and prepare the public for the idea that sacrifices have to be made; and (3) generate public anxiety, thus expanding the authority of public officials to act or enact laws or regulations previously thought to be extreme (Edelman 1964). The disparity between those who are required to make sacrifices and those who are not is determined by those who exert the most powerful political muscle (Weber 1946; Estes 1979). Ultimately, the accumulation and disaccumulation of economic and other material advantages from crises are most likely to be unevenly distributed (Edelman 1964).

The State

The study of the state is central to the understanding of old age politics and policy and especially for the life chances of older people. The state has the power to allocate and distribute scarce resources to ensure the survival and growth of the economy, mediate between the different needs and demands across different social groupings (according to gender, race, ethnicity, age, class, [dis]ability, and sexuality), and ameliorate social conditions that could threaten the existing order (Estes 1991a).

Four theoretical frameworks are relevant to critical gerontology in studying the state, crisis, and old age policy: (1) critical theory of capitalism and the state (class theories), (2) feminist theories of the state, (3) theories of systemic racism (Feagin 2006) and racial formation (Omi and Winant 1994), and (4) theories on the political economy of aging and ageism (Estes 1979; Estes et al. 2009b). These are not mutually exclusive but rather highlight interlocking oppressions (Collins 1991) that are highly consequential for old age policy design.

Capitalism and the State

The capitalist state has three major functions which are contradictory according to a number of critical theorists (O'Connor 1973; Alford and Friedland 1985) and those writing on the political economy of aging (Estes 1991a, 1999; Estes and Associates 2001; Phillipson 2006; Walker 2006) and the welfare state and aging (Myles 1984; Pampel 1998).

The first and major function of the state is to ensure conditions favorable to economic growth and private profit. The ability of the U.S. state to ensure favorable conditions for capital accumulation within its borders is challenged by the globalization of capital. Contemporary issues concern the extent and effects of the decline in state power and control over key policy levers designed to ensure continuing U.S. corporate hegemony over the global economy.

The second state function is to ensure continuing social harmony across the nation and the undisturbed legitimacy of the existing social order (the status quo). The state does this by alleviating or mediating the worst effects of problems generated by the free enterprise system (e.g., unemployment, hunger, and destitution of those who are left behind by, or expelled from, the market). As Piven and Cloward (1971) argue, the state intervenes in social problems and wrests social control in order to stem potential social unrest.

A contradiction arises between these first two-state functions, each of which requires the expenditure of increasingly large public resources that must be raised through taxation. Jointly (as in the Great Recession of 2008), the cost of maintaining these two functions may spend the state into fiscal crisis (O'Connor 1973). Paradoxically, when federal bailouts are needed most, there is less access to tax revenue, as free market ideologues rage against taxation.

The third function of the state is to ensure continuation of democracy and protection of the democratic process (Alford and Friedland 1985). Responsibility for meeting the needs of the human community and the assurance of opportunities for human development are associated principles. Many critical scholars cite the inherent tensions between the state's democratic function and the state's function of ensuring conditions favorable to the advancement of capital accumulation (Myles 1984; Alford and Friedland 1985). This tension is specifically illuminated in issues surrounding the economic and health security of the aged. Pampel's observation that "national differences in pension policy programs (and the welfare state more generally) reflect two basic and fundamentally contradictory principles" (1998:114–15) is supported by Myles (1984). One principle, according to Pampel (1998), is based on:

> the growth of capitalist economies [and] reflects the logic of the free market [where] pensions represent wages set aside for old age in place of current payment and should reflect wage differences during the work life of pensioners … The other principle stems from the presence of political democracy in capitalist economies. Democracy emphasizes equality and citizenship rights rather than inequality in wages and salaries … Democratic pressures for equality … tend to favor universal programs for pensions and other social needs rather than programs based on economic contributions. (Pp. 114–5)

Feminist Theories of the State

Acker (1988) argues that theories of the state and social class that do not explicitly address the subordination of women and the *privileging of men* fail as comprehensive frameworks for understanding social phenomena. Social class is produced through gendered processes that are structured by production and distribution. Distribution, in particular, is vitally affected by the dominance of market relations as the basis of distribution; however, distribution is also affected by the indifference of the economic system to the reproduction of the working class and to the demands of working class daily life (Acker 1988), the demands of which fall most heavily on women.

Quadagno (1994) faults class and state theory for its inattention to the role of state policy in mediating race relations and for its blindness to "a defining feature of social provision: its organization around gender" (p. 14). Connell (1987) observes that the state not only regulates institutions and relations like marriage and motherhood but also manages them. The state actually constitutes "the social categories of the gender order" as "patriarchy is both constructed and contested" through the state (Connell 1987:130).

Women's dependency has shifted from the man to the state (Brown 1995) and from the family to the state (Dickinson and Russell 1986; Estes 1991a, b; Orloff 1993). "Instead of private patriarchy dependent on a husband, women are subject to public patriarchy of a paternalistic state" (Lorber 1998:44). This situation renders women of all ages, particularly older women and younger, single mothers, extremely vulnerable to state policies that are subject to politically charged partisan conflicts and uncertain policy changes and swings. The outcomes of these struggles subject those who are most dependent upon the state (ethnic minorities, women, low-income individuals, the disabled, and elders) to erratic and sometimes radical and regressive policies. For the large majority of older women dependent upon the state, there is the triple threat of *cumulative disadvantage* which is brought on by a lifetime of sex-gender and racial-ethnic discrimination that is further exacerbated by widowhood, divorce, living alone, ill health, and the *spend down* of financial resources in old-old age (Crystal and Shea 2003; Dannefer 2003; O'Rand 2003; Harrington Meyer and Herd 2008). Current, threatened *entitlement reforms* imperil recipients of Social Security, Medicare, and Medicaid who are the most significantly affected (e.g., women, ethnic and racial minorities, and the oldest old).

The Racial State

In their work on racial formation theory, Omi and Winant (1994) contend, "the state is inherently racial. Far from intervening in racial conflicts, the state is itself increasingly the preeminent site of racial conflict" (p. 82). The racial state consists of institutions, policies, conditions, and rules backed by "legitimating ideologies" enforced by a "repressive apparatus" (Omi and Winant 1994:84–5). Racial politics and racially based social movements engage with the state over time to produce racial formation, through patterns of conflict and accommodation. These struggles and outcomes are linked to hegemony, "the way in which society is organized and ruled" (Omi and Winant 1994:56). Macrolevel political processes are linked to the microlevel, everyday experience; "[t]o recognize the racial dimension in social structure is to interpret the meaning of race" (Omi and Winant 1994:57). Socio-historically, the meaning of race is fluid and a source of contest.

At its outset, Social Security excluded domestic workers and migrant labor from coverage and consigned African-Americans to punitive and highly variable state level welfare policies and programs. Poole (2006) identifies the shared interest of white policy makers in "preserving white race privilege," illustrating the "existing marginality of the country's 12 million African Americans … [since] Social Security rewarded those who were already privileged" (p. 174).

Contradictions and Crisis Tendencies in the State

Over the past 30 years, critical scholars (Offe 1973; Habermas 1975; O'Connor 1973, 1984, 1987) have concurred that the contradictions between the different functions of the state (support for the processes of capital accumulation, social integration, and democracy) produce crisis tendencies that are an integral part of late capitalism. A major conundrum is that resources to pay for the state

infrastructure and functions (taxes and other revenues) are dependent upon the success of the capitalist economy and the willingness of its economic dominants to be taxed (O'Connor 1973; Offe and Ronge 1982). The Bush tax cuts of 2000 exemplify such difficulties: Revenues lost from the tax cuts of 2000 are a substantial cause of the U.S. deficit in 2010, which in turn provides fiscal hawks with a rationale for cutting Social Security.

Legitimacy and Legitimation Crises

The fate and ultimate viability of all institutions and organizations are contingent, to a major degree, upon their legitimacy (Weber 1946). To understand crisis and old age policy and politics, attention must be given to the legitimacy of the state, to the nation's economic and democratic institutions, and to civil society. Without legitimacy, institutions may be defined as being in crisis.

Legitimation refers to "the process by which 'power is not only institutionalized but more importantly is given moral grounding'" (Marshall 1998:363). It is "the authority of an institution, person, or practice to command obedience" (Silby as cited in Turner 2006:332). For Habermas (1975, 1984), legitimacy means hegemony, although once challenged, true claims of legitimacy are undermined. *Political legitimacy* is "the quality of 'oughtness' that is perceived by the public to inhere in a political regime. That government is legitimate which is viewed as morally proper for a society" (Merelman 1966:548).

A feature of modern capitalist societies is that there are multiple sources of legitimacy for its major institutional sectors that include the state, capital, and democracy (including civil society). Public activity is legitimated almost universally for functions of the police and national security, while profit-making entities, historically, have been deemed inappropriate for these purposes. An increasingly contested sector is the nonprofit sector (NPS). To the extent that the NPS represents pluralism (voluntary and participatory action), the state's support has been a significant source of legitimation. However, since the early 1980s, state support of the NPS has eroded as pressures to fund for-profits versus nonprofits have accelerated, and the state has bolstered this trend under Medicare, the Older Americans Act, and other state policies (Estes et al. 1984; Estes, Alford, and Egan 2001).

The State as Site of Economic, Political, and Social Struggle

Systemic crises arise not only from the sphere of production but also from the inability of the political system to prevent or compensate for economic and social crisis tendencies that inhere in (and/or are exacerbated by) capitalism. Critical scholars generally concur that under modern capitalism the struggles between workers and capital (traditional class struggle) have been transported into the state. Concurrently, other major social struggles also have increasingly been transported into the state for resolution, heightening challenges to the legitimacy of the state on multiple fronts (O'Connor 1973; Offe 1973; Habermas 1984). It is not surprising that in the present socio-historical moment social struggles involving the economy and race, ethnicity, gender, and age are at a fever pitch, embroiling the state, congress, the presidency, political parties, and the public in intense ideological conflicts. With both economic and social crises together displaced into and within state administration, additional political crises may be produced, as the state is required to:

> organize the dysfunctional social consequences of private production, [while] state policy is not supposed to infringe on the primacy of private production. [The contradiction is that] if state policy is to be adequate, however, it is forced to rely on means which either violate the dominant capital relation or undermine [the state's] functional requirements—the legitimacy and administrative competence of state regulation itself. (Offe 1977)

Critical Sociology, Crisis, and Old Age Policy

Estes (1979, 1982) and others (Estes and Associates 2001; Walker 2006; Svihula and Estes 2009; Phillipson (2010)) have identified the import of the social construction and reproduction of crises surrounding the aging society and old age policy, including Social Security. Gramsci's construct of hegemony underscores the crucial roles of discourse, rhetoric, and speech that frame policy, its processing, and its management. Social problems related to age, gender, race, home, family, women's reproduction rights, and access to work are increasingly being adjudicated through the state (Estes and Associates 2001:92, 97; Harrington Meyer and Herd 2008).

Recent socio-cultural theorizing includes postcolonial and postmodern theories that underscore the significance of identity politics of race, ethnicity, sexuality and gender, (dis)ability, and age and generation through new social movements. Critical gerontological scholarship on identity, alienation, and meaning has proliferated in the last two decades with exploration of the stability and fluidity of aging identities and the relationship between biological and social aspects of aging (Biggs 2001, 2003), as has work on the concept of the *colonization of the life world* (Habermas 1986:392).

Baars (2006), Dannefer (2006), Walker (2009), and others offer trenchant critiques of postmodernist work in aging that promotes the *individualization of the social* (Ferge 1997), emphasizing "presumably autonomous preferences and choices" to the neglect of profound "problems of social inequality … material reproduction … in favor of conflicts that arise in the domain of cultural reproduction" (Baars 2006:26–7).

Crises and Old Age Policy

Old age politics and policy have both provided a series of institutional buffers and served as a battleground for framing, defining, and resolving different crisis tendencies in past and present sociohistorical moments. Construction of the aging population in crisis terms serves two ideological purposes. First, the "demographic imperative" has been a rallying point for those who argue that the elderly are living too long, consuming too many societal resources, and robbing the young, thus justifying rollbacks of state benefits for the aged. Second, ideological attacks on health care as an earned right for the elderly use projections of a pandemic of chronic illness – yet another version of crisis.

The social contract embodied in the founding of Social Security is based on the commitment that we each take responsibility and contribute to universal earned benefits through our wages, in order to insure ourselves and our families against the unpredictable events of death of a parent or spouse or of being orphaned, disabled, or retired. Kingson, Cornman, and Torre-Norton (2009) emphasize the intergenerational ties implicit in programs like Social Security, in that "[t]he social insurance approach rests on an understanding that generations depend on each other; they are interdependent. It gives concrete expression to values supporting mutual aid and the obligation to care for our families, our neighbors, and ourselves." (p. 107); furthermore, "[t]he debate is about how much added risk [that] society, through public policies and private practices, wants to place on families now and into the future, and the place of our country's current social insurance programs like Social Security and Medicare in that balance" (p. 95).

Contested ideas about what one generation owes another generation and pointed questions about fairness between different age cohorts penetrate and shape political discourse. The specter of *intergenerational war* emerged as an important product of the Reagan years (Estes 1991b:75). A reenergized *gender war*, Estes (2004) asserts, also "laid the affective base for increased pressures for

family responsibility," that is, women's free labor over a lifetime of never-ending caregiving for multiple generations. At the center of these conflicts are what may be characterized as a fierce attack on the nation's bedrock entitlement programs of Social Security and Medicare.

Social Security and Medicare are the U.S. welfare state, according to Myles (1984), Quadagno (1999), and Walker (1999). Hence, legitimacy problems that attend the state would be expected to extend to programs of the state. Social Security and Medicare are now the focal point of intense struggles of class, gender, race, and generation, involving both the corporate sector and the state. Deeply implicated in these struggles are the cultural institutions of media, religion, and education (intellectuals' think tanks).

Corporate demands that the state redirect its resources away from safety net programs and earned rights, such as Social Security, and instead press for deficit reduction and additional state subsidies for the financial and other sectors of capital are a response to economic crisis tendencies as well as to the crises of administration, legitimation, and rationality described by Habermas (1975) and others (O'Connor 1973; Ronge 1974; Offe 1977; Offe and Keane 1984). Since these crises are interrelated (although each may each have its own trajectory), the state must respond in some measure to the appearance of each.

Market Fundamentalism, Crisis, and Aging

Myles and Boyd (1982) underscore the economic significance of a *graying America*, in that it "increases the size of the public economy and reduces the share of the national income directly subject to market forces. Thus, while population aging is unlikely to break the "national bank," it will alter the bank's structure of ownership and control" (p. 19). This may explain the relentless attacks on Social Security. Market ideologists contend that Social Security reduces the public's reliance on the market, increases the individual's dependency on government, and diminishes incentives for private sector saving and investing that are a major source of the capital deemed essential for economic growth (Rahn and Simonson 1980). The fact that the retirement wage in the form of Social Security is administered by the state (Myles 1991:304) means that market actors do not retain control over the deferred wage for distribution during retirement. Myles (1991) notes the fact that:

> public pensions are now the major source of income for the retired in all capitalist democracies … [is] an event of enormous significance in the … distributive practices of these nations … [and tantamount to] … an ever-growing and increasingly important portion of the national wage bill … removed from the market and subject to a democratic political process, one in which workers, in their capacity as citizens are able to claim a share of the social product … independent of … their capacity as wage earners. (Pp. 304–5)

In effect, this form of the retirement wage is actually "a citizen's wage, [with] an income entitlement partially independent of the commodity value of the worker's labor power" (Myles 1991:305). This fact mediates the raw discipline that is imposed by the market on wage workers.

Legitimacy Crises of the State, Capitalism, and Democracy

Old age and ageism are deeply implicated in the legitimacy crises of the state, capitalism, and democracy. Ageism has been virulent and violent, yet unrelenting for three decades, although rarely acknowledged. Ageism is intertwined with sexism, racism, class struggle, and abelism as ideological and structural forces. The socially constructed debt crisis is an identifiable vehicle by which a divisive war among opposing forces is underway.

> A giant window of potential social change has opened. And with it … the "mother" of all class struggles, gender struggles, and race and ethnic struggles. The issues … starkly underscore the crucial importance of social insurance and the peril of the choices that will be made concerning the nation's economic and health security. (Estes et al. 2009a:436)

Legitimacy Crisis of the State

Beginning with the vigorous claims of President Reagan (Estes 2004) that "government is the problem," legitimacy problems of the state have intensified with the incessant rhetoric by neoliberal politicians and think tanks that government is incompetent and/or inappropriate to deal with most (if not all) problems of the society. In the face of the pervasive market ideology, the state is confronted by real and profound problems in its attempt (rather than its inability) to effectively perform its steering functions, in view of the state's multiple and contradictory functions outlined above. Habermas (1975) defines the results of such a predicament as a *rationalization crisis* that contributes to legitimacy problems of the state, including charges that the state is incompetent.

Legitimacy Crisis of Capitalism

The "meltdown" of Wall Street and the Great Recession of 2008 are burned into the memory and psyche of millions of people around the globe as more than 14 trillion dollars in the wealth of individual Americans was destroyed. Bail outs for *too big to fail* banking, insurance, and Wall Street corporations cost trillions more. The recession itself and double-digit unemployment are an additional high state cost including millions of workers forced into early retirement and millions of more workers jobless and not paying into Social Security or Medicare. Uncertainty is particularly threatening to middle and working class Americans in view of the success of Market Fundamentalism in instantiating "individual autonomy as official state policy" (Dean 2003).

A core element of the legitimacy crisis of capitalism is the objective fiscal crisis of capitalism produced by the combination of deregulation, speculation, derivatives, corporate greed, and a host of perverse incentives, instruments, and contradictions initiated in the United States spread globally. Stiglitz (2010) describes this *freefall* as *the sinking of the world economy* (see also O'Connor 1987; Krugman [2007] 2009; Tabb 2008).

Legitimacy Crisis of Democracy

A major contributor to tensions surrounding the legitimacy of democracy in the United States is the inherent contradiction between democracy and capitalism (Myles 1984; Alford and Friedland 1985; Dean 2003).

To comprehend the relationships between crises and old age policy and politics, attention must be given to legitimacy issues confronting the nation's democratic institutions. In a democracy, all individuals existing within the geo-political jurisdiction of the democracy have equal and inalienable rights, regardless of property. Democracy accords rights of citizenship to everyone who is a member of the society. Recently, scholars note that the current sway of market fundamentalism is being used to alter the concept of citizenship rights to mean property rights. (Note the Supreme Court's historic and recent rulings on corporations with the rights of individuals.) From the

neoliberal perspective, citizens are seen primarily as taxpayers (as are corporations) who have the right to decide what the state does with its resources, while the state is there to protect and advance the defense of the nation and the property rights therein (in contrast to the individual person and the democratic community).

Democracy is predicated on the principle that every individual and every vote counts: one person, one vote. Democracy assumes the will of the people and government by and for the people, all people. Basic equality across all members of the democratic society is a core value, belief, and principle. Capitalism is predicated upon economic competition to accumulate private wealth, producing inevitable inequality in the distribution of resources and the stratification of society. Survival of the fittest is an essential element of capitalism. In contrast, democracy is about the greatest good for the greatest number. Capitalism thrives on individual entrepreneurship and private shareholder *bottom line*, theoretically, in free markets, unencumbered by responsibility to larger social collective and communal responsibility embedded in the notion of *the common good*. In short, democracy relies on inclusion of all members of society, while capitalism relies on exclusionary privileges bestowed according to property and wealth and the power to dictate "choices" flowing wherefrom.

More direct challenges to democracy reside in mounting charges of voter fraud and disenfranchisement arising with the contested 2000 Bush presidential election, Diebold voting machine controversies, and accusations of vote suppression designed to intimidate people of color and ethnicity. Examples, accusations, and deep distrust abound: Florida's massive purge of eligible voters, Ohio's eight hour waits for voting, Georgia's photo IDs, and other mandates, such as Arizona's "Papers Please" law. These tactics exploit racial and other societal divisions (Krugman [2007] 2009:197). The Tea Party and screaming Town Hall meetings, reeking with disgust for members of Congress, is a symptom of legitimacy problems in democracy. Attacks on, and disrespect for, democracy and democratic institutions are both a cause and an effect of widespread public cynicism.

These signs of legitimacy crisis tendencies in the United States have serious implications for old age politics and policy. Economic and health security across the life course are key elements of citizenship (Grossman et al. 2009:115). This is consistent with the concept of the social rights of citizenship grounded in the notion of *life course interdependence* (Twine 1994). Indeed, the "quality of life in old age strongly reflects the different costs of life course interdependencies, of child-rearing and employment [and long-term caregiving in old age], and these vary by social class and gender" (1994:34).

In opposition, the neoliberal ideology of individualism posits a different view of citizenship rights, supporting the concept that we are independent, *as if* independent of society. This is "a form of *freedom from society* or more specifically, *freedom from the state*" (Twine 1994:29). The reluctance of neoliberals to embrace the principle of *interdependence* stems from the fact that to do so "would present us with moral obligations to compensate those who bear the costs of our progress" (Twine 1994:29).

A critical approach to social policy and aging is consistent with Twine's assumption that "the material and human reproduction of society involves relations and processes of interdependence" (1994:29). It is appropriate for social policy on aging to reflect (and even more importantly, to account for – and where inequitable burdens arise – to compensate for) these life course and society-wide interdependencies. "The burdens of not doing so are profoundly unequally borne" (Estes et al. 2003:143).

Somers (2008) observes that "access to public services and social insurance are institutionalized expressions of rights internal to the *inclusionary ethic of citizenship* and the common good" (p. 33). An "inclusive citizenship regime" (Somers, 2008:38) rejects the narrow concept of citizenship advanced by anti-immigration forces, which is both exclusive and xenophobic. Somers argues that the concept of *privatized citizenship* is tantamount to a market morality where individual responsibility is substituted for social morality – responsibility to the community and society and to the national and global commons.

Somers (2008) argues against the current threat to *the right to have rights* through *the contractualization of citizenship,* by which "the poor and low-income members … experience *statelessness* in a particularly virulent way … They … become today's socially excluded. As such, they no longer have meaningful membership in civil society – that which confers recognizable human identity" (p. 134). This represents a "conquest by market powers of a state's institutions of inclusion, protections, and rights" (Somers 2008:135). Likewise, Dean (2003) critiques the *individual responsibility project* under capitalist social relations. Describing the deleterious effects upon both citizenship and democracy, she states that " … self-reliance is demanded under threat of future impoverishment. The structurally irrelevant [workers/individuals] are just that: irrelevant. Their fate depends on the readiness of governments and their electorates to dole out ever more meager and grudgingly offered sustenance" (2003:162).

Debt Crisis Framing and Old Age Politics

A frame of *apocalyptic deficits* (author's term) is the new mantra applied by opponents of government spending on health care, the social safety net, jobs, and Social Security. The deficit *rant* of fiscal conservatives is compatible with the *generational equity* argument (Williamson, Watts-Roy, and Kingson 1999) that is being advanced by the Social Security opponents who argue that elders are getting more than their fair share of benefits from the program. As these Social Security opponents frame arguments within terms of generational equity and the economic unsustainability of this bedrock social insurance program, little or no attention is given to income adequacy during old age or to how retirees can sustain a habitable living standard. It is noteworthy that 20% of all retirees and 40% of retired African-Americans and Hispanic-Americans count on Social Security for 100% of their annual income, while two-thirds of all Americans depend on Social Security for more than 60% of their retirement income (U.S. Social Security Administration 2009).

The successful deployment of deficit crises, structurally produced and politically constructed by the state and capital from the 1980s to the present, underscore the inherent tendencies to the legitimacy problems of the state, capitalism, and democracy. Such crises, objective and subjective, are an effective mechanism that calls into question the legitimacy of the state "and even of democratic actions," particularly at the federal level. Utilizing Habermas's (1975) framework, the deficit situation foregrounds the steering and rationalization crisis tendencies of the state in a capitalist society. In the case of the United States, legitimation crisis tendencies inhere in the failed state oversight and regulatory powers regarding finance capital of gigantic proportions and offshore oil drilling. The confluence of multiple crisis tendencies operating at several levels of society and the state may produce a near-toxic extreme crisis.

Presently, such crisis tendencies (however produced) have provided the rationale for sustained ideological attacks and deficit crisis rhetoric aimed at retrenchment in welfare state commitments to the American public. This "debt crisis" is often blamed on older U.S. citizens who had nothing to do with it. The primary solution proposed is to cut the only program that has not contributed to the deficit, Social Security (currently with a surplus of $2.6 trillion). The entrenchment of the *deficit crisis frame* on both sides of the aisle (in Congress, the White House, corporate America, and the media) reflects the strength of adherents of market fundamentalism who unalterably opposed to safety net domestic spending.

With the debt crisis framing and the legislative and administrative wrangling over "entitlement reform," it appears that the state's legitimation problems are being "hived off" from the state writ-large. With the support of market ideologists and fearful deficit hawk democrats, the primary alternative solutions are being guided away from the White House and pressure for tax increases. Instead, the preferred solutions are cuts to the specific entitlement programs of Social Security,

Medicare, and Medicaid. Significantly, as well, federal entitlement programs are defined as budgetary problems to be solved by budgetary means only (Quadagno 1999) rather than as programs designed to provide economic security and a collective community of pooled social risk at times of grave economic vulnerability for the majority of the nation's middle class during the demonstrated failure of the market.

The attention of policymakers, economists, and the media to the conflicts and challenges facing Social Security has shaken the confidence of many Americans that Social Security will be there for future generations. Nevertheless, there remains strong consensus that Social Security is crucial, especially in the U.S. market economy during precarious economic times. Rockeymoore and Maitin-Shepart (2010) confirm a long line of prior research, showing that:

> Americans want to make sure that Social Security is strengthened for current and future generations … [More than 65 percent of Americans] … support strengthening Social Security over cutting its benefits … [while] 88 percent of African Americans, 84 percent of Hispanics, and 74 percent of whites agree that preserving Social Security for future generations is critical, even if it means increasing Social Security taxes on workers. (P. 1)

In summary, the legitimacy problems of the state, capitalism, and democracy have been transported into all aspects of social policy for the aging, and particularly targeted against the bedrock programs of Social Security and Medicare. The state's responses to its legitimacy problems are numerous and the source of conflicts among contending parties. Responses include: the imposition of deficit reduction ideology and law; tax cuts for the wealthy and the call for more of them; funding cuts in politically weak programs; policies to stimulate the market; erosion of government entitlements; devolution of federal fiscal responsibility; deficit reduction to constrain social spending; and a health policy and health reform agenda of market stimulation, privatization, for-profit managed care, and individual responsibility (Estes 1991b). A capstone illustration of the attacks on the legitimacy of the state came from the ranking minority member of the Senate Finance Committee, Senator Charles Grassley, as he declared during the Health Care Reform debate that "[g]overnment is not a competitor for health insurance. With a public option, government is a predator" (PBS News Hour Online 2009).

Thirty Years of Critical Thought: The Future

Future scholarship in the sociology of aging, crisis, and the attendant policy and politics of old age is paramount. Despite advances in work on diversity and risk, including the cultural turn of postmodernism, unfolding global and national events and conditions underscore the urgent need for frameworks to guide research on the construction and uses of crises in the welfare state politics of societal aging and their distributive consequences. The pressures are to "responsibilize a new senior citizenry to care for itself" (Katz 2003:26) and to engage in "productive aging" by "aging well." Failure to meet such expectations threatens to provoke negative moral sanctions (Estes, Mahakian, and Weitz 2001; Holstein 1993; Estes et al. 2003).

A weakness in the sociology of aging over the past three decades is its inadequate attention to macrolevel societal forces that are transforming the experience of growing old and the responses of societal institutions to these transitions. In the developed West, normative aging patterns involving work, family, and leisure are seriously challenged by economic and political events (and struggles) that produce subjectively and objectively rendered crises.

New challenges to both "usual aging" and "successful aging" (Rowe and Kahn 1997) of older persons stem from: forced early retirements caused by high unemployment; the need to work well into old age as private pensions and home equity crash; low interest rates to savings; augmented resource transfers from old to young due to the bleak economic situation of young and middle age adult children; and increased, unceasing caregiving work and costs of long-term care and grandparent caregiving. These shifts are occurring in the historical moment of power struggles

over the social position, rights, responsibilities, and the decline in the perceived deservingness of older people. Research in needed on:

- Theorizing the aging society, ageism, and crisis
- Globalization, state theory, and social rights
- Social inequality and social policy, age and intergenerational relations
- Social movements and old age politics
- Praxis and public sociology in old age politics and policy

Theorizing the Aging Society, Ageism, and Crisis

The idea of society as a bounded, self-sufficient entity (a theme most associated with functionalist theory and Talcott Parsons (1951)) is generally assumed, within mainstream sociology of aging, as being built around questions of how social integration in old age is possible given the shocks of late life (e.g., retirement, bereavement, and chronic illness). Such formulations assume a coherent and bounded society into which integration is attainable, an idea rendered problematic by globalization. Minimally, it is essential to recognize the diverse and unequal networks which interact throughout the life course to produce differences in national, global, and subcultural aging (and for some, the wish or the probability of not aging at all).

A cornerstone of the political economy of public policy and aging is the unpacking of social issues that are framed as crises and remedies to deal with the dominant and marginalized subgroups within the aging population. A second cornerstone is concerned with the processes by which – and for whom – these frames, definitions, and ideologies serve as political, economic, and cultural determinants of the policy agenda, policy formation, and policy implementation affecting the aged.

A task for sociological theory is to examine the national and global power dynamics that perpetuate the dominant, competing, and repressed (Alford 1975) frames of old age, aging, and ageism. Priority areas include studies of discursive constructions of aging, intergenerational relations, and associated crises; the politics of representation; and the emerging (and dissembling) forms of human and political agency, especially the effects on social policy and societal aging.

Frameworks and research must advance a creative amalgam of two streams of the sociology of aging: *agency and structure*, as linked to crises and social policy. Without a valid account of social structure, a decidedly microfoundational approach to aging is isolated from the effects of period, cohort, and history (Hagestad and Dannefer 2001). At the same time, macro approaches that ignore the everyday lives of people also offer limited insight into human development, self-reflection, and real, existing human agency and emancipation.

The intersection of agency and social structure is acknowledged in Marshall's (2009) perspective on *the life course as a policy tool*, particularly in reference to cumulative advantage and disadvantage. Scholarship is needed to explicate the successes and limits of agency, particularly since the realization of agency is key to social change. "Situational events and interactional opportunities" for agency occur within the context of "structural constraints that limit the range of possible interactions … reinforcing certain lines of action while barring others" (Estes 1981:400).

In addition, research on ageism and its relationship to old age politics and policy is essential. There has been little detailed empirical work on the topic either at the meso- or macrolevel. Measurement of ageism and its empirical and theoretical specification are necessary at the level of particular social institutions and at the broader social system level. Attitudinal and public opinion research on the aging society, policy, and crisis is similarly lacking and necessary. Media studies are needed to investigate the framing, rhetoric, and ideology used in political discourse via congressional testimony, government reports, think tanks, and the debates of political, economic, and cultural elites (Svihula 2005; Svihula and Estes 2007).

Globalization, State Theory, and Social Rights

The phenomenon of globalization renders many problematic concepts employed by sociologists, such as the collective and individual meanings of the state, citizen, gender, social class, ethnicity, and generation. Each of these concepts is substantially challenged at the level of global actors and institutions (Bauman 1998). With some exceptions, older persons have been marginalized or made invisible in research on globalization (Estes and Phillipson 2002; Vincent 2006; Phillipson 2009, 2010; Walker 2006, 2009) except for the perceived threat of demographic aging.

The social production of crisis as a vehicle for promoting political and economic objectives has taken center stage in old age politics as global shifts portend a world in which growing old is becoming an increasing risk, threatened by detachment from the protective welfare states that once comprised the core of Western society (Phillipson 2009). The paradox for older, as well as younger, generations is that the macrolevel has become *more* rather than less important as a factor influencing daily life.

Major areas for investigation must concern the effects on elders and other vulnerable populations of: the changing and contested forms of the nation state and its welfare provisioning; threats to democracy posed by nationalism and issues surrounding citizenship; the enhanced and largely opaque roles of globalization and supranational bodies which remain unencumbered by formal democratic processes; the concentration and power of financial capital and multinational corporate interests; and the persistence and emergence of new forms of class-, gender-, race-, ethnic-, (dis) ability-, generation-, and age-based inequalities and divisions. The new social construction (and contradiction) of old age and aging societies is to socially reconstruct old age as a personal rather than collective responsibility, on the one hand, and to wring our hands about global aging, on the other. Nevertheless, the risks associated with old age and aging are relatively unchanged and increasing only in intensity and severity in terms of the threat of poverty, the need for long-term care, and the likelihood of serious illness. What has *changed* is that the duty and the necessity to cope with these risks is being transferred to individual elders and individual families. These shifts in risk apply particularly to individual elders in attempting to sustain finances during old age and to women as caregivers (Bauman 2000; Hacker [2006] 2008; Estes 2008; Harrington Meyer and Herd 2008; Settersten and Trauten 2009).

Aging as a global phenomenon is transforming developed as well as developing nations (Estes and Wallace 2010). It is imperative to identify the ways in which global institutions and global governance (chaotic or not) are employed to promote (or not) the needs and rights of older citizens. Studies are needed not only in single societies but also comparatively in the global community of the first, second, and third worlds.

Social Inequality and Social Policy, Age and Intergenerational Relations

Calasanti (2009) observes that age relations encompass "the ways …age serves a social organizing principle such that different age groups gain identities in relation to one another" and that "being old, in and of itself, confers a loss of power of all those designated as 'old' regardless of their possible advantages on other social hierarchies" (p. 475), for example, labor market discrimination, ageism, and gender-based lower job opportunities for women. This is a reminder that work on social inequalities and social policy must incorporate, conceptualize, and explicate frameworks for age relations and for intergenerational relations. Theoretical developments need to incorporate the excellent developments already made on intersectionality and interlocking oppressions (Collins 1991) that are essential in the study of inequality and difference.

A critical perspective theorizes and interrogates power relations and the social, economic, and political processes and structures that are institutionalized and insinuated into everyday encounters and relationships between older adults and other generations and between older adults and the professionals who interact with them. Links must be made between macro, meso, and microlevels of analysis so that the sources and processes of the production and reproduction of social inequalities may be fully delineated. Only then will it be possible to identify the potential malleability of persistent inequalities in old age to policy or other social interventions.

Sociological work on inequality and aging, as developed by scholars of cumulative advantage and disadvantage theory (Crystal and Shea 1990; Crystal and Waehrer 1996; Dannefer 2003; O'Rand 2003, 2006), has been advanced by the *Cumulative Inequality Theory* (CIT) of Ferraro et al. (2009). The axioms, propositions, and methods of CIT are promising in light of the authors' insistence that social systems are a vital part of the production and reproduction of inequality across the life course. Also, the theory attends to life course trajectories, population aging, and "cohorts [that] provide the context for development, structuring of risks, and opportunities" (Ferraro et al. 2009:419).

There remains a need for understanding how social inequalities in old age may be exacerbated or ameliorated in society and addressed through social policy (J. Angel and R. Angel 2006; R. Angel and J. Angel 2007). Scholarly research will be enriched by attention to two macro areas: (1) the roles of dominant political, economic, and culturally elite organizations and institutions as they manufacture, reproduce, perpetuate, change, and/or exploit social divisions in the society; and (2) the role of the state and of global politics and economics in these processes.

A cautionary note is needed. Current social and policy sciences studies of inequalities in aging (generally) take as "given" the existing systems of medicine under capitalism, as scholars work largely within "definitions of the situation" framed by classical economic paradigms and functionalist sociological assumptions, models of cost effectiveness, and individual level outcomes (Clarke et al. 2003). The end result is that such investigations consider only a limited array of potentially viable policy options; thus ensuring, almost exclusively, the serious consideration of primarily incremental (status quo) changes that will do little to alter underlying root problems that confront older people or the societies in which they age.

Social Movements and Old Age Politics

Social movements, as a broad social alliance of persons who seek to effect or block an element of social change within a society, have been instrumental in U.S. politics and policy related to aging from the nation's earliest days. Much of such social movement literature focuses on the Townsend Movement of 1933, the Social Security Act of 1935, and the 1965 passage of Medicare, Medicaid, and the Older Americans Act. Binstock (1972), Marmor (1973), Estes (1979), Quadagno (1988), Campbell (2003), and Amenta (2006), Schultz and Binstock (2006) have produced many of the best treatises on policy and aging. Campbell (2003) argues that senior organizations were not influential in creating Social Security but rather were an outgrowth of the legislation itself. The result was the development of a constituency of interest group entrepreneurs with increased income, time in retirement, and political interests and opportunities. The founding of AARP in 1958 is seen as a secondary effect of policy. Amenta (2006) contends that the Townsend Movement was formative in producing Social Security. His major work focuses on identifying the short- and long-term consequences of social movements.

The growth in the number and scope of providers and organizations in "the aging enterprise" (Estes 1979) after 1965 coincided not only with Medicare and Medicaid but also with the Older Americans Act. As the numbers of senior organizations expanded throughout the 1980s and 1990s, they became synonymous with the *gray lobby* (Pratt 1993) and are presently loosely organized

under the national umbrella of the Washington, DC-based Leadership Council of Aging Organizations (LCAO). Social movement theories have embraced multiple potential explanations for their trajectories, including struggles over meaning and interpretations, identity politics, resource mobilization, and political opportunity structures, among others (McAdam, McCarthy, and Zald 1996). As Hudson (2009) observes, the "aged's new policy and political presence will represent an impressive counterweight against those who would pare away existing benefits" (p. 550). Highlighting the import of continuing research in this area are the deficit crisis and swirling attacks on Social Security and entitlements for the aged.

Praxis and Public Sociology in Old Age Politics and Policy

Praxis is a key element of critical and public sociology in aging. Critical gerontology supplies evidence and perspectives designed to assist groups and individuals in assessing their situations to make the links between personal experience and structural inequities and to engage stakeholders in collective change. Praxis is "practical action on the world, or … the practical transformation of the world in accord with a desired end or finality" (Sartre 1960 as cited by Macey 2000:311). Praxis is a vital source of agency, calling attention to "the socially constructed nature of economic and social institutions and the possibility of changing these – humanity's capacity for freedom, which cannot be achieved entirely at the individual level" (Jary and Jary 2005:485).

Burawoy (2005) contrasts four types of sociological knowledge: professional (classical-traditional) sociology, policy sociology (e.g., applied and health services research), critical sociology, and public sociology. In mapping the division of sociological labor, Burawoy identifies critical sociology and public sociology as reflexive knowledge that "interrogates the value premises of society as well as our profession" (Burawoy 2005:11). Critical sociology is "a dialogue about ends within the academic community about the foundations of its research" (Burawoy 2005:11). Public sociology is a conversation "between academics and various publics about the direction of society" (Burawoy 2005:11). The "sociological field of power" is comprised of "a ruling coalition of professional and policy sociology and a subaltern mutuality of critical and public sociology," which Burawoy (2005) defines as "a pattern of domination … [reflecting that] in our society power and money speak louder than values and influence … and [has] a public sphere [that] is not only weak but overrun by armies of experts and a plethora of media" (p. 18). Being *subaltern* means that critical sociology and public sociology are subordinate, marginalized, and lower in status. Burawoy (2007) continues by defining critical sociology as "the conscience of professional sociology" and public sociology as "the conscience of policy sociology" (p. 33). Scholars of all sociological types have contributed, and will continue to contribute, to much that is understood about the relationship between the construction and consequences of the insertion of crisis discourses that drive old age politics and policy.

A major foundation for critical and public sociology in aging is directly attributable to Maggie Kuhn as a sociologist and cofounder of the Gray Panthers. Maggie's speeches, writings, and activism contributed to the identification and early study of identity politics, intersectionality, cultural and media studies, the sociology of knowledge of gerontology, the political economy of aging, and global and world imperialism (Estes and Portacolone 2009). Kuhn and Tish Sommers (co-founder of the Older Women's League) demonstrated the real meaning of agency and public sociology in aging. For Maggie and Tish, praxis and possibility framed the adventure that was daily life for each of them (Estes 2008). They worked through living as public sociologists, as Burawoy describes, "in close connection with visible, thick, active, local and often counter-publics" (2005:7).

Serious attention in the sociology of aging must be given to the promise and limits of agency, because the realization of agency is key to public sociology and public gerontology (Estes 2008). Discourse, social constructions of reality, ideologies, and framing are integral to the relationship

between meaning and action. Framing is all about power relations that eventually become embedded in the mind and the structure of our worlds (Estes 2008). "Framing itself is an action," (Lakoff and the Rockridge 2006:25), while "reframing *is* social change" (Lakoff 2004).

Organic intellectuals (Gramsci 1971) are integral to mobilizing for social change and to praxis in its pursuit. Intellectuals may serve roles in the production of both (or either) hegemony and resistance to its domination. They may work in relation to dominant or oppositional groups or classes that seek *a new hegemony* designed to generate widespread public consent for political and social reform. The promise of emancipatory knowledges and critical pedagogy in the sociology of aging, crisis, politics, and policy is possible through critical and public sociology. Critical gerontologists are already engaged in larger discourses, emancipatory knowledges, and critical pedagogy (Moody 1993; Katz 2001; Ray 2003; Baars, Dannefer, Phillipson and Walker 2006; Powell 2006; Estes and Phillipson 2007). Examples of emancipatory knowledges appear in the literature on regimes of truth that comprise critical feminist, race, ethnic, class, and generation discourses. Critical pedagogy engages education as the practice of freedom, possibility, and social transformation, much of it building off Paulo Freire's *Pedagogy of the Oppressed* (1972) and bell hooks's (1994) invitation to *teach to transgress*.

It would be remiss to conclude this chapter without acknowledging the deep epistemological and ontological tensions in sociology and other social sciences and humanities that are raised by some of the work considered here. Dorothy Smith (1990) warns of the danger of a social science that is captured by and envisioned through the "relations of ruling" and the limitations of gendered and raced knowledge and epistemologies. Work on feminist standpoint theory and the epistemic advantage (Harding 1996), queer theory, heteronormativity, and (dis)ability signal additional important developments for inclusion in the sociology of aging, politics, and policy. A blooming literature on the sociology of science (sociology of knowledges) includes work in grounded theory (Clarke 2005) and symbolic interactionism (Clarke and Star 2003) that attests to the vitality and significance of such concerns for the sociology of aging.

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Chapter 20
Welfare States: Protecting or Risking Old Age

Jill Quadagno, Ben Lennox Kail, and K. Russell Shekha

The modern welfare state was created in the long economic expansion of the post-World War II era, as rising productivity and economic growth made it possible for governments to fund an array of benefits that provided a modicum of income security across the life course. Although welfare states everywhere included benefits for unemployment, health and disability, the bulk of expenditures went to public pensions. In all western capitalist democracies, expenditures for the aged represented the single largest item in national budgets. As Myles (1989:2) states, "the contemporary welfare state in the capitalist democracies is largely a welfare state for the elderly." Public pensions made it possible for older people to retire before any actual physiological decline occurred. More importantly, they exempted the wages of the old from the control of the market with its laws of supply and demand and instead subjected them to a process of political decision-making that led to ever more generous pensions as elected officials competed to claim credit for benefit hikes.

The public pensions created in this period represented a break with the poor law tradition of means-tested benefits for the needy. Rather, they were designed around the concept of social insurance; individuals who contributed during their working years would automatically be eligible for benefits in retirement. These benefits would not merely allow for a bare subsistence but instead would provide income replacement at levels that allowed recipients to maintain the same standard of living in retirement that they had had during their working years. Social insurance systems were distinctive also in that they coupled the private insurance principle of shared risk with the power of the state to require participation (Hacker 2006).

Beginning in the 1970s, the era of welfare state expansion slowed. The immediate cause was a stagnant economy and rampant inflation, but long-term social trends associated with population aging and expanding public budgets also put strains on the fiscal capacity of states. Many European nations and the United States enacted modest measures to reduce public pension expenditures, for the most part without abandoning the underlying principles of social insurance. In Latin America, by contrast, the World Bank provided a model and incentives for countries to privatize social insurance programs in hopes of promoting economic stability (World Bank 1994).

Rising public budgets were not the only challenge faced by all western nations. Rather, welfare states designed for an industrial economy and the male breadwinner family type that accompanied it needed to be retooled for service-oriented economies where dual-earner and female-headed households were becoming the norm (Esping-Andersen 2009). In response to new needs associated with changing family structure and the rising labor force participation of women, some nations began also

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restructuring public expenditures. These reforms not only targeted benefit formulas for retirees but also involved measures to improve support systems for working women across the life course.

In this chapter, we first discuss theories of the origins of social insurance systems. We then examine patterns of welfare state restructuring in Europe and the United States, where the commitment to social insurance has endured, and in Latin America where most pension reforms included privatization. In the process, we ask whether gender inequality can be alleviated by adjustments to public pensions or whether more comprehensive changes are needed that take into account the needs of working women.

The Origins of Welfare States

The Logic of Industrialism

When social scientists first sought to explain the phenomenal post-World War II growth of the welfare state, manifested foremost in public pension programs, they drew upon modernization theory, a broader theory of economic development. Modernization theory presumed that nations could be arrayed on a continuum from most to least modern and that all would converge along a similar trend line.

Elements of modernization theory were then modified to explain the development of the welfare state. According to the "logic of industrialism" theory, in preindustrial economies the social character of old age was structured by the family, community and local labor market. Industrialization disrupted these traditional relationships by eroding kinship ties and the patrimonial traditions of agrarian societies and increasing dependence on wage labor. As declining mortality resulted in rising life expectancy and population aging, local institutions lost the capacity to care for growing numbers of the old and the sick and disabled. Industrialization also spurred rapid economic growth, creating surplus funds that made it possible for governments to provide the support that families and local communities could no longer provide. Every industrial nation created public pensions that seemed to support the thesis of convergence.

Thus, some theorists concluded that population aging was the main motor of welfare state development: "If there is one source of welfare spending that is most powerful – a single proximate cause, it is the proportion of old people in the population" (Wilensky 1975:40).

The logic of industrialization theory had one fatal flaw. It could not explain variations around the trend line. Yet numerous studies showed that public pensions varied significantly in generosity and structure, even in nations with comparable levels of economic development (Myles and Quadagno 2002). By the end of the 1970s, social scientists began looking for an alternative explanation that could take into account human agency. The central premise of this new approach was that political forces, not level of development, were responsible for welfare state diversity.

Explaining Variation in Welfare States

Social democratic theory represented an attempt to explain why nations vary in the structure and quality of benefits. Its central claim is that, in an industrial economy, the programs that protect the elderly against income loss and allow for a dignified retirement are determined by politics, not demography. Public pensions do not arise as just an automatic response to need but rather are produced by political groups and economic institutions that establish the parameters of the distributional choices available in the policymaking process (Myles 1989).

What determines the organization of benefits and the degree of generosity? One argument, termed power resource theory, contends that variations across nations in welfare state structure and spending are due to the relative success of left parties aligned with strong trade unions in shaping the democratic class struggle. The most generous welfare states occur in nations where trade unions are able to form a political party and also create cross-class coalitions with other groups. They then use their numerical superiority to enact programs that protect the working class against the vagaries of the market and provide a secure income in old age (Korpi and Palme 1998). Thus, according to power resource theory, variations across nations in public pensions can be explained by the strength of trade unions and degree of working class solidarity.

Welfare States and Social Stratification

Welfare states are not only produced in the struggle between classes but also become mechanisms of social stratification. Once enacted, social programs can reduce inequality produced by markets and even out income over the life course across class, gender, and racial lines (O'Connor et al. 1999). The extent to which welfare states redistribute resources depends on the allocation of responsibility for social needs between the state, the market, and the family. These distributional choices have made it possible to devise typologies that group together nations that adopt similar strategies. One widely-cited typology (Esping-Andersen 1990) identifies three regime types characteristic of Europe and North America: liberal, conservative, and social democratic. Liberal welfare states are characterized by a reverence for the market, a preference for government subsidies to encourage private benefits, and extensive reliance on means-testing in public benefits. Conservative regimes are less concerned with market efficiency and rather emphasize supporting the traditional family and maintaining a hierarchical social order inherited from the past. Finally, social democratic regimes provide universal welfare benefits granted to all as a right of citizenship with private benefits having a marginal role.

Analyses of the distributional consequences of regime types show they can have a significant impact on the well-being of older people. Tai and Treas (2009) found that older adults are significantly less likely to be poor in social democratic and conservative welfare regimes than in liberal regimes. However, in a country classified as liberal, such as Taiwan, multigenerational living arrangements and the associated family support compensates for the lack of public support. Thus, regime type alone is not the only factor in determining how older people fare. Familial traditions also matter.

Determinants of Welfare State Restructuring

The era of welfare state expansion ended in the 1970s, as governments everywhere faced rising deficits and growing awareness of the fiscal strains of population aging on pension and healthcare budgets. Although expenditures in the western, capitalist democracies continued to rise in the 1980s, they rose at a slower rate than in earlier decades and then leveled off in the 1990s. In recent years rollbacks have been commonplace, although they have not occurred without a political struggle (Myles and Quadagno 2000). As many elected officials have learned, it is easier to give benefits than to take them away. This is especially true of benefits that not only protect the poor against destitution but provide income security for the middle class.

As nations have sought to rein in public expenditures, a key question is whether pensions have retained the social insurance principle or rather shifted toward increased private responsibility for

income security in old age (Hacker 2006). Privatization refers to a reduction in public responsibility and an increase in private activity in the financing and provision of social benefits (Gilbert 2002). As a general trend, the private share of spending for retirement income has increased everywhere, even in countries traditionally associated with a collectivist ideology, redrawing the boundaries between the state and the market. Although privatization has occurred to some extent in many European countries and the United States, it is most pervasive in Latin America, a region not included in most typologies.

Budget reduction is not the only item on the political agenda for welfare states. Gender relations and family forms have become central to welfare state restructuring in the contemporary period in ways that they were not during the age of expansion. The social insurance systems created in the postwar period were designed to protect workers against the loss of income in old age and presumed that the typical household consisted of a male breadwinner and a dependent spouse. In the male breadwinner model, married women were subordinated to their husbands in terms of social insurance eligibility and were expected to care for children and other family members with no public support (Lewis 1998). Policies developed around this model took the form of protection for widows and spouses who were not employed outside the home.

Widow and spouse benefits did improve women's income security in old age, but have proved insufficient for an era marked by a dramatic rise in women's education and labor force participation. Working women not only require protection against the loss of a spouse; they also need social benefits that support their multiple familial responsibilities and resultant intermittent employment patterns (Esping-Andersen 2009). Rising divorce rates and increasing numbers of out-of-wedlock births and single parent households also have generated new needs (Castles et al. 2010). Some nations have consciously abandoned the male breadwinner model and enacted policies designed to do more than even out income inequality in old age but also support working women across the life course.

Welfare State Restructuring in Europe

Since the 1980s, many nations have sought to reduce expenditures on public pensions by encouraging greater private responsibility for income security in old age. The transition toward private responsibility comes through an increase in individual savings vehicles and through shifts in the structure of employer-based schemes, which have been stimulated by tax incentives and legal mandates (Gilbert 2002).

Trends in Privatization

Since the 1950s, Sweden, the prototype of the social democratic welfare state, has had a universal, guaranteed basic pension coupled with earnings-related pensions funded through payroll taxes, which also pay for disability benefits and coverage for widows and orphans. Although pension reform moved to the top of the political agenda in the mid-1970s, it was not until 1994 that a new framework was established. In that year Sweden revised the existing social insurance scheme by coupling the basic pension with mandatory private accounts. Individuals and employers "contribute" to these accounts during their working years and accrue pension credits with benefits based on lifetime earnings (Anderson et al. 2008). While this may appear to represent a move toward privatization, the important point about pension reform in Sweden is that no contributions are actually deposited in individual accounts. Rather, retirement benefits are paid based on pay-as-you-go

financing. Further, although Sweden's pension reform seemingly shifted responsibility for retirement income from the public sector toward the individual, balances in individual accounts are protected by the government (Schulz and Binstock 2006). Thus, Sweden retains a substantial amount of government responsibility for the well-being of the aged.

Pension reforms have also taken place in nations classified as conservative welfare state regimes. Italy has enacted reforms that are similar to Sweden's (Schulz and Binstock 2006). In 2000, Germany restructured its pension system, reducing benefits from 70% of average wages to 67%, while offering substantial tax breaks and subsidies to encourage workers to deposit 4% of their earnings into a private pension fund (Jochem 2008). In 1997, France passed a law authorizing private firms to establish employee pension funds. The public pension system remains protected, however, because contributions to private pensions are not deducted from the payroll taxes that fund it (Gilbert 2002).

Although some European countries have introduced or expanded private options, the structure of social insurance remains intact. What is happening is a modest trend toward greater reliance on private funds in some countries. However, this is no guarantee that more radical changes will not take place in the future.

Welfare State Restructuring for Gender Equity

Many countries in Europe have sought to reduce gender inequity in old age by making it easier for women to obtain pension credits during adulthood. These measures reflect the recognition that the male breadwinner model no longer accurately describes the typical family. Throughout most of Europe, female educational attainment now exceeds that of males, and, in several countries, female labor force participation, even among mothers with young children, has soared. For example, in Sweden only 38% of mothers with small children were employed in the early 1960s compared to 82% in the 1980s, a level that has remained stable since then. In Great Britain the change has been more gradual and stabilized at 60%, while Italy and Spain lag behind.

In some European countries, high rates of female labor force participation have been fostered by an activist state and the adoption of family policies that encourage work. Much of the increase has been in part-time work, but there is a significant difference in support for part-time work across countries. Beginning in the late 1960s, Sweden consciously moved toward a dual-breadwinner nation by introducing separate taxation for married couples, generous parental leaves, universal, state-run day care, and policies to encourage greater involvement of fathers in childrearing. Sweden also expanded the definition of work to allow pension credits to be earned for childrearing as well as for military service, spells of illness, unemployment, and disability (Anderson et al. 2008). Most Swedish women working part-time have full benefits and the right to work three-quarter time while their children are young. Thus, Swedish women remain full participants in the public pension system. In the Nordic countries as a whole, the full-time housewife has basically disappeared with part-time work serving as a bridge between childbirth and full-time employment (Esping-Andersen 2009). France also has an array of services and subsidies to support dual-earner families.

This trend is not universal, however, for the Netherlands upholds the male breadwinner model and encourages mothers to stay home with young children (Morgan 2006). Similarly, Great Britain created an allowance for unpaid care work for infirm dependents in the 1970s, but married women were ineligible for this benefit, because caregiving was considered part of their normal duties (Lewis 1998). In Great Britain, part-time work involves short hours and few benefits (Lewis 1998). British women are largely excluded from the public pension system during periods of caregiving.

Variation in approaches to gender equity have inspired alternative typologies based on the extent to which welfare policies are used to encourage a male breadwinner model or promote female labor

force participation. Although some nations have allowed women to earn pension credits for care work, these measures are insufficient to guarantee gender equity. Rather family policies that support working mothers and encourage men to take a more active familial role reduce the penalty women pay for caregiving responsibilities. Such policies recognize that the ability to have secure retirement income for most women depends on interventions earlier in the life course.

Welfare State Restructuring in the United States

In all models that classify nations into regime types, the United States is the archetype of a liberal welfare state, because of its preference for private sector solutions to public problems. In the past quarter century, the U.S. has adopted policies that have gradually eroded the value of Social Security and shifted private pensions from a guaranteed benefit to tax-subsidized savings vehicles (Schulz and Binstock 2006). Thus, privatization in the U.S. involves both a trend toward less public and greater private responsibility for income in old age and a shift in risk from employers to individuals and families (Hacker 2006).

The Trend Toward Privatization

When Social Security was enacted in 1935, it included a strict earnings test. Any beneficiary between the ages of 65 and 69 who earned more than $15 a month lost all benefits. Beneficiaries were expected to retire. In 1956 an early retirement option was extended to women who could retire at 62 with a 20% benefit reduction; in 1961 this privilege was extended to men. The early retirement option decreased the incentive to work and led a long term decline in the average age of retirement (Schulz and Binstock 2006).

Since the 1970s, policies designed to restore the fiscal solvency of the Social Security trust fund have begun to reverse the decline in labor force participation and encourage people to work longer. The 1983 amendments to the Social Security Act, enacted in response to a shortfall in revenues, raised the age of eligibility for full benefits from 65 to 67, and increased the early retirement penalty from 20 to 30%. These changes represented a significant benefit cut over the long term but the pain was not felt immediately because they were phased in gradually. Then in 1994 Social Security benefits for higher income retirees were taxed for the first time. The net effect has been to reduce the value of Social Security benefits relative to wages (Gilbert 2002). The elimination of the earnings test in 2000 for people 65–69 provided a further incentive to encourage work. Thus, incremental changes in Social Security benefits over two decades increased the value of work over retirement and made individuals more responsible for income security in later life.

In 2004 President George W. Bush proposed diverting a portion of Social Security payroll tax revenues into private accounts. His plan created a public uproar, as polls showed that most Americans feared that privatization would destroy the safety net for the elderly poor and reduce income security for the middle class. The proposal was subsequently withdrawn (Beland 2007). The Bush administration's failure to partly privatize Social Security illustrates the principle of middle class universalism (Esping-Andersen 1990). Welfare programs that provide income security for the middle class create a constituency of beneficiaries who mobilize against any threat to their benefits (Pierson 1994).

How, then, did previous efforts to reduce Social Security succeed? There are two explanations. First, the 1983 benefit reductions were enacted during a trust fund crisis, had bi-partisan support and were phased in gradually in the distant future, while the 1994 taxation of benefits affected only a

small percentage of beneficiaries at the time. Second, unlike Sweden, the U.S. already has a private pension system and numerous tax-subsidized options for saving for retirement. That made it difficult to make the case that an additional savings vehicle was needed.

Changes in the nature of private pensions have also increased work incentives. Since the 1940s, private pensions have been an important source of retirement income for many workers (Quadagno 1988). These took the form of defined benefit plans (DB), which were subsidized by the tax system and provided a fixed income for the duration of a retiree's life (McDonnell 2008). A new provision in the tax code, Section 401(k) of the Revenue Act of 1978, shifted employers' incentives away from DB plans to defined contribution (DC) plans (Even and Macpherson 2007). Under DC plans employers make contributions to a tax-protected retirement savings account in the employee's name. Employees are allowed to match a portion of these funds. DC plans encourage work, because the more money in the account, the higher the retirement income. Yet DC plans also increase risk, because income in the funds is not guaranteed for any period of time and can be spent down early. Further, since the funds may be invested in the stock market, retirees could lose a significant portion of their savings in an economic downturn, as occurred in 2008–2009 (Hardy and Shuey 2000; O'Rand and Shuey 2007). Thus, the growth of DC plans has increased private responsibility for income in old age.

Distributional Issues

From the 1930s to the 1970s, Social Security was based on a vision of a male breadwinner and a dependent spouse, and the main policy objective was to provide better protection for wives and widows (Harrington Meyer et al. 2005; Harrington Meyer and Herd 2007). Initially, only workers were eligible for Social Security, but in 1939 a benefit for spouses and widows was added. The benefit paid spouses 50% of the worker benefit while widows received 75% of the combined worker/spouse benefit. In 1961, the widow's benefit was increased to 82% of the deceased workers benefit and then in 1972 to 100%. In response to rising divorce rates, in 1965 spouse benefits were granted to divorced wives, if the marriage had lasted at least 20 years; in 1977 this was reduced to 10 years (Harrington Meyer et al. 2006).

While spouse benefits are available *de jure* to both men and women, *de facto* it is almost always women who receive them. Recently, however, more women have drawn Social Security benefits based on their own earnings, but they receive lower benefits than men, because they earn less and have more breaks in employment (Harrington Meyer 1990; Herd 2005). Social Security has maintained a breadwinner model that has not responded to rising numbers of single parent families and increasing female labor force participation.

The Family and Medical Leave Act of 1993 did allow employees to take job-protected leave for a serious illness or to care for a family member but the leave is unpaid. Further, the FMLA does not include businesses with fewer than 50 employees, part-time workers, or workers who need time off to recover from a common illness like a cold, or to care for a family member with a short-term illness. More importantly, workers who do take leave receive no child care or elder care credits in Social Security to compensate for breaks in employment. In terms of child care, public funds are available only for the very poorest families, mainly those who are recipients of Temporary Assistance for Needy Families (TANF) (Morgan 2006).

Social Security evens out income inequality by providing higher replacement rates for low-wage workers but disparities in benefit levels remain, especially for racial and ethnic minorities. Compared to whites, African-Americans receive less in Social Security income over the life course, because they have lower wages and higher mortality rates (Kail et al. 2008). This disadvantage is exacerbated among African-American women who are less likely than white women to be married, more

likely to be divorced and thus less likely to be eligible for spousal and widow benefits (Harrington Meyer et al. 2006; Herd 2005). Moreover, because African-American women are usually married to African-American men (Jacobs and Labov 2002; Kalmijn 1998), they receive smaller spousal benefits when eligible at all (Harrington Meyer 1996).

Welfare State Restructuring in Latin America

The western, capitalist democracies have introduced some policy initiatives to reduce public pension expenditures and respond to women's rising labor force participation. Yet these initiatives have often been fiercely resisted and in some cases modified or even rescinded. As noted above, in mature welfare states, benefits are difficult to cut because they generate constituencies with a vested interest in the status quo. Compared to Europe, Latin America has moved more rapidly toward privatization, for several reasons: existing social insurance systems had not reached maturity or were failing entirely, public funds were poorly managed, inflation had reduced the real value of benefits, and rates of contribution to the old system had declined. Thus, some changes were necessary, even inevitable, as aging populations, rising life expectancy, and the weakening of the traditional family increased the need for secure income in old age (Barrientos 1998a). The question was what form restructuring would take.

In 1994 the World Bank issued a report, *Averting the Old Age Crisis: Policies to Protect the Old and Promote Growth*, which criticized the failing social insurance schemes and promoted instead a multitier pension system. As an incentive to adopt the new model, developing countries were promised large loans for restructuring purposes (Brooks 2009). Many Latin American countries quickly adopted the multitier system, though to differing degrees (Holzman and Hinz 2005). The consequence was a new regime type.

The Latin American Welfare State Regime

The World Bank program was based on a plan first adopted by Chile in 1981, when the military dictator, General Pinochet, transformed Chile's public pension from a social insurance scheme to a multipillar system (Arenas de Mesa et al. 2008). The first pillar consisted of a means-tested benefit to prevent destitution in old age. The second pillar involved mandatory contributions of 10% of earnings to privately-managed individual accounts, and another 2–3% for administration and survivor and disability benefits. Those who contributed for at least 20 years were guaranteed a minimum pension (MPG), with a government subsidy for low wage workers. The third pillar was a voluntary scheme that allowed workers to contribute additional tax-subsidized savings to privately managed funds (Arenas de Mesa et al. 2008; Williamson 2001).

Many nations followed suit. The pension reforms adopted in Latin American consist of three types. In the first instance, the new system completely replaces the existing program (Bolivia and Mexico in 1997, El Salvador in 1998, and the Dominican Republic in 2003–2006). A second type involves parallel schemes where the private and public systems compete (Peru in 1993 and Colombia in 1994). Finally, in the mixed scheme (Argentina in 1994, Uruguay in 1996 and Costa Rica in 2001), everyone is eligible for a flat pension and those who contribute to private accounts receive an extra, supplementary benefit (Arenas de Mesa and Mesa-Lago 2006; Arza 2008).

Overall, Latin American pension reforms are similar across the region, although specific rules regarding coverage, contributions, and regulations vary from country to country. For example, in Argentina the first pillar is a flat-rate Universal Basic Pension (UBP). After 30 years of work, men

can retire at 65 and women at 60 and receive a benefit that replaces 27.5% of average wages. One percent is added to the pension for each additional year of work up to a maximum of 31.62% (Arenas de Mesa and Bertranou 1997). At age 70, workers with at least 10 years of contributions and widows receive 70% of the UBP (Arenas de Mesa and Mesa-Lago 2006; Arza 2008; James et al. 2008).

Argentina's second pillar allows employees to choose between two systems. The first is a defined-contribution scheme, similar to the Chilean system, where workers contribute 11% of wages to privately managed individual accounts (James et al. 2008). Alternatively, workers may instead invest in another publicly-funded system for additional retirement income (AP). The UBP combined with the AP pays the flat-rate and then an additional percentage for each extra year of service.

Mexico uses a multitier system that includes a Social Quota, which is a prefunded benefit to induce low-income workers to participate in the formal economy, and a second pillar of individually funded retirement accounts (James et al. 2008). Workers contribute 11.5% of wages of which 6.5% goes to an individual retirement account, and 5% to a fund to purchase housing. If the funds are not used for a home purchase, they are refunded to the individual's retirement account (James et al. 2008). While Chile relies solely on individual contributions to fund accounts, Mexico also requires employers and the government to contribute. Workers who contribute for 24 years, and retire (age 60 for women and 65 for men) may arrange for scheduled withdrawals or purchase annuities (Dion 2006).

Distributional Consequences of Privatization in Latin America

One of the World Bank's (1994:20) major criticisms of social insurance systems was that they were unfair to women and low-wage workers:

> Since access to earnings-related benefits is based on employment history, these plans are of limited help to women and others who have had little or low-paid labor market experience. In OECD countries with earnings-related benefits, old women living alone have a much higher poverty rate than other groups.

A stated goal of privatization was to increase coverage rates among women and low-wage workers. Under the former social insurance schemes, coverage rates were low for some groups, participation for the self-employed was voluntary, and women had lower employment rates and wages due to familial responsibilities and employment discrimination. In addition, a flourishing underground economy allowed low wage workers to escape the payroll taxes levied on workers in the formal sector (Barrientos 1998a, b; James et al. 2008; Arza 2008). Yet claims that the multipillar scheme would reduce distributional inequities have not been realized.

In non-Latin American country did privatization lead to the large increase in coverage that policy makers had expected. Rather, in Latin American countries, privatization has had a negative effect on coverage and benefit levels for low-income and women workers. For example, coverage rates in Chile before reform were low and declining. In 1970, the social insurance program covered 75.6% of the labor force compared to just 61.2% in 1980 (Mesa-Lago 1994). Following the 1981 reform, coverage rates increased temporarily to 79.2% in 1985 (Mesa-Lago 1994) but then decreased to 63.6% by 2000 (Arenas de Mesa et al. 2008). Coverage rates for the self-employed, always low, dropped from 12.4% in 1986 to 5.4% in 2004, while the gap in coverage between the richest and the poorest increased from 14.7 to 23.4% from 1992 to 2003 (Arenas de Mesa and Mesa-Lago 2006).

Privatization failed to improve benefits for women. For example, a 2002 survey in Chile found that, on average, women receive pensions that are 50% lower than the average for men, and that

45% of covered women receive benefits that are lower than the minimum pension (Arenas de Mesa and Mesa-Lago 2006). Other countries that pursued the Chilean model have had similar outcomes. There are several reasons why gender inequity remains a problem. In Latin America, as in most other countries, women receive lower pay than men, have higher unemployment rates, and participate more in the informal sector where their work effort is invisible. All these factors result in lower coverage, contribution, and accumulation rates that can't be solved by pension policy alone. For example, nearly all the countries that adopted the World Bank model allowed women to retirement earlier, but lower retirement ages give women have fewer years to qualify for minimum pension guarantees or accumulate sufficient funds to receive high benefits (Arenas de Mesa and Montecinos 1999). The rules regarding eligibility and payout for the contributory schemes exacerbated these problems. Further, many countries use gender-specific tables for benefit calculation. Because women live longer than men on average, the new formulas ensure that they receive lower monthly benefits (Arenas de Mesa and Bertranou 1997; Bertranou 2001; Dion 2006). Guatemala was one of the few Latin American countries that did not adopt the World Bank model but retained a contributory social insurance scheme. Interestingly, although overall pension benefits are lower in Guatemala than in other Latin American countries, female-headed households receive higher benefits compared to Mexico, Peru, and Uruguay (Pederson and Sheka 2010). This suggests that gender inequality in old age cannot be addressed simply through restructuring pension schemes but rather must involve equalizing women's employment opportunities across the life course.

Conclusion

In most western capitalist democracies, the welfare states created in the post-World War II era were social insurance systems designed to provide a guaranteed income in old age at replacement rates that would allow workers to maintain a preretirement standard of living. As welfare states reached maturity, they faced fiscal strains associated with population aging, resulting in fewer workers supporting more retirees. This conundrum was accompanied by fundamental challenges to the core assumptions around which pension programs were structured – that the primary beneficiaries were male workers with a dependent spouse. Thus, nations were faced with dual objectives, to reduce expenditures for future generations and to reconfigure benefits to more adequately reflect the needs of dual-earner families and single parent households.

Some European nations have restructured public pensions in an attempt to reduce gender inequality in benefit levels. These efforts have taken the form of pension credits for years out of the labor force for caregiving responsibilities or reductions in the number of years required for full benefits. Yet these measures are insufficient from a life course perspective. Gender inequity is not a problem that can be resolved solely through pension restructuring. Rather what is needed are policy changes that support women's employment during their adult years and thus reduce the penalty women pay for family caregiving. Higher earned income during adulthood leads to gains in income in old age in both the public and private sphere.

In response to fiscal pressures, many countries have modified the public pensions that were organized around the principles of social insurance and experimented with a variety of options that have increased the importance of private income sources in retirement. The most dramatic changes have occurred in Latin America. Facing ever increasing budget deficits, mismanaged public funds, corrupt government agencies and the fiscal insolvency of social insurance programs, nations from this region created a new regime type based on the World Bank multipillar model. While women and low-income workers were part of the focus, the main goal of privatization was to reduce budget deficits, remove the control of funds from the hands of government, and increase financial stability.

The result did not solve the problems but instead increased old age income inequality for women and the poor.

The Latin American experience provides lessons for nations seeking to cut public expenditures and achieve greater distributional equity. Given that the promise of reducing gender inequality and improving income security for low-wage workers has not materialized, western democracies involved in restructuring welfare states need to be wary. The solution to reducing costs and evening out disparities need not come by destroying social insurance and privatizing a program that spreads the risk across generations and social classes.

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Chapter 21
Volunteering in Later Life: From Disengagement to Civic Engagement

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The topic of volunteering in later life has a long tradition in gerontology, perhaps because historically volunteering was one of the few formal roles available to older adults after leaving the workforce. Volunteer activity fit well with the "busy ethic" that shaped modern retirement (Ekerdt 1986) and was in line with the involvement promoted by activity theory (Havighurst 1963). Yet volunteering was considered a leisure activity (Musick and Wilson 2008), a discretionary role that might fill in for roles losses in employment and parenting. Recently, the discussion has changed, as an upsurge of academic and political interest in volunteering in later life begins to dominate the discourse on civic engagement.

There are several explanations for this change in perspective. First, dramatic gains in health, education, and longevity over the past half-century have increased individuals' capacity and desire for civic roles in later life. Second, the nonprofit sector and many government agencies are struggling to meet increasing demands with stagnant or decreasing resources. In this environment, volunteer labor has become crucial, and maximizing the deployment of older adults depends on knowledge about volunteers that have grown old and volunteers who come forward for the first time in later years. Finally, Robert Putnam's (2000) argument that social capital and civic participation have declined in the later part of the twentieth century has sparked considerable academic and political interest in civic engagement.

Civic engagement is a broad concept with many definitions, but the term usually associated with membership in voluntary associations, volunteering, and political participation. Volunteering through formal organizations has dominated discussions of civic engagement and drawn the most attention from researchers (Martinson and Minkler 2006). In this paper, we focus on formal volunteering, defined as an activity undertaken by an individual that is uncoerced, unpaid (or paid minimal compensation to offset costs), structured by an organization, and directed toward a community concern (Cnaan, Handy, and Wadsworth 1996). We discuss definitional struggles later, but our working definition excludes informal helping and caregiving, two productive activities of great importance to families and communities. This exclusion is in line with the view that volunteering is an altruistic behavior that is aimed at others to whom the volunteer owes no contractual, familial, or friendship obligation (Musick and Wilson 2008). It is, in part, that characteristic that has attracted scholarly attention to volunteering among older adults as a way simultaneously to address societal needs and promote the health of the aging population.

Research on volunteering among older adults has evolved with the emergence of new paradigms about old age and aging, the development of gerontological theories, the production of more and better social science on volunteering, and the creation of new public policies. This

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chapter begins with a brief overview of concepts and theories about volunteering that have emerged over the last several decades. We then summarize the current knowledge base on older volunteers. We end with a review of challenges and opportunities for older adult civic engagement research and policy.

Central Concepts and Developments in Volunteering

Gerontologists long have argued that active engagement in society is related to well-being in later life, and accordingly have promoted various forms of activity and engagement – social, productive, religious, educational, and intergenerational. Today, as the demographic, economic, and social realities of our world shift, another type of active engagement is gaining attention: civic engagement. The confluence of increasingly complex social problems and the burgeoning numbers of people who can expect to live 20 or 30 years past retirement calls us to consider the possibilities of a civically engaged older population. Having older adults vitally involved in volunteer activities aimed at the social good is a win–win scenario that has captured the imagination of many gerontologists, policymakers, and government and nonprofit leaders.

That said, our national efforts to invigorate volunteering have focused largely on youth. Volunteer opportunities for young people have seen impressive growth and improved incentive structures to attract participants. They include volunteer work as a graduation requirement, service learning curricula in schools and universities, and selective young–adult services corps like Teach for America and City Year. Older adults participate in our national service programs, but they are underrepresented in the largest and most widely known programs. For example, volunteers over age 50 account for only 6% of the Peace Corps volunteers (Peace Corps 2009), and fewer than 9% of AmeriCorps volunteers are over the age of 50 (O'Neill 2006–2007). The notable exception is the federal government's network of Senior Corps programs: RSVP, Foster Grandparents, and Senior Companions. Strict income and age eligibility requirements for the latter two programs, however, limit the involvement of large numbers of older adults.

Recently, the focus of civic engagement initiatives has shifted to include older adults. Service programs have emerged that specifically recruit older adults and that hold older age criteria for inclusion (see Morrow-Howell, Carden, and Sherraden 2005). To counter the prevailing view of aging as loss and decline and to combat the focus of public discussions on the significant costs of population aging, gerontologists have begun to use new terms like the new gerontology (Rowe 1997), active aging (World Health Organization 2002), and positive aging (Katz 2001–2002). Scholars now emphasize the health and vitality of the older population, the growing human capital and experience reserves within the older population, and the potential for ongoing and new involvements in later life. As Hudson (2008) summarizes, today's seniors are classified by production and contribution, not just consumption and need. In this changing context, older adults have been called the "new trustees of civic life" (Freedman 1999:19).

Volunteering fits squarely with emerging paradigms of successful and productive aging. Rowe and Kahn (1998) proposed three characteristics of successful aging: physical and functional health; high cognitive function; and active involvement in society. Societal involvement includes both close personal relationships with family and friends and continued involvement in productive activities. In the productive aging perspective (Morrow-Howell, Hinterlong, and Sherraden 2001), volunteering takes center stage – along with working and caregiving – as an activity that should be promoted because it produces economic and social benefits to communities. In fact, the term "unpaid work" gained popularity as a way to recognize the value of volunteering. In these paradigms, volunteering gained new respect, and now is viewed not just as a leisure activity but as a vital function in society and as an indicator of successful aging and a key to wellness in later life.

Volunteering as a health-producing activity is particularly compelling, given the rising costs of health care and the aging of the population. It is a win–win: volunteering not only improves civil society, it also improves the lives of older adults. Advocates call for expanding volunteer involvement of older adults – for the sake of communities as well as older adults themselves – and researchers have supplied the evidence that volunteering has positive effects on older adults, perhaps more so than on younger people (Van Willigen 2000). Of all the aspects of volunteering that social scientists study, the effects of volunteering on older adults' physical health, mental health, and life satisfaction have received the most attention (see Grimm, Spring, and Dietz 2007 for a review). This literature, which we review later, has accumulated to the point that volunteering is viewed as a public health strategy for an aging society (Fried et al. 2004; Tang 2009).

Theoretical Roots Within the Study of Volunteering

One of the original formal theories in social gerontology focused on engagement in later life and proposed that disengagement of older adults from social roles benefited both older adults and society as a whole because it facilitated an orderly transfer of power from one generation to the next (Cumming and Henry 1961). Yet disengagement theory stood in contrast to activity theory with its central proposition that active engagement was a key to a satisfying later life (Havighurst 1963). The positive outcomes associated with volunteering in later life have been explained by activity theory; and this theory is the conceptual base of programs aimed at recruiting and sustaining older adults in volunteer roles. Challenging both disengagement and activity theories, scholars put forth empirical evidence suggesting that late life satisfaction was related to continuing patterns of engagement and that the maintenance of previous activity patterns over time was related to positive outcomes for the individual (Neugarten, Havighurst, and Tobin 1968). Continuity theory (Atchley 1971) continues to explain patterns of volunteering; recent data clearly show that volunteering is a stable activity from midlife on, with past volunteering being the most powerful predictor of current volunteering (Chambré and Einolf 2008). A life course perspective also has been instructive in understanding how motivations, opportunities, and social roles affect the dynamics of volunteering over a lifetime. In the following sections, we review trends, social contexts, and outcomes of volunteering, presenting empirical and conceptual work that has advanced since these theoretical beginnings.

Volunteering in Later Life

Trends and Life Course Patterns

The number of people volunteering in the United States has fluctuated over the past 30 years, causing some observers to express concern about the decline of civic life in America. The volunteer rate for adults 65 years and older, however, has shown a continuous, upward trajectory throughout the last three decades. About 23.9% of adults aged 65 and older who participated in the current population survey (CPS) reported volunteering for an organization in 2009, which was 67% higher than in 1974 (Bureau of Labor Statistics (BLS) 2010; Grimm, Dietz, and Foster-Bey 2006). No other age group experienced such a large rise in its volunteer rate over the same time period.

Research consistently shows a distinct life course pattern of volunteering. Among the U.S. population, the rate of volunteering is shaped like an inverted U, peaking in midlife. On the other hand, the number of hours per volunteer rises linearly with age (Musick and Wilson 2008). September 2009

CPS data show that 26.8% of the U.S. adult population (age 16 and over) volunteered with an organization at least once over the previous year. When delineated by age group, adults aged 35–44 years are most likely to volunteer (31.5%), while adults aged 20–24 years are least likely (18.8%). Older adults (age 65 and over) fall in between, with 23.9% having volunteered over the past year (BLS 2010). The data, however, shows a different trend when one considers the annual number of hours each volunteer devotes to service activities. Older volunteers invest the most hours of any age group, boasting an average of 90 h per year; all other age groups fail to match this, with averages between 36 (ages 25 to 34) and 60 (ages 55 to 64) hours per year. In addition, those aged 65 and over are more likely than any other age group to volunteer more than 500 h per year (BLS).

When asked which type of organization volunteers considered their primary organization, 44.8% of CPS respondents aged 65 and over selected religious organizations. This was followed by social or community service organizations (18% of respondents) and hospital or other health-related organizations (10.1% of respondents). Volunteers aged 65 and older identified public safety organizations or environmental organizations as their primary organizations least frequently (1 and 1.9%, respectively) (BLS).

Although almost one quarter of older adults devote some time to formal volunteer activities, their engagement varies widely by individual characteristics (BLS 2010; Zedlewski and Schaner 2005). Older adults who are in the workforce – especially those in part-time positions – are more likely than their nonworking counterparts to volunteer; older adults with comparatively high levels of education and managerial experience are more likely to begin volunteering than older adults with low levels of education and without managerial experience; older adults who are in excellent or good health are more likely to begin volunteering than their peers with fair or poor health; married older adults are more likely to volunteer than are their peers who are unmarried; and retirees who consider religion important and who are active in their religious communities are more likely to volunteer than their nonreligious counterparts (BLS; Musick and Wilson 2008; Wilson 2000; Zedlewski 2007; Zedlewski and Schaner 2006). The tendency for these individual characteristics to be associated with greater likelihood of volunteering can be explained both by applying a life course continuity theory that asserts that in old age, individuals maintain previously held levels of activity (Atchley 1999; Chambré and Einolf 2008), and by exploring the social context in which an individual resides (Musick and Wilson 2008; Tang 2006).

To test continuity theory, Zedlewski (2007) employed both cross-sectional and longitudinal methods to explore characteristics of older adult volunteers. Her data, taken from the 1996 through 2004 waves of the health and retirement study (HRS), suggest that 81% of the older adults who volunteered before retirement (one-third of adult workers aged 55–64 years) continued to volunteer after retirement, while only 27% of the older adults who did not volunteer before retirement took on volunteer positions after retirement. Similarly, Chambré and Einolf (2008) analysis of data from the 1995 and 2005 waves of the midlife in the United States (MIDUS) survey reveals that the strongest single predictor of whether or not a participant volunteered in 2005 was the participant's volunteer status in 1995; those who volunteered in 2005 likely also volunteered in 1995.

Butrica, Johnson, and Zedlewski's (2009) analysis of HRS data collected over the four consecutive 2-year periods between 1996 and 2004 also reveals stability of volunteer participation over time. Their results show that almost 40% of participants who volunteered in 1996 also volunteered in all three subsequent periods. In contrast, almost every participant who did not volunteer in 1996 also did not volunteer in any subsequent period. Butrica et al.'s data also reveal that the rate at which older volunteers dropout starts relatively high, but declines over time – meaning that the longer an older person volunteers, the less likely he or she is to quit volunteering. Similarly, the likelihood that an older nonvolunteer will begin volunteering starts out low and declines over time, meaning that a nonvolunteer is unlikely to begin volunteering, and the longer an older nonvolunteer refrains from volunteering, the less likely he or she is to start volunteering. In looking closely at the charac-

teristics of the participants who volunteered throughout all four periods, Butrica et al. characterize the most consistent volunteers as those with the highest education, greatest religiosity, and marriage to a spouse who also volunteers.

Social Context

When considering social context, researchers theorize that the traits associated with higher rates of volunteering – continued workforce involvement, high socioeconomic status and educational attainment, good health, marriage, and high religiosity – leading to both greater awareness of and access to volunteer opportunities (Zedlewski 2007) and an increased likelihood of being asked to volunteer (Mutchler, Burr, and Caro 2003; Musick and Wilson 2008; Rotolo and Wilson 2004; Tang 2006). Older adults who remain in the workforce, are married, or are active in their religious communities, have larger social networks and experience greater social connectedness than older adults who are retired, unmarried, or nonreligious. This connectedness increases the likelihood that an older adult both will become aware of volunteer opportunities and will be asked to volunteer (BLS 2010; Gonyea and Googins 2006–2007; Musick and Wilson; Wilson 2000; Zedlewski 2007; Zedlewski and Schaner 2006). Further, older adults who work in managerial or salaried positions tend to have more flexible work schedules and have likely acquired more civic organizational and leadership skills than their lower-status counterparts, making them more desirable recruits, and therefore more likely to be asked to volunteer (Chambré and Einolf 2008; Mutchler et al. 2003; Rotolo and Wilson; Wilson 2004).

Being asked personally to volunteer is more effective than an impersonal appeal (Wilson 2000). According to September 2009 CPS data, 43.5% of volunteers over age 65 became involved with their main organization after being asked to volunteer, often by someone already involved in the organization (BLS 2010). Further, the Committee on an Aging Society reports that when not asked, only one of five people volunteer, but when asked, four of five people volunteer (Independent Sector 2000).

Older adults' volunteering practices and motivations are rooted in their social networks and goals. Tang (2006) found that the importance of one's social network in inducing volunteering is positively related to age. Studies have shown that older volunteers are much more likely than non-volunteers to have friends who volunteer (Wymer 1999). In comparison to younger adults, older adults rely more heavily on their social networks to become involved in volunteering. Plus, compared to younger adults, older adults are more motivated to volunteer by religious beliefs, a desire to interact with friends, and a need to be valued by others, whereas younger adults are more likely to adopt volunteer roles to explore their strengths and interests and to gain advancement in their careers (Chambré and Einolf 2008; Morrow-Howell 2006–2007; Musick and Wilson 2008; Okun and Schultz 2003). These age differences in types of volunteer organizations and activities may be due to different avenues of recruitment as well as different motivations for volunteering.

Older adults adjust their volunteer obligations based on each obligation's relevance for and effect on their well-being. Erikson's "generativity versus stagnation" stage of human development is rooted in an older adult's desire to leave behind a legacy and to pass wisdom and knowledge to younger generations (Erikson, Erikson, and Kivnick 1986). Chambré and Einolf's (2008) analysis of the MIDUS survey showed that older adults' sense of generativity – measured by six statements that discerned a participant's level of concern for the next generation – was highly correlated with the likelihood of volunteering. Cheng (2009: 46) hypothesizes that "because generativity is often manifested in a social context (e.g., assistance to others in need), the judgment of impact [of a volunteer activity], therefore, largely depends on others' feedback." Cheng's results show that when older adults volunteer to benefit younger generations, older adults' belief that they have achieved

their generative goals depends on their perception of respect from younger people. If older people do not feel valued or fail to receive adequate recognition for their volunteer efforts, they likely will discontinue their service (Wilson 2000).

Carstensen's socioemotional selectivity theory explains that later in life, when adults recognize that their time and energy are limited, they pursue only the most meaningful social interactions and avoid those that are least meaningful (Carstensen 1992). When applied to volunteerism, socioemotional selectivity predicts that older people will have fewer overall volunteer commitments than younger adults, but their commitments will be more concentrated. CPS data fit this theory, showing that with age, a volunteer's total number of service hours increases, but these hours are concentrated among fewer organizations than for younger volunteers (BLS 2010; Hendricks and Cutler 2004).

Societal and Personal benefits of Volunteering

Societal Benefits

Older adults' volunteering is tremendously valuable to communities, measured both in economic terms and by the benefits reaped by the recipients of older adults' services (Zedlewski and Butrica 2007). Using data from the 2002 HRS and moderate-cost assumptions for estimating the value of work, Johnson and Schaner (2005) approximate the value of older adults' formal volunteer activities (defined as volunteering through or for an organization) at $44.3 billion per year.

Further, in modeling the Experience Corps Baltimore program's short- and long-term economic contributions to society, Frick and colleagues (2004) calculated that over a 2-year time period, each volunteer showed an average medical expenditure savings of $273 (when compared to a control group), which offset a portion of the program costs. Their models also showed that, in the long-term, if the program could cause even a mere 0.4% of students who would not have graduated otherwise to graduate eventually, the long-term benefits to the economy would far offset the program costs. These few additional graduates could expect increased lifetime earnings, and could expect to reap the health and sociocultural benefits associated with higher education.

Although these economic estimates are striking, they do not capture fully the personal benefits reaped by the recipients of older adults' services. Wheeler, Gorey, and Greenblatt (1998) conducted a meta-analysis of 37 studies published in the prior 25 years, nine of which measured the benefits to recipients of older adult volunteerism. Out of these nine studies, care recipients in four were nursing home residents, recipients in two were community-dwelling older adults, recipients in two were disabled children, and recipients in one were elderly caregivers. Studies measured various outcomes, but all included one of the following: life satisfaction and happiness, depression and isolation, client-assessed helpfulness, and goal attainment. When controlling for sample size, selection of participants, country, major design typology, and type or validity of dependent measures, Wheeler et al. found that 85% of people served by older adult volunteers showed improvement in the target area.

Additional research has found that older adult volunteers in preschool classrooms greatly help struggling kids adjust to school, and promote manners, appropriate behavior, and language development under stricter guidelines than are set by the professional educators (Larkin and Newman 2001). Older adult volunteers in primary and secondary schools significantly help improve attendance, academic achievement, and well-being, and significantly help decrease behavioral problems and substance use and abuse (Blieszner and Artale 2001; Rebok et al. 2004; Rogers and Taylor 1997). Older volunteers help increase graduation and retention rates of high school children and college freshmen, respectively (Coleman and DeRosa 2006; Muir 2006); and older volunteers' services help frail older adults remain independent and delay institutionalization (Barker 2002).

Personal Benefits

In addition to its value to the community, volunteering significantly benefits older adults. In fact, Van Willigen (2000) found that older volunteers reaped greater benefits than their younger counterparts. Volunteering in later life has been associated with improved physical health and decreased functional dependency (Fried et al. 2004; Luoh and Herzog 2002; Morrow-Howell et al. 2003; Tan et al. 2009; Tang 2009; Thoits and Hewitt 2001; Van Willigen), decreased morbidity (Fengler 1984; Luoh and Herzog 2002; Musick, Herzog, and House 1999), increased psychological well-being and fewer depressive symptoms (Greenfield and Marks 2004; Hao 2008; Jirovec and Hyduk 1998; Morrow-Howell et al. 2003; Morrow-Howell, Hong, and Tang 2009; Newman, Vasudev, and Onawola 1985; Sugihara et al. 2008; Thoits and Hewitt 2001; Windsor, Anstey, and Rodgers 2008), increased life satisfaction and quality of life (Van Willigen; Wheeler et al. 1998), improved cognitive ability and slower age-related cognitive decline (Carlson et al. 2008; Fried et al. 2004; Hao 2008; Park et al. 2007; Stine-Morrow et al. 2007), increased self efficacy (Li 2007), increased resilience and protection against role loss and negative life events (Greenfield and Marks 2004; Li 2007; Sugihara et al. 2008), and decreased mortality (Glass et al. 1999; Musick et al. 1999.). What is more, if an older adult is not civically and socially engaged, they risk experiencing decreased purpose in life (Greenfield and Marks 2004), health decline due to stagnant physical activity levels (Tan et al. 2009), and increased mortality, especially in the case of an emergency (Cannuscio, Block, and Kawachi 2003). In an extreme example, Semenza and colleagues (1996) studied deaths related to the July 1995 Chicago heat wave – three-fourths of which occurred among adults aged 65 and older – and found that socially isolated older adults (i.e., those who didn't participate in community groups) faced the highest risk of death; social isolation prevented many older residents from seeking shelter in community cooling centers and from being drawn out of their homes by concerned neighbors, friends, and colleagues.

Although countless studies identify the benefits of volunteering for older adults, research that explores the optimal amount of volunteering is inconsistent. Many researchers' data support a linear pattern, in which increased volunteering is associated with increasing benefits (Hinterlong, Morrow-Howell, and Rozario 2007), whereas others' data show that the positive effects of engagement persist to an upper limit, and any engagement beyond the limit has no further effect (Butrica and Schaner 2005). In contrast, Musick and colleagues' (1999) and Windsor and colleagues' (2008) data reveals a curvilinear pattern, in which increased volunteering is associated with increased benefits until a moderate number of hours (Musick et al. assign this upper limit at 40 annual hours and Windsor et al. at 800 annual hours), at which point increased volunteering hours are associated with decreasing benefits.

Explanations

Several mechanisms have been suggested as being responsible for the benefits of volunteering. For example, volunteering has been associated with greater social support and a stronger sense of responsibility and purpose that accompanies social and productive engagement. According to role theory, ebbing social roles (i.e., student, parent, spouse, employee) associated with later life can lead to decreased well-being. Therefore, adopting a formal volunteer role may serve to moderate the negative effect of role loss, especially for older adults who have experienced the most significant role losses (Adelmann 1994; Greenfield and Marks 2004; Sugihara et al. 2008; Van Willigen 2000). In fact, Musick and colleagues' (1999) data show the strongest protective effect of volunteering for participants who previously engaged in the least informal social interaction; specifically, lower-income, lower-educated, single, and minority older adults reaped more benefits than their higher-income,

higher-educated, married, and nonminority counterparts (Carlson et al. 2008; Fengler 1984; Morrow-Howell et al. 2009). This supports widely-accepted notions that social interaction and the accompanying affection, behavioral confirmation, and support attained through engagement actually is responsible for volunteerism's beneficial effects (Fried et al. 2004; Glass et al. 2006; Grundy et al. 2007; Li 2007; Luoh & Herzog 2002; Park et al. 2007; Rowe and Kahn 1997; Steverink and Lindenberg 2006; Stine-Morrow et al. 2007; Sun and Liu 2006; Tang 2009; Thoits and Hewett 2001).

An alternative explanation for the benefits of engagement is the sense of responsibility, purpose, productivity, and usefulness one feels when engaged in volunteering (Greenfield and Marks 2004; Langer and Rodin 1976; Luoh and Herzog 2002; Mannell 1993; Rowe and Kahn 1997). To demonstrate the power of a sense of responsibility and purpose, Wilson et al. (2007) analyzed and reported 12 years of data from The Religious Orders Study; participants included 997 older Catholic nuns, priests, and brothers recruited from more than 40 groups across the country. Upon enrollment, each participant underwent a uniform clinical evaluation that included a medical history, a complete neurological examination, and a set of 20 cognitive evaluations. This set of evaluations was repeated annually for up to 12 years. In the case of death, a participant's brain underwent a full neuropathologic evaluation.

Results show that high conscientiousness, defined as "an individual's tendency to control impulses and be goal directed . . . be self-disciplined, scrupulous, and purposeful" (Wilson et al. 2007:1204–1205), is associated with reduced risk for Alzheimer's disease, even when controlling for all covariates individually and collectively: age, sex, education, the effect of other personality traits (neuroticism, extraversion, openness, and agreeableness), physical activity, frequency of cognitive activity, size of social network, depressive symptoms, and mild cognitive impairment. Further, when examining participants' brains during autopsies, many highly conscientious participants had lesions and tangles that would meet criteria for Alzheimer's, but those patients did not exhibit any symptoms of dementia before death. Although Wilson et al.'s sample was relatively homogenous and does not represent the general population, their data strongly suggest that reduced risk of Alzheimer's disease is associated with the sense of purpose and discipline that accompanies holding volunteer roles in later life.

Challenges and Directions for Future Research

Institutional Lag

Aging advocates long have pointed to the asynchrony between the human capital resources of the aging population and the capacity of organizational structures to engage older adults in socially valued and productive roles (Riley and Riley 1994). A current concern is that organizations are not ready to take advantage of the growing numbers of older volunteers (Casner-Lotto 2007; Freedman 1999). In a large survey of nonprofits conducted by the Urban Institute (Hager and Brudney 2004), researchers noted that organizational adoption of recommended volunteer management practices was not widespread. About 30% of older adults drop out of volunteering after 1 year of service (Foster-Bey, Grimm, and Dietz 2007), a loss of volunteer labor that is estimated at about $38 billion a year (Eisner et al. 2009). Plus, turnover tends to be associated with the nature of the volunteer work. For example, volunteer tenure was the shortest for those providing general labor or supplying transportation and longest for those providing professional or management services (Foster-Bey et al.).

To advance understanding of these issues, new models of volunteer engagement have focused on organizational structures rather than individual volunteers' characteristics. Invoking Riley and Riley's (1994) concept of structural lag, researchers have begun systematically to define and measure aspects of institutional capacity that affect the recruitment, retention, and effective use of

older volunteers (Sherraden et al. 2001; Hong et al. 2009). For example, in a study of 374 volunteers across 51 service programs, Tang, Morrow-Howell, and Hong (2008) document the importance of flexibility in terms of time commitment, schedule, and type of volunteer activity to older volunteers in general, and to low-income and non-White volunteers in particular. In another study using the institutional perspective, McBride et al. (2009) demonstrate the role of stipends in increasing diversity among older volunteers and ensuring retention. Other work suggests that volunteer turnover can be reduced by ensuring that volunteers gain a sense of accomplishment and are recognized for their contributions by effectively monitoring and supervising their activities and by providing various cash or in-kind compensation to meet expenses (Cnaan and Cascio 1998; Finkelstein, Penner, and Brannick 2005; Wilson and Musick 1999; Netting et al. 2004). In addition, characteristics of volunteer programs like adequate training, supervision, recognition, flexibility, and stipends, are associated with more positive outcomes in terms of meeting volunteer expectations, intensity and duration of volunteer service, and perceived benefits of participation (McBride et al. 2009).

As Musick and Wilson (2008) point out, individual characteristics, such as capacities, values, and attitudes, are necessary but not sufficient to move people into volunteering. Given the low likelihood of modifying *individual* capacity, especially in older populations, improving *institutional* capacity may be the most promising direction for future research aimed at maximizing volunteer engagement and outcomes.

Critical Perspectives

Evidence to date indicates that civic engagement benefits both participants and the broader community. That fact notwithstanding, scholars must heed concerns from critical gerontology (Holstein 2006; Hudson 2008; Martinson and Minkler 2006). Martinson and Minkler have argued that the "politics of [welfare-state] retrenchment and devolution" over the past three decades have served as a "powerful motivator for the current promotion of volunteering in later life" (p. 321); there is concern that older adults are being called on as substitutes for critical public funding support to nonprofit and public organizations that meet community needs. Also, researchers express concern that civic engagement among older adults is dominated by high-resource individuals and fails to include the ethnic and socioeconomic diversity of the older population. Because the term civic engagement commonly favors formal volunteer activity, it devalues informal volunteering or helping outside of an official volunteer structure. Neighborhood- and family-based helping, however, is common among minority groups, including African-Americans and Hispanics, who often do not define helping as "volunteering," and therefore are unlikely to report it as such on a survey. Nor do most immigrant groups, which have rich traditions of helping others, self-describe their roles in terms of "volunteering" (Yoshida, Gordon, and Henkin 2008). Studies have noted that "volunteering" and "service" are cultural constructs of specific segments of American society that may be understood differently across different groups. For example, in low-income populations, the term "community service" may have negative connotations, conjuring images of court-ordered community service. Studies also have found that the term "volunteer" does not resonate well among African-American and Hispanics who traditionally have been viewed as recipients of services rather than as contributors engaged in community problem solving (Center for Health Communication, Harvard School of Public Health 2004). In presenting volunteering as a normative retirement role, older adults who do not engage risk judgment (Kaskie et al. 2008). Holstein (2006) and Ekerdt (1986) express concern that coercive social expectations, comparable to the notion of a work ethic or a "busy ethic" around older adult civic engagement, may denigrate those who are too ill, too poor, or otherwise unable to join the movement. The challenge for policymakers, program leaders, and researchers is to expand older adults' opportunities for civic contribution while addressing their economic, social, cultural, and physical diversity.

Bowling Alone or Blogging Together?

Putnam's claim that participation in virtually every traditional civic, social, and fraternal arena – including politics, churches, labor unions, parent–teacher associations, and even organized bowling leagues – has declined since the 1960s has generated vigorous discussion and debate among academics and policymakers alike. Critics claim that his argument relies too heavily on statistics showing declines in membership in fraternal organizations like the Boy Scouts, 4-H Clubs, Shriners, and Elks, but overlooks newer organizations that have risen to take their places, such as Habitat for Humanity and Meals on Wheels (Rich 1999; Schudson 2006). The United States, Putnam's detractors maintain, simply is experiencing a transformation in its forms of civic engagement rather than a decline. More traditional civic associations, such as the PTA., the League of Women Voters, or the American Legion, are giving way to new and alternative forms of political and civic engagement, particularly those facilitated by the Internet. Volunteering, in particular, is expanding through the Internet. Indeed, some researchers have faith that the Internet will launch and nurture forms of civic engagement that will be as important to communities as were the Rotary, Kiwanis, and Lions Clubs in past decades (Ester and Vinken 2003).

The Internet is creating new ways for people to connect and engage with one another. According to data from VolunteerMatch.com, an online database of volunteer jobs, interest in "virtual" or remote volunteering is rising dramatically. In 2005, volunteers matched themselves to nearly 40,000 virtual positions on VolunteerMatch.org, compared with 15,000 in 2000. The increase of websites like onlinevolunteering.org, an initiative by the United Nations Volunteers program, helps nonprofits around the world find online volunteers for jobs like editing or translating documents, writing newsletters, mentoring, and creating databases. Nonprofits and charities find that recruiting online volunteers not only helps them expand their searches beyond their immediate geographic areas but also helps them appeal to people with busy schedules and attract a more diverse and skilled volunteer corps than they otherwise might. Also, online volunteering offers those with physical limitations, home-based obligations, or transportation barriers opportunities to engage. People who volunteer through the Internet find that because they work around their own schedules – and avoid commuting – they are able to donate more time and energy to causes that really matter to them (Vail 2008).

Although Putnam worries about the Internet's tendency to separate people from each other rather than bring them together, others see the Internet as an opportunity to reestablish connections – through email lists, affinity groups, chat rooms, and blogs – that have been lost as fewer people join civic organizations (Uslaner 2004). Scholars like Ester and Vinken (2003:667) argue that the evidence about the Internet, taken together, makes "a strong case that the potential for advancing civil society is more likely to be rising than declining." Moreover, a study by Best and Krueger (2006) that uses nationally representative data and more refined measures of online social interactions than previously available finds that online interactions do foster connections critical to expanding social networks and producing residuals – jointly known as "social capital" – such as generalized trust, integrity, and reciprocity. Finally, although Gilleard, Hyde, and Higgs (2007) found a decreased attachment to the physical community with increased technology use, their data assert that communication technology use does not decrease the sense of trust and friendliness of a neighborhood.

Clearly, there is a need for research and theory on civic engagement to consider how the Internet is developing as an alternative to traditional civic engagement structures. As Ester and Vinken (2003) note, however, standard political and civic engagement participation scales found in mainstream survey research do not cover such new forms of political and civic involvement. The authors argue that scholars must develop ways to measure these contemporary forms of civic engagement before conclusions can be drawn regarding the decline of civic life in the twenty-first century.

A "Civic Core"?

Despite the popularity of Putnam's work, recent research finds little support for his claim that levels of civic engagement are declining in the general population (Foster-Bey et al. 2007) or that baby boomers will volunteer in smaller numbers than previous elderly cohorts (Einolf 2009; Rotolo and Wilson 2004). Putnam's observation that some individuals are considerably more engaged in civic activities than others, however, has stimulated new research that raises questions about the challenges of citizen engagement. Using data from the 2000 National Survey of Giving, Volunteering, and Participating conducted by Statistics Canada, Reed and Selbee (2001) identify the principal contributors in each of three modes of civic engagement: volunteering, charitable giving, and participation in community organizations. Their data reveal a small cadre – a civic core – of individuals who are involved heavily in giving, volunteering, and participating. Indeed, the authors find a remarkably high degree of concentration: one quarter of adults account for about three quarters of all time and money contributed to communal and charitable activities. Furthermore, the disparity in engagement levels likely is not unique to Canada. Several U.S. studies suggest that a small proportion of older adult volunteers account for the majority of volunteer time (Fischer, Mueller, and Cooper 1991; Kaskie et al. 2008). Burr, Mutchler, and Caro's (2007) finding that a small group of "super helpers" are engaged heavily in a cluster of productive activities in later life lends support to the thesis that most civic activity is done by a small proportion of the population. Although the finding may not seem surprising – and conforms to popular notions of "super volunteers" – its implications for strengthening civic engagement among older adults have not yet been addressed by researchers or policymakers. Clearly, further research is required to determine accurately the disparity in levels of civic activity among older Americans.

The Search for a Consensual Definition of Civic Engagement

Before researchers truly can measure civic engagement, they must agree on a common definition. To date, there is no prevailing definition, although many have been offered (National Academy on an Aging Society 2009a). The term currently encompasses a range of activities, "[f]rom volunteering to voting, from community organizing to political advocacy." Central to most characterizations is the notion that civic engagement is *action* that contributes "to the improvement of one's community, neighborhood, and nation" (Philanthropy for Active Civic Engagement 2009, ¶ 7). The types of activities identified as civic engagement fall into two broad categories: social (including most behaviors classified as volunteering and public service) and political (including participation in all levels of the political process; McBride 2006–2007). The multifaceted character of civic engagement likely is responsible for a lack of consensus regarding its definition. Not only does the concept of civic engagement cover a number of different activities, but it encompasses volunteering done on behalf of formal organizations, including schools, churches, hospitals, and nonprofit organizations, and on behalf of informal entities, such as friends, neighbors, and relatives (Putnam 2000).

Further complicating matters is that some observers include both paid and unpaid contributions under the same rubric. The advent of incentive programs, such as educational vouchers, stipends, and other forms of compensation has blurred the line between paid and unpaid participation. Moreover, some scholars argue that unpaid caregiving constitutes a vital form of civic engagement (Herd and Meyer 2002; Martinson and Minkler 2006). Others suggest that civic engagement includes the acquisition of knowledge and skills required to perform various civic actions (Fisher, McInerney, and Petersen 2005).

Recently, Toppe and Galaskiewicz (2006) proposed that civic engagement be conceptualized and measured along four dimensions: (1) helping, including volunteering and neighboring; (2) giving to people, organizations, and causes; (3) influencing, including political and cause-related activities; and (4) participating, as in group memberships or bowling leagues. Their detailed typology has been applied in recent work (e.g., Yoshida et al. 2008) and shows promise as a starting point for a systematic approach to the conceptualization and measurement of civic engagement. Given widespread efforts to promote civic engagement, a more precise definition will help policymakers and program administrators target the activities that receive public and private support. Further, as Kaskie et al. (2008: 370) note, "being able to define and differentiate individuals who occupy this role may help researchers conduct a more rigorous evaluation of the relationships among civic engagement, social capital, and individual health outcomes."

Policy Implications

The retirement of the baby boom cohort over the next 20 years offers an unprecedented opportunity to tap into a large base of potential volunteers. But policy interventions are needed to ensure that all older adults have opportunities to engage in volunteer activities that can benefit the community as well as the volunteers themselves (Kahana and Force 2008). Key findings we have highlighted can guide policy initiatives to maximize volunteer recruitment, retention, and benefits. Evidence suggests that the most effective way to recruit a volunteer is to ask them (Independent Sector 2000). In light of the fact that the American Time Use Survey finds that adults aged 65 and over spend much more time watching television (4 h) than do younger adults (2.5 h), it may prove effective to disseminate such information through public awareness campaigns that would educate older adults about volunteer opportunities and the positive health outcomes of engagement (Kaskie et al. 2008). Further, media campaigns targeting those of lower socioeconomic status might yield the largest payoffs because these individuals report the lowest levels of volunteer activity. Another recruitment strategy could come from the finding that past volunteering is the leading predictor of future volunteering. Zedlewski (2007), for example, showed that the share of working persons who start volunteering after retirement is much smaller than those who continue to volunteer after retirement. With little evidence that retirement inspires volunteering, recruiting initiatives may experience greater payoffs by targeting young and middle-aged adults while they are still in the workforce. The strong link between work and volunteering spotlights the critical role of the business sector in promoting volunteering among the aging population. Work-based volunteer programs in particular have the potential to promote a commitment to volunteering among workers that will extend into retirement (Gonyea and Googins 2006–2007). Recognizing the importance of volunteering continuity, policymakers might offer subsidies, tax credits, and other incentives to encourage employers to expand community service opportunities for their employees as they approach retirement (O'Neill 2006–2007).

From an institutional perspective, research reviewed here has demonstrated that voluntary organizations can facilitate the inclusion of older adults from diverse backgrounds by offering stipends, increasing role flexibility in the volunteer position, and providing public recognition for the volunteers' contributions. Furthermore, expanding home-based volunteer opportunities (via telephone or computer) could increase access for older adults with disabilities, transportation difficulties, or mobility challenges. Policymakers also can use rewards and incentives to encourage activities that benefit the public. Studies suggest that small incentives – such as education credits, access to group health insurance, or a modest monthly stipend – might reap large benefits by attracting more adults into community service (Bridgeland, Putnam, and Wofford 2008). Indeed, the utilization of stipended volunteers long has been seen as a route to maximizing the participation of low-income older adults. For example, older adults at or below 125% of the poverty line can serve in the

voluntary programs of the national Senior Corps for 15–20 h per week in exchange for a modest stipend of $2.65 an hour. Also, under Experience Corps, a school-based program, older adults work one-on-one with young children, create and run before- and after-school programs, and receive modest stipends for their services. Not only does this program reach out to an underutilized group of volunteers (generally older, low-income African-Americans), but it also helps to address their economic needs. Morrow-Howell and colleagues (2003, 2009) go so far as to recommend that because of the benefits reaped, it might make sense to select low-income and minority volunteers because of the greater likelihood of maximizing returns to the individuals.

Although advocates for these programs agree that they do a great deal to facilitate the involvement of low-income older adults, the age, income, and commitment requirements often are viewed as exclusive of a broad population of older adults – especially among baby boomers (Freedman 1999). In April 2009, however, President Obama signed the Edward M. Kennedy Serve America Act; it calls for the increased engagement of older adults in volunteer roles, allotting 10% of AmeriCorps' total FY 2010 budget of $372.5 million for organizations enrolling adults aged 55 and older, and funding $1,000 higher education awards – transferable to children and grandchildren – to older volunteers who contribute 350 h of service annually (Edward M. Kennedy Serve America Act 2009, § 2142). The new law also expands service options for older Americans by lowering the age requirement for the Foster Grandparent and Senior Companion programs from 60–55, and increasing hourly stipend eligibility for these programs from 125 to 200% of the federal poverty level.

The passage of this landmark legislation – the largest expansion of national service since the Civilian Conservation Corps during the Great Depression – highlights the need to increase the amount of science-based research aimed at improving recruitment and retention of older volunteers.

Conclusion

Civic engagement among older adults is gaining attention in both popular and academic press. As the health and education of aging Americans continue to increase, so does the opportunity to engage this population in civic activities aimed at improving communities. Furthermore, older adults' volunteer activities help governments and nonprofit organizations meet the growing demand for social services. As we have highlighted, increased volunteerism has a palpable effect on the economy, and potentially reduces government costs, as the resulting healthier older adults require less health care (Zedlewski and Butrica 2007).

This win–win scenario has captured the attention of social scientists, policymakers, and nonprofit leaders who promote civic engagement and has spawned a host of related activities. The three major professional associations focused on aging in this country – the American Society on Aging, The Gerontological Society of America, and the National Council on Aging – have made civic engagement a programmatic priority. Research on volunteering has benefitted from keen interest by private foundations. The Atlantic Philanthropies and the MetLife Foundation, in particular, have invested significant resources in program and policy developments. These developments have created opportunities for applied research and community-academic partnerships. Research has played an important role in building a civic engagement movement and expanding the Civic Enterprise (National Academy on an Aging Society 2009b), the network of interrelated initiatives focused on civic engagement among older adults. For example, the accumulation of more and better evidence on the health benefits of volunteering is responsible for the push to expand volunteer opportunities as a public health strategy. In other ways, however, action is outstripping knowledge development, especially in regards to effective strategies to recruit and retain older volunteers. Applied social science knowledge about engaging older volunteers to guide program and policy initiatives has never been more important.

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Chapter 22
Business and Aging: The Boomer Effect on Consumers and Marketing

Janice I. Wassel

This chapter provides a foundation for understanding businesses' emerging interest in the older adult as a consumer and introduces the silver market phenomenon dedicated to the mature market. We present the influence of consumerism on the life courses of American baby boomers and the importance of considering the life course perspective for researching older adult consumers. Finally, we discuss the potential of aging boomers and older adults as valuable economic contributors.

With increasing numbers of people currently living to old age and the first American baby boomer reaching the traditional retirement age of 65 years in 2011, we experience the demographic shift from America being a young country to an aging country. The success of longevity over the past 50 years spawns major challenges for vast and complex social and economic systems on which government agencies, businesses, and individuals depend. In response to this demographic shift, attention has been focused on the projected costs and issues of an aging society. Recurrent themes characterize older adults as unproductive members of society and "passive consumers of public services, especially of health care and pensions" (Moody 2008:4).

The meaning of old age rooted in social and cultural contexts of classic age-graded roles diminishes with the democratization of old age and the democratization of good health at older ages (Cutler 2002). In the past, little attention was paid to the nearly 80% of adults aged 65 and over with no limitations in movement, sensory, or cognition as consumers (National Center for Health Statisics 2009). Expectations of societal disengagement after orderly transitions from birth to death through education, family, and work stages to retirement and death no longer holds for engaged older adults and aging boomers (Dannefer and Miklowski 2006). Businesses and nonprofits now find that older adults continue to be productive and active consumers. As the sizeable boomer cohort approaches the traditional retirement age of 65, there is increased interest in the mature market, a traditionally neglected group. The United States lags behind aging countries such as Japan and Germany in valuing the older consumer.

Macrolevel economics of aging focus on retirement saving and policy, labor market behavior, sustainability of Social Security, and relationship of health and economic circumstances. Aging and business concentrate on developing and marketing products for older adults (Coulmas 2008). Aging and business address the opportunity for profits while providing services and products and meeting the needs of the growing population of older adult consumers. Neither is the economics of aging and business mutually exclusive, but complementary in seeking to better the lives of older adults.

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Consumers Through the Life Course Lens

The richness of the life course perspective provides a method to examine dynamic influences on lives at earlier years to explain outcomes at later years. The life course perspective measures continuity and change sequences as individuals move through complex roles and the influence that the sequencing and timing these roles have on later outcomes (Elder 2006). Moreover, life course analysis may be used at a population level to examine the cumulative effect of social and historical change resulting in intracohort and intercohort variation. For example, the life course perspective helps understand the *cumulative advantage/disadvantage* of inequality as a cohort ages in boomer's wealth. Recently, the life course analysis serves as a paradigm for family physicians understanding individual patients' health in context over time (Daaleman and Elder 2007; Dannefer and Miklowski 2006; Hughes and O'Rand 2004).

Moschis (2007) proposes that the life course perspective is an appropriate methodology with which to study consumer behavior. Current consumer research has been dominated by cross-sectional studies observing different age groups and then comparing consumption behaviors for different age groups. Studies have not considered consumption patterns over the individual's life course or how past experiences within the historical or social context may influence consumption later in the life course (p. 295). For instance, while recent studies conclude that stressful family events during adolescence affect the development of materialism and compulsive consumptions, Moschis suggests that conclusions would be richer if the timing and duration of the stressful events were measured. Television's role or peer influence on consumer behavior might be advanced if individual exposure and timing was integrated into the research model. Although marketers use role transitions or events as criteria to target certain consumption behaviors, they do not consider how life events and historical consumption patterns contribute to consumer behavior.

As individuals age and move through complex roles within social and historical time, patterns of consumption and saving emerge. Modigliani and Brumberg (1954) developed the "Life Cycle Theory of Consumption" whereby individuals make rational consumption choices fluctuating by individuals' age. Based on total expected lifetime earnings, individuals at different ages adjust personal spending. Savings behavior, they conclude, is driven by the desire to prepare for retirement. They observed that consumption and income often are unequal throughout the life cycle. Younger individuals' consumption usually exceeds income. By middle age, consumption tends to level or decrease while earnings, on average, increase resulting in higher savings levels. At older ages and in retirement when incomes declined, individuals use savings for consumption. This model of savings and consumption assumes a static and traditional life course from education to work and family to retirement. Yet, the role of consumption and savings throughout the life course may have changed since the 1950s as individuals' life courses have changed.

In societies that value consumption, older adults with resources and with a life history of consumption are increasingly important. Rather than devaluation at retirement as modernization theory suggests, older consumers' status should increase as valuable economic contributors (Blaikle 2006). Older adults' consumption may be constrained by health status and resources, but it may also be biased by the perception of them as poor consumers. The demographics of the baby boom and their role as consumers throughout their lives should influence businesses to see older adults as a viable and profitable market.

The American Baby Boom: A Business Opportunity

> Your future is great in a growing America. Every day 11,000 babies are born in America. This means new businesses, new jobs, new opportunities" read public service posters hanging in the New York Subway in the 1950s (Jones 1980:37).

Boomers have been a business phenomenon since they were babies and will continue through old age. The baby boom that followed World War II was a "boom" for businesses, marketers, and the economy (Lindop and DeCapua 2010). Beginning in 1946 and lasting through 1964, America experienced unparalleled and unanticipated fertility. Historically a young nation, with each baby boomer born America became even younger. The median age of the general population dropped from 30.2 years in 1950 to 26.3 years by 1970 (U.S. Census Bureau 2003). The economic and public spotlight on the thousands of babies increased the status of children. Children became a focal point for families, government policy, and business. Public service announcements posted in the New York subway stations during the 1950s advertised innovative and ever-increasing business possibilities this surge of babies and expanding families brought to the American market (Jones 1980). This flood of babies both shaped and was shaped by the culture and times in which the baby boomers were born. The life course perspective is constructive to understand how boomers influenced businesses since infancy and businesses marketed to boomers as they aged.

The boomers are the first generation of children cultivated as consumers through a new technology, television. As the baby boomers grew into kids, teens, and young adults, they set the fads, spent the money (even when their parents paid), and popularized new products and services (Jones 1980). In the 1960s, youth spending grew the economy, on average $12 billion yearly. Fifty-three percent of boomer teens purchased movie tickets, 43% records, and 20% of high school seniors drove their own cars (Hamilton et al. 2000). Never before in American history had youth influenced the economy as the uninterrupted economic growth of the 1960s surpassed the prosperous 1950s. Yet disparity persisted through this economic growth. Nearly 20% of Americans in 1964 lived in poverty leaving many boomers unable to purchase the products they saw advertised on television (DeNavas-Walt et al. 2006).

Overlooked in the social construction of Baby Boom Generation is their diversity. Whether in news articles or conversation, regularly boomers are lumped into a single entity. Yet, as the last boomers (born in 1964) entered kindergarten, the first boomers (born in 1946) might be fighting in Vietnam. Described both as selfish and negative or idealistic and positive, highly educated, affluent, innovative, and "The Me Generation" (Hughes and O'Rand 2004; Moody 2008), this image clouds disparities in household incomes, home ownership, and net worth of current middle-aged and older boomers. Hughes and O'Rand found increased disparity in affluence and poverty between the leading-edge boomers (those born 1946–1954) and late boomers (born 1955–1964) with late boomers significantly at higher risk of near poverty at middle age.

Late boomers comprise the largest population share of all adults aged 18 and older (26%) and are 73% larger than the leading-edge boomers who are only 15% of the adult population. Identified as Generation Jones by Jonathan Pontell, the "Gen Jonesers" grew up in the shadows of early boomers (Sheridan 2008). Unlike the leading boomers, Gen Jonesers in the 1970s found an economy shaken by the Vietnam War, the OPEC price hikes and an already boomer saturated job market. Television was not just entertainment, but brought Watergate into family living rooms. The 1980s economy made home ownership increasingly difficult for Gen Jonesers (Hamilton et al. 2000).

Experiences of early childhood and adolescence for late boomers differed from the robust 1950s and 1960s economy perhaps contributing to lack of boomer identity by late boomers. A 2008 nationally representative sample of 500 U.S. adults born in 1961 were asked: "Do you consider yourself to be a member of the Baby Boom Generation, Generation X, or a lost generation in-between (usually called Generation Jones)?" Only 22% of respondents considered themselves to be part of the Baby Boom Generation, while 57% identified with Generation Jones (Sheridan 2008). Generalizations of the Baby Boomer Generation obscure possible early life course effects on early and late boomers' intracohort differences whether in purchasing power or differential job market experiences.

Historical Beginnings of the Aging and Business Industry

The earliest business endeavors for older adults were that of long-term care or supportive services. These businesses and industries specifically targeting the older adult market have been named "Silver Industries." Silver Industries refers to "businesses that create, produce, market and sell goods and services" to older adults (Cutler 2004–05:6).

As early as the 1600s, England established regulations and laws governing the institutionalization of elderly who were sick and poor in the first long-term care industry (Dennis 2004–05). Following the English model for institutional care of the elderly into the New World, the American Colonies established laws requiring families, including grandchildren, to financially support their sick and poor elderly family members (Farkas 2001). Rapid industrialization splintered many of the established norms of family care for elders, resulting in increasing pressure for long-term care institutions. A supportive service sector for the elderly developed. By the 1950s, the influx of Social Security to older adults' income increased the demand for long-term care. Private sector investors, encouraged by attractive government loans, began building the long-term care housing industry (Dennis 2004–05). In general, the interest in aging and business did not advance into other business sectors and remained focused on frail elderly long-term care.

Beginning with Social Security in 1935 and later the 1965 Older Americans Act creation of the Administration on Aging (AoA), the aging network became the "major vehicle for the organization and delivery of social and nutrition services" to older adults, aged 60 and older (Administration on Aging 2009). Providing the majority of supportive services and nutrition programs to those aged 60 and older, AoA monopolized the mature market. Identified in 1979 as the aging enterprise, Estes envisioned the public aging network of hospitals, care facilities, and services coordinated by area agencies on aging working in partnerships with private businesses for the good of older adults (Moody 2004–05). However, progress in this direction has moved at glacial-like speed obstructed by bureaucratic structure, programs that treated all older people exactly the same and the socially constructed negative stereotypes of older adults.

As organizations evolve into mammoth bureaucracies, multiple layers and appendages are constructed. Bureaucracies develop rigid policies and rules and assign responsibilities to specific departments or programs (specialization of tasks) for efficiency. Fragmented and not rewarded for efficiencies, large organizations have difficulty coordinating and cooperating within, let alone with external competitors. Self-preservation is a strong incentive for monopolizing the market (Thompson 1967). AoA and its aging network retain many bureaucratic characteristics. This does not discredit the significant advancements by the AoA and the aging network for older adults; it does, however, help explain the monopolization of the older adult market.

A commonly held perception is that the profit essential to the private sector outweighs businesses' concerns for the older adults; therefore, older adults need to be protected from private sector businesses. Stereotyping the private sector as predatory businesses exploiting the elderly solidified the aging networks' power and control over the older adult market as the aging network strategically worked to monopolize the products and services provided to older adults (Estes 1969). With growing numbers of current and future older adults, many of whom are wealthier and healthier than previous cohorts, the older population is outpacing public providers' budgets. The projections of having more consumers than public resources as boomers age are forcing a reexamination of resources allocated based on age regardless of personal circumstances. And, it should be a call for revisiting of the public–private partnership proposed by Estes in 1969 but considering boomers' consumer preferences while recognizing their intracohort differences.

Ageism may account for lack of products and advertising to old adult consumers until recently. Invisible to most markets, health aide marketing played on stereotypes of frail and dependent elderly. Hendricks (2005) noted ageism is "woven into the wool of our social fabric." Early

constructs of negative stereotyping of aging and seniors in sitcoms, dramas, and commercials of the 1950s targeted younger audiences and used older adults as comic relief by displaying elders as physically or mentally incompetent (Montepare and Zebrowitz 2002). Later, the 1960s' public service announcements of compassionate ageism depicted the elderly as frail, poor, senile, and "deserving" aired on television to earn public support for older adult programs. By the late 1970s, Americans "had learned the catechism of compassionate ageism well" (Binstock 2005:73). In the 1980s, a new ageism emerged, that of older Americans burdening society, self-serving, and depleting the future of America. In response, Longino (2005) presented a more positive view of aging noting private businesses development of products and services encouraging health and autonomy for older adults, together with their higher education and income levels, could over time decrease costs associated with aging.

The New Mature Market: Age of Aquarius

As leading-edge boomers' 60th birthdays grew near, the media renewed its interest in them. Stories about the new "well-elderly" and the wealth and preferences of boomers, together with the massive numbers of boomers soon eligible for early retirement, increased awareness of aging. Interest in the older consumer and mature market grew. While not all boomers are wealthy, the potential customer market of approximately 76 million wallets is a gigantic and attractive economic opportunity for businesses.

A contributing factor to increased interest in the boomers' aging, according to Wolfe (2004–05:91), is their occupying the psychological center of gravity (PCG). The PCG principle is that those "who are within 5 years of the adult median age have a disproportionate influence on society's *zeitgeist,* the spirit of the times." In 2005, when the adult median age was 45, the PCG bracket ranged from ages 40–50, or approximately 40 million boomers. With boomers both comprising the PCG and with their numeric size, Wolfe observed that it should be no surprise that the boomers are "the most influential source of cultural and consumer behaviour trends" (p. 16). An interesting example of the boomers' PCG influence is found by reviewing trade marketing books focusing on boomers. Using the keywords "marketing" and "boomers," we find 43 trade marketing books published between January 2000 and December 2009 available at the online bookstore Amazon.com. Of those, 31 (70%) were published after January 2005.

Another factor in the growing interest of business opportunities for older adults may be the aging of the workforce and the parallel aging of the private business owners and entrepreneurs. Suddenly, the old middle-aged business boomer rejects the ageist stereotype of older adults. As aging consumers themselves, boomers and older adults envision business potential in products and services that are not patronizing or offensive to the older consumer. The data provides support for this assumption. A 2009 study from the Kauffman Foundation found those aged 55–64 to have the highest entrepreneurial activity since 1996 forward. The Kauffman Foundation projects an "entrepreneurial boom" in part as the result of the boomers' aging (Stangler 2009). Later-life entrepreneurs are more apt to have the means or borrowing power for business start-up, a lifetime of work experiences on which to draw, and the desire for social good (Rogoff 2009). Zhang (2008) concludes that the knowledge economy together with an aging workforce offers more opportunities for older adults to be entrepreneurs finding that being aged 62 or older increases the likelihood of entrepreneurship by about 11%.

The convergence of demographics, boomers' controlling PCG, interest in private–public partnerships, increased resources of older adults, and the aging of the workforce and entrepreneurs elevate the older consumer market into the business spotlight. When businesses first envisioned opportunities in the boomers, they were babies; now the opportunities lay in silver industries and silver markets.

Growth of Silver Industries

Silver industries create, produce, market, and sell goods and services to older adults. These include products adapted from existing products and made attractive and useful for older adults and innovative new products or businesses targeting older consumers (Cutler 2004–05). Yet, the most "successful and innovative silver products are those that attract across the life course: ageless or age-neutral with value to older adults and attractive to younger customers. Silver industries are those developing and marketing transgenerational or universal solutions that can be used regardless of age, yet connect and integrate multiple generations" (Kohlbacher 2008:18). Industries targeting silver consumers have been an economic boom for Japan, a superaging society where one out of four Japanese will be aged 60 or older by 2015 (Vogt 2008).

The United States lags behind in innovation, design, and product development for the older consumer market when compared with other superaging countries. Leading innovations and businesses for older Japanese adults, Japan's business community and government both embrace and promote "silver" for economic development (Yashiro 2008; Vogt 2008). The use of "silver" to modify industries and markets targeting older adults evolved from a simple act during 1973, Respect for the Elderly Day, when the Japanese National Railway introduced "silver seats" for the silver-haired seniors and the disabled. Since then silver has become a "common epithet for all sorts of institutions, activities and products designed for and catering to senior citizens" (Coulmas 2008, p. vi). In Japan, it is common for products to include silver when naming products and services, such as the "silver pass" for transit.

Japan's jump on the silver market may in part be contributed to governmental old-age policies encouraging product development for the care and well-being of Japanese elders. As a superaging society faces extreme shrinking of both population and the labor force, new forms of caregiving and products are needed to care for the growing numbers of elders (Yashiro 2008). In addition, with average Japanese senior households controlling nearly half of the entire national savings, lack of spending by elders became an economic concern (Usui 2008). Producing attractive products for older Japanese increases consumption returning capital to the economy which would otherwise be tied up in senior's savings.

Examples of the emerging silver industries span low to high technology. Travel, a traditional mature market product of low technology, reaches new silver markets when agents specialize in "grandtravel packages" for intergenerational travel experiences. Opportunities may be a low-cost investment such as grocery stores that widen aisles, lower shelves, and increase lighting to attract the older customer. Gerontechology combines the use of technology with an understanding of gerontology to promote autonomy and lifestyle preferences into old age (International Society for Gerontechnology 2009). The U.S. Jitterbug and the Japanese Raku-Raku cell phones designed for those with cognitive impairment are examples of midtechnology. Motion sensors in continuing care retirement communities, such as Samsung's Noble County, support autonomy by providing unobtrusive fall monitoring involving all technology levels. Humanoid robots, such as the Japanese Paro, a fuzzy seal-like robot that mimics facial expressions found to increase social interaction for those with dementia, are excellent examples of high technology silver industries (Paro Robots Website, 2009). A further example is mobile robotic guides activated through voice commands being tested in Japanese nursing homes to assist residents' movements (Montemerlo et al. 2002). One of the most complex robotic devices is the supportive HAL Bionic Suit developed at Tsukuba University, designed to assist in movement of limbs and carrying of heavy objects (Kohlbackher 2008). Massachusetts Institute of Technology's AgeLab is studying multiple systems at all levels of technology from health to housing to transportation bringing technological advancements for old adults to businesses. New technologies of all complexity that support autonomy, provide physical care, encourage leisure activities, and combat isolation are a burgeoning area of research and of interest to venture capitalists.

Silver industry opportunities are limitless as long as there is the demand by older adults for products that promote independence, healthy lifestyles, sustained mobility, and financial independence and are transgenerational. Japan's advanced development of silver industries was propelled by the demographic consequences of the Japanese superaging society, existing technology expertise, and their long tradition of honoring elders. While the United States is an aging society invested in technology development, there is no strong tradition of honoring elders in a society that continues to revere youth. Perhaps aging boomers themselves, who refuse to age, will add to the lagging technological development in silver industry production in the United States.

The Future of the Mature Market: Aging is Good Business

The silver market is complex and reaches beyond segmentation by age, product, or service category. The drawback to innovative strategies for the silver market has been a static perspective and undervaluing of older adult consumers. In reality, silver consumers comprise the most diverse market of all age groups. Identified as those aged 50 and older, the silver consumer market includes people from age 50 to centenarians. Silver consumers have very different needs, desires, and lifestyles determined in part by their varied life courses. Some are wealthy, others middle class or poor. Some very fit, others unhealthy or frail. While many remain in the workforce, others have retired (Kohlbackher 2008). The limited success of some products designed and marketed to older adult might be attributed to the lack of understanding of the diversity of the mature market and the life course influences on consumption.

Furlong (2007) proposes that the power to reach the older adult consumer lies in understanding the life stages and events boomers and older adults experience as they age. Once considered an uneventful stage of life, middle-age and older adults "move through more transitions in their 50s and 60s than any other phase of life" (Furlong 2007:11). Each event can generate a business opportunity by marketing to "life-transitions." Examples include family transitions (becoming empty nesters, paying for kids' college, parental deaths, and birth of grandchildren); health transitions (onset of heart disease, health clubs, sexual enhancement drugs, as well as traditional medical services); housing transitions (relocations, downsizing, building, refitting for ageless living); work transitions (increased attention to financial planning, retirement, civic engagement); and daily living transitions (increased leisure, volunteerism, personal activities).

American society has progressed through decades of demographic change, yet a myopic youth-centered marketing focus nurtured by an earlier social construct that "old people" are poor, frail, demented, sexless, or pathetic remains. A rich market of middle-aged and older consumers cultivated since babies await discovery. The concept that aging is good business is novel and perhaps even offensive to some. Over the past decade, astute businesses and marketers have begun, albeit slowly, to appreciate the profitability of the middle-aged and older adult consumer market. There are potential social and economic consequences for ignoring business opportunities that come with an aging society.

The future of good business practices in providing products and services for an aging society lies in understanding the diversity of the boomers and how boomers differ from their parents and within themselves. Boomers were cultivated as consumers throughout their lives. With their PCG influence, there is every reason to expect change for older consumers. Recognizing the influence of the life course on boomers' consumption preferences and needs has positive economic potential for the U.S. economy and the status of older adults. Ruffenach of the *Wall Street Journal* wonders why gerontologists aren't knocking at the doors of companies and businesses to help them understand the needs of the older consumer (2004–05). After decades of productive work, savings, and investment in America, boomers may remain the productive economic driver as consumers at older ages. Recently, the struggling economy has affected Americans of all ages. In 2001, those aged 50 and

older held 69% of America's total net worth, an increase of 13% over 20 years for those ages (Peters and Barletta 2005). The 2008 collapse of the housing bubble and the continuous volatile stock market since have implications for baby boomers' wealth and their housing equity (Baker and Rosnick 2009). Notwithstanding, unless the U.S. economy experiences even greater downturns, those currently aged 50 and older will continue to control the majority of wealth and purchasing power as they age.

In a society like the United States that values consumption, older adults with savings and resources together with a life history of consumption will be increasingly important. In this emerging area of aging and business, understanding the distinct boomers' preferences has great potential for producing new and innovative products and linking generations. It is an area calling for research to understand how past life trajectories and current life stages will impact boomer consumer behavior at older ages, the status of older adults, and the economy. Rather than viewing aging as a taboo subject, opportunities arise from recognizing that the aging consumer can make aging "hip." Every day, nearly 11,000 boomers are reaching retirement age. This means new businesses, new jobs, and new opportunities. Those New York subway public service posters from the 1950s can be *recycled* to read: "Your future is limitless in an aging America."

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Chapter 23
Consumption and Aging

Chris Gilleard and Paul Higgs

Over the past 30 years, consumption has become a major aspect of the new dynamics of later life. Where the social reproduction of old age was once viewed as an issue of providing basic subsistence for those at risk of absolute poverty, today the pressing issue has become one of maintaining lifestyles into later life. As a 2009 report from the United Nations points out: "*older persons constitute an increasing consumer group with specific needs and significant aggregate purchasing power*" (UNECE 2009:1). This transformation in the significance of consumption for the social reproduction of later life in the most affluent global economies is the focus of this chapter.

Before addressing this transformation, however, it is necessary to outline first the principal ways in which the term "consumption" is used within sociology and within the study of economic processes, and secondly to locate current interest in consumption in later life within the broader development of a sociology of consumption. Four terms are commonly used to encompass the principal phenomena of consumption. *Consumer behavior* focuses on how and why people consume, focusing upon individual acts of consumption. *Consumption expenditure* addresses the question of what and how much households and householders spend their money on, focusing upon aggregate or collective consumption. Terms such as *consumer society* and *consumer culture* are concerned with the social and cultural dimensions of consumption and consumer practices. These latter terms can be interpreted as constituting "an institutional field, i.e. a set of interconnected economic and cultural institutions centered on the production of commodities for individual demand" (Zukin and Maguire 2004:175). Collectively these terms demonstrate the potential inter-disciplinary framework surrounding consumption; from the economic decisions of households to the social psychology of consumers. Consumer activity occupies an increasing amount of people's time and resources and the structures organizing consumption exercise a correspondingly wider influence over social life, turning individuals into "citizen consumers" throughout the life course (Cohen 2003).

However, despite Adam Smith's admonition that "Consumption is the sole end and purpose of all production; and the interest of the producer ought to be attended to only so far as it may be necessary for promoting that of the consumer" (Smith 1936:625[1776]), it has taken some two centuries for consumption to feature significantly in sociology. The classical sociologists writing in the midst of the industrialization of the nineteenth and early twentieth century Europe – most notably Karl Marx, Emile Durkheim, and Max Weber – centered their concerns upon the work process and occupational structures. The lives of most adults were seen to be organized not around the consumption of the goods and services needed to maintain their own lives but around their role in their production. Although there were other voices drawing attention to the social significance of consumption practices, such as Georg Simmel's work on the importance of fashion and Thorsten

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Veblen's ideas of conspicuous consumption (Veblen 1912/1959; Simmel 1904), it was not until the 1960s that consumption began to emerge as an important theme in the social sciences in both the United States and Europe (Miller et al. 1998).

Part of the explanation for this shift in sociological interest toward consumption was because such practices expanded in an era of generalized mass production and relative freedom from scarcity (Bell 1973; Ransome 2005). After the First World War, the time spent working or engaging in household maintenance fell while the resources for "surplus" consumption increased (Gershuny 2000:63). Sociologists began to recognize this shift in observing the "roaring" 1920s and the rise of the "flapper" generation. Writing in the *American Journal of Sociology* in 1922, Lloyd suggested that America was experiencing a new "third age of leisure," where "the liberation of men [sic] from some condition of subjection and distribution of the leisure attending liberation to all in some portion and to as many as possible in large portion" (Lloyd 1922:167). But it was not until the second half of the twentieth century that *mass consumption* properly arrived with the spread of commodities and commodification into most spheres of social activity. The sheer scale with which this happened led to both a quantitative and qualitative shift in the nature of industrialized societies. As choice and consumption began to play an increased role in people's lives, consumption was transformed into "consumerism" (Campbell 2004).

The development and evolution of consumer society became a topic of sociological interest in the 1960s (Riesman 1989 [1961]; Bell 1973). Central to this transformation was the growth in leisure (more "free" time to spend), aggregate consumption expenditure (purchasing a wider range of goods and services), and the complexity of consumption (moving from simple, relatively unmediated acts of consumption to acts "which are deemed by the actor to provide satisfaction of something more than basic needs") (Ransome 2005:67). This fostered not just a widening choice in the type of goods and services that could be consumed but also a broader interpretive framework governing consumer behavior. Marketing played a particularly important part in helping shape that framework (Brown 1995). In order to sell a wider range of goods and services to more people, during the 1950s and 1960s market researchers developed the concept of market segmentation (Cohen 2003:295). This idea – that products should cater to and be marketed for particular segments of the population, defined by "age, affluence, and lifestyle" – led to a growing interactive relationship between business studies, marketing, and sociology.

Since the 1960s, there has been a growing sociological interest in the study of consumption, consumerism, and consumer "lifestyles," often providing an explicit contrast to the earlier dominance of educational and occupational stratification in understanding and analyzing society. This "cultural turn" linked together consumption, lifestyle, and leisure and provided some tentative bridges between business and the social sciences (cf. Lazer 1963). It also saw the identification of consumption and consumer society as ways of explaining the social whole (Baudrillard 1998 [1970]; Miller 1998), and of understanding the practices of social distinction through culture (Warde and Bennet 2008), food (Warde 1996), and fashion (Lipovetsky 1994).

Consumption and Later Life: Some Early Starts

Consumption and the study of later life began to be linked quite early in the post-Second World War development of American sociology. The increase in the numbers of people retiring led some sociologists to suggest that a new "leisure class" was appearing in American society (Michelon 1954). Michelon's study of retired trailer park residents was prescient if somewhat optimistic for the time. It potentially resonates more strongly now as the retired population has continued to increase, while poverty in later life has diminished (Iceland 2003). As a result, perhaps, this term is now employed more critically and "retired Americans are being quietly reframed as the [new] leisure class living off the younger generation" (*The Boston Globe*, June 26, 2005, E. Goodman).

These early attempts to frame later life as a field of study not just for health and disability but for leisure and lifestyle were handicapped by the evident poverty among the retired population and the consequent weakness of older people's consumer power. As one researcher noted, throughout the 1950s and 1960s "*the aged segment of the market*" continued to allocate "*their limited resources [to] the point of view of survival (food, housing and medical care)*" (Goldstein 1968:67). At this time, the vast majority of men retiring did so out of necessity rather than from a desire to or expectation of living a life of leisure (Costa 1998:133). The dominant assumption was that older people were uninvolved in the post war consumer boom: "teenagers" or "youth" were seen as the leading age group developing consumer-oriented lifestyles and subcultures that were designed in part in order that they would be distinct from the older generation (Hebdige 1979).

The tendency, at least until recently, of most American sociologists generally to underplay the topic of consumption and more particularly the participation of older people in "complex consumption" has meant that both empirical and theoretical studies of consumption, leisure, and lifestyle in later life have been limited. This is so, despite the early, prescient interest shown by researchers such as Goldstein, Havighurst, and Michelon. That consumption may come to play an active part in later life was however anticipated, when Goldstein wrote "in the future an increasing number of older people will probably receive larger incomes through a widening participation in pension plans, social security and other benefits [and] as a result they may be able to remain important consumers for longer… and at a level which is above a mere subsistence standard" (Goldstein 1968:69). How well those predictions have been realized provides an important backdrop for this chapter. We aim first to provide an overview of consumer expenditure in later life, drawing upon current and historical household expenditure survey data to show how older households' "complex" consumption has increased relative to other age groups and earlier cohorts. Such empirical data provide the necessary context for understanding how the shift from consumption to consumerism has affected older households particularly over the last 3 decades. We then consider some of the evidence that older people are indeed significant actors, participating as knowing subjects within contemporary consumer culture. This evidence, we argue, indicates that the majority of older people are behaving more like the "leisure class" that was advocated nearly three quarters of a century ago, when the Townsend movement for pension reform articulated the slogan "Youth for work – age for leisure" (in 1934 Graebner 1980:194). We consider the limits to the full realization of that sentiment, both now and in the future before concluding the chapter with some thoughts on future directions for this field and its significance in understanding the new dynamics of aging of the twenty first century.

Household Consumption Expenditure in Later Life: National Survey Data

Most nation states in the prosperous parts of the world conduct regular surveys of household expenditure as part of their processes for determining rates of inflation. These surveys provide useful sources of information on the relative expenditure of later life households on a wide variety of goods and service as well as serving as indicators of well-being and quality of life (UNECE 2009:2; Hurd and Rohwedder 2005). In addition to the use of such surveys to calculate overall consumer expenditure, the nature of household expenditure can also be used to provide a broad distinction between expenditure on basic household welfare directed at supplying necessities such as clothing, food, housing, and fuel/energy and expenditure directed toward nonessential goods and services such as leisure/recreation, personal care, luxury household goods, travel, and holidays – the former representing "simple consumption," the latter "complex consumption" (Ransome 2005:79). This distinction is important both theoretically charting the expansion of "complex" consumption or consumerism and empirically demonstrating differential and often contrasting trends in consumption.

What follows are a series of case examples illustrating contemporary patterns and recent trends in later life household consumption in the United States and in Europe. Although there now exists a growing body of national statistics on household expenditure, we have limited our focus to France and Germany because these European economies yield comparable data over a similar time frame to that of the United States (Casey and Yamada 2002). Our first example is drawn from French household expenditure for 2006. The various categories of household expenditure are summed into indicators of "simple" vs. "complex" consumption, broken down by age group. As Table 23.1 shows, necessary household welfare expenditure (simple consumption) now constitutes less than half the expenditure of all but the very oldest French households (those aged 75 years and over). Historical analyses reported by the French National Institute of Statistics and Economic Studies (INSEE) also indicate that, between 1985 and 2005, the gap between retired householders' expenditure and that of the average French household has narrowed while the consumption expenditure of those in their thirties, forties, and fifties has moved closer to the average (INSEE 2008 Figure VII:1:77).

Data from the United States Consumer Expenditure Survey over a similar time period (1985–2008) demonstrate similar trends (see Fig. 23.1). The proportion of household expenditure devoted to simple consumption (spending on housing, fuel, energy, food, and clothing) by people aged 65–74 years has remained relatively constant (compared to the average U.S. household) while the proportion spent on complex consumption (entertainment, leisure, personal care products, and services) has risen from two thirds to nearly 90% of the national average. In Britain, a similar trend has been observed with spending on leisure goods and services rising by 47 and 75% among pensioner households compared with only 10 and 58% for nonpensioner households, between 1995 and 2007 (Leicester et al. 2009:Table 3.7a, 27).

Incorporated into most surveys of consumption expenditure are reports on household ownership of key consumer durable goods. These illustrate the relative rates of "penetration" of household (domestic) technology into later life households. Such goods also serve as useful indicators of engagement with leisure-oriented consumer culture, since they provide opportunities or serve as resources for leisure activities by members of the household. Data from the 2008 German Household Expenditure Survey (Table 23.2) illustrate rates of domestic technology ownership by age group.

Over three quarters of all German households currently own a bicycle, car, and cell-phone, over two thirds own a CD player, and between one half to one third own a satellite/cable TV. This is the case for all age groups. The majority of households (except the oldest) also own personal computers (PC) while between one third to a quarter of all households (except the youngest) own some type of sports equipment. The household ownership of key items of such "second generation" domestic technology among older age groups is of relatively recent origin. The ownership of microwave

Table 23.1 Household expenditure patterns by age of household respondent: France, 2006

Category	25–34 years (%)	35–44 (%)	45–54 (%)	55–64 (%)	65–74 (%)	75+ (%)
Food	13	16	17	18	21	22
Housing, fuel, utilities	19	15	14	14	17	21
Clothing	9	9	8	7	6	4
Health	3	3	3	4	5	6
Simple consumption	44	43	42	43	49	53
Transport	16	17	17	17	13	8
Eating out	6	6	5	4	3	3
Leisure and culture (excl. holiday travel)	7	8	8	8	8	7
Holiday travel	1	1	1	2	2	1
Hairdressing/personal care	1	2	2	2	2	2
Other expenditures	25	24	24	25	25	26
Complex consumption	56	57	58	57	51	47

Source: Dépense annuelle moyenne par ménage selon l'âge de la personne de référence. L'INSEE 2008

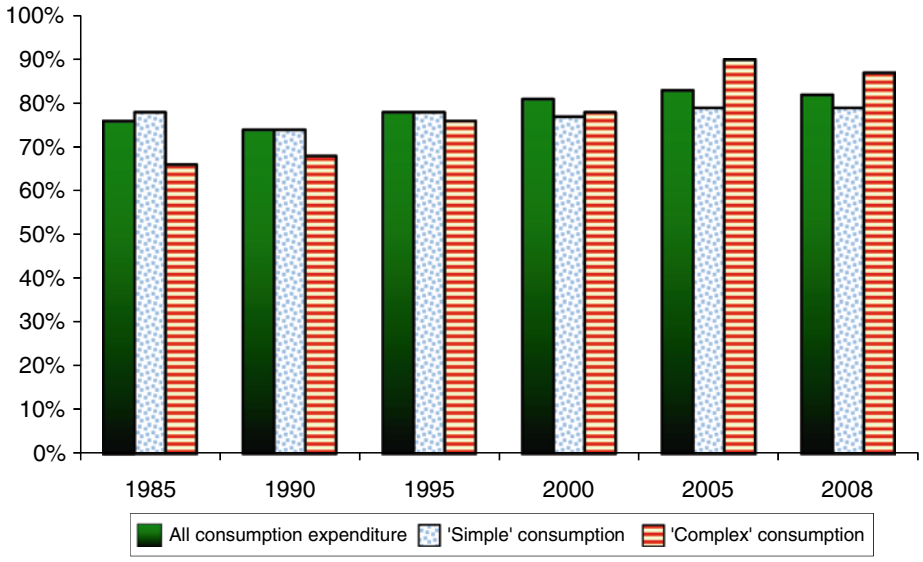

Fig. 23.1 Simple, complex, and overall consumption in U.S. households headed by people aged 65–74 years as a proportion of the national average: 1985–2008. Source: U.S. Consumer Expenditure Surveys, 1985–2008

Table 23.2 Ownership of key "domestic technology" goods in German households according to age of the household reference person (2008)

Consumer durables	25–35 years (%)	35–45 years (%)	45–55 years (%)	55–65 years (%)	65–70 years (%)	70–80 years (%)
Automobile	78	84	82	79	76	72
Bicycle	83	89	86	79	76	67
Home trainer	21	28	31	31	31	28
DVD player	87	86	79	67	52	39
CD player	87	91	87	79	73	62
Satellite TV	35	46	42	40	37	35
PC	91	92	87	76	61	44
Mobile phone	97	95	92	86	78	70
Camera	46	62	64	67	70	69
Digital camera	75	74	67	56	43	30

Source: Statistisches Bundesamt, Statistisches Jahrbuch 2009, Table 22.1.2 (p. 550)

ovens, dishwashers, VCRs, and PCs by U.S. households headed by people aged 65–74 years of age has shown a steady increase in penetration over the last 2 decades from the point when they were absent from or owned by only a small minority of such households to the point where the majority of households now own these goods (Fig. 23.2).

Data on household expenditure show clearly how, over the last quarter century, older age households have become much more engaged with "complex" consumption. Although overall household expenditure tends to decline after retirement, the extent and nature of this decline is no longer as steep nor as excluding as it was once. As Hurd and Rohwedder have observed, most "households seem to be pleasantly surprised by their level of resources… [and] the adequacy of [their] retirement income" (Hurd and Rohwedder 2005:17) with many retired households consuming significantly more than they had anticipated (Ameriks et al. 2002:28). Arguably, the conditions for consumerism in later life are now being met.

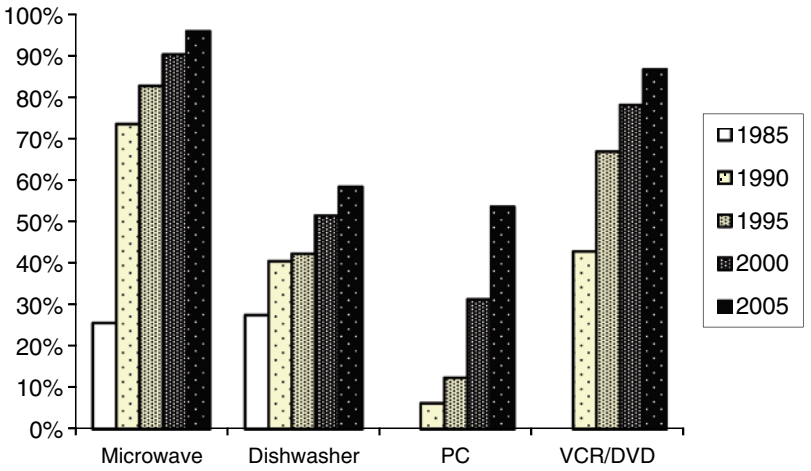

Fig. 23.2 Trends in the ownership of selected items of domestic technology by U.S. households for respondents aged 65–74 years (1985–2005). Source: Division of Consumer Expenditure Surveys, Office of Prices and Living Conditions, U.S. Department of Labor, 1985–2005

Nevertheless, there is still a long way to go and many householders of all ages remain at least partially excluded from consumer citizenship. Consumer expenditure among the oldest old – people in their eighties and nineties – is still dominated by expenditure on basic household welfare. Health status, gender, and ethnicity influence household expenditure, while period and cohort effects also play an important part in accounting for later life consumer inequalitis (Keister 2000; Rentz, Reynolds and Stout 1983). Effects arising from the lifelong inequalities associated with ethnicity may however be less open to change than those associated with either education or gender, even if the overall level and form of consumption inequalities within the older population continue to diminish (Newman 2003). We shall return to this issue of expenditure inequalities later in the chapter.

Market Segmentation and the Dissolution of Old Age

Of course, inequalities in consumption are not the same as differences and distinctions in consumer behavior. Since the universalization of retirement and the expansion of compulsory education, older people (those over age 60) have gained more "free" time with which to engage in consumption than all other age groups. But until relatively recently, members of this age group have not enjoyed an equivalent increase in levels of disposable income to realize the opportunity to do so. Throughout the 1950s and 1960s, older people were significantly over-represented among the poor (Townsend 1979; Pampel 1998:5). By the 1980s, this had changed and in North America, Australasia, and Western Europe, the income of the retired population was rising faster than that of the working age population (Gilleard and Higgs 2005) while the numbers in poverty had dropped below that of the under 65s (Hourriez et al. 2001; Pampel 1998). In France, for example, the purchasing power of retired people increased more than sixfold between 1945 and 2000; that of workers only fourfold (Juvin 2005:43). By the end of the twentieth century, as we have tried to show in the previous section, the conditions for a mass "leisure class" in later life were beginning to materialize.

Despite the growing significance of older households as sites of "complex consumption" the sociological analysis of older people as consumers remains extremely limited (Higgs et al. 2009). One area where research has been more actively undertaken has been in business and marketing studies.

During the late 1970s, market researchers in the United States began to take an active interest in later life and retirement, both as sources of market expansion and segmentation (Burnett 1989; Lazer 1986). This field has continued to grow significantly, and age and generation have become important market factors (Bone 1991; Moschis 1996; Stroud 2005). Within this area, a number of themes have emerged that are of particular interest for the sociology of later life. These include studies emphasizing the salience of "generation" or "cohort" influences as potential sources of market differentiation (Moschis 2009), the heterogeneity of consumption-oriented lifestyles in later life (Stroud 2005:124 ff), the contextual nature of market segmentation within discrete areas of consumption (Moschis and Unal 2008; Shoemaker 2000), and the role of later life status change in stimulating consumption practices (Mathur et al. 2008). Though socioeconomic status continues to have an important role in influencing the consumer power of older people, this traditional structuring of the population is less evident in market research studies than that of generation, life stage, and lifestyle.

Such studies demonstrate the heterogeneity in consumption and consumerism within an older population, the limited significance of chronological age *per se* on consumption and consumer orientation, the relative absence of obvious "conservatism" in consumer choice, and the signal failure of age and agedness to sell products (Gunter 1998; Moschis 2009; Stroud 2005). Ruiz et al. (2004), for example, asked shoppers in a Canadian shopping mall about the various activities that they engaged in at the mall during their visit. From the responses they constructed four "clusters" of shopper – "recreational," "full experience," "browsers," and "mission" shoppers. People aged 65 and over were evenly spread across all categories, although people aged over 65 were more often identified as "recreational shoppers" than other age groups. Similar conclusions have been reached in relation to travel and tourism consumer profiles within the older population (Horneman et al. 2002).

The existence of distinct cohort or generational differences within the consumption patterns and consumerist orientations of the older population has been propounded by several advocates of market segmentation (Cravit 2008; Smith and Clurman 1997). Much of this "generational" focus has been upon the so-called "boomer" generation who as a cohort, some argue, "have played a central role in influencing… corporations and organizations to buy into the market model as well as instilling… a consumer mentality" (Bibby 2006:60). Evidence of such distinct cohort effects on consumption is limited but not completely lacking. Warde (1996), for example, in an analysis of food consumption from the British Family Expenditure Survey, showed how "a particular age cohort, [those] born in the 1940s" brought about an "abrupt transformation in… food culture" (op cit., p. 170). Gilleard et al. (2005), have demonstrated significant "birth cohort" effects on the ownership of key consumer goods in late life British households, a finding that has been replicated in a larger national sample (Higgs et al. 2009). These and similar studies provide some albeit limited empirical support for generational marketing strategies and generational consumer "habitus." Arguably, generational marketing is itself fostering a new generational consciousness within the older population (Gilleard and Higgs 2005).

This segmentation of later life into distinct and distinguishable consumer groups can be linked conceptually to the cultural sociology of Pierre Bourdieu. Bourdieu was interested in how taste formed a new site for class distinction. In doing so he utilized the idea of a cultural or symbolic capital that was aligned with, yet distinct from economic capital (Bourdieu 1987). Drawing upon extensive analysis of preferred food, music, reading, and entertainment, Bourdieu demonstrated how disparate features of consumer choice could be subsumed within an implicit cultural structure that organized preference along a status hierarchy that mapped onto the class divisions of French society. Few attempts have been made to apply Bourdieu's methodology to studies of age or cohort-based distinctions in people's consumer choices. Bourdieu's emphasis upon social class rather than generation or birth cohort as a source of consumer-based distinctions has found echoes in Formosa's recent study of social class in later life in Malta (Formosa 2009). He found that while the processes of class have become more individualized, definite patterns of distinction based upon consumption practices still were evident between working and middle class older Maltese people, most notably in relation to home-based consumption.

Lifestyle and Identity Among Senior Citizen Consumers

While generational marketing strategies have focused upon the significance of cohort and life stage for consumer behavior and consumer choice in later life, other studies have examined consumption as a significant element in maintaining identity, lifestyle, and social differentiation in later life. As pointed out above this theme can be traced back to the work of Veblen and Simmel and their focus upon "conspicuous consumption" and "status differentiation" (Veblen 1912; Simmel 1904), but it was Baudrillard who first made popular the argument that modern consumer society and the complex consumption it supports flourishes through a system of consumption-mediated "symbolic" exchange. He argued that the objects of consumption are embedded within a network of signs that are created, manipulated, or reframed through the media, through advertisements and marketing. For Baudrillard, consumption is both a process of classification and social differentiation and a process of signification and communication – a system of symbolic exchange (Baudrillard 1998:60). As McCracken (1987) notes this, "cultural turn" recognizes that complex, nonutility-focused consumption is more than just a means of indicating status as Simmel and Veblen implied. The goods and services individuals purchase signify more than just an individual's wealth. They respond as much, if not more, to what an individual desires as to what an individual simply needs. They convey a message and a meaning that is shaped by the market, the media, and the social and cultural contexts within which individuals spend their time and money. Traditionally, older people have been considered to be preoccupied with simple, necessary consumption (Goldstein 1968). The goods and services they purchased were seen to privilege their use value, their capacity to satisfy older people's "basic" needs – for food, fuel, shelter, and clothing – not to reflect or reinforce their desires. In the 1950s, the British Ministry of Labour and National Service specifically excluded the consumption expenditure of pensioner households in calculating the cost of living because of their then very limited finances (Ministry of Labour and National Service 1957).

The subsequent shift toward older people's engagement with complex consumption has facilitated what McCracken (1990) described as a "North American" style of cultural categorization that is more indeterminate, elective, and dynamic than the earlier status-based consumption patterns. This socio-economic and cultural transformation of later life is only now being studied. A small but growing number of studies are beginning to illustrate how consumption impacts upon the social processes of being or becoming "old." These studies indicate how complex consumption in later life is creating new sources of differentiation that fragment what was previously considered a homogenous "subculture" of aging (Rose 1965). Increasing numbers of older people can and do engage in consumer lifestyles that ignore, avoid, or deny the identification of self with a social and cultural identity conferred by a chronologically defined agedness. The consumption and identity work that was located in the teenage and early adult years during the "cultural revolution" of the 1960s has since spread upward and outward across the lifecycle. Propelling this lifestyle agenda is a plethora of lifestyle manuals directing the "mature" consumer toward a variety of seemingly "ageless" lifestyles (Gilleard 1996).

Empirical research on consumption, identity, and lifestyle in later life is beginning to show how older people – singly, collectively, or as couples – actively use the purchase of leisure goods and services to frame, change, or expand their identities. Most of this research focuses upon complex consumption – and in particular the consumption of leisure goods and services such as travel, tourism, and entertainment. Therkelsen and Gram (2008), for example, have examined how mature couples use holidays "as a vehicle of identity construction" for themselves as a couple as well as individuals in their own right. Schau et al. (2009) describe a process of "identity renaissance" in retirement in their multidisciplinary, multi-method qualitative study of people aged 61–83 years old. From interviews, questionnaires, and focus groups, they conclude that "[c]onsumer identity renaissance… takes place in a cultural context that favors individuality and where identity play is permissible, where retirement and leisure consumption ideologies are in flux and where there is a multitude of available and attractively

priced options" (Schau et al. 2009:272). Studies of attitudes toward and experiences of travel and tourism indicate the particular role that these experiences can play in conferring "identity" and "meaning" (Nimrod 2008; Russell 2008; Sedgeley et al. 2006) and in the process diluting or dissolving the significance of chronological age. These and similar studies indicate how "older consumers [are] becoming increasingly ageless in their consumption behavior" (Szmigin and Carrigan 2000:505).

Other, less direct approaches to exploring the identity and lifestyle influences derived from consumption have used the images of later life present in advertisements and the media. In a study of newspaper articles about retirement and retired people, Katz and his colleague analyzed 138 published personal profiles and biographical narratives (Katz and Laliberte-Rudman 2005) from which they identified two types of lifestyle. The first was an historical identity they called "retired worker" based upon past working roles, while the other was what they describe as that of the "opportunity-seeking consumer." This latter "type" is "a person who chooses specific lifestyle options in the consumer market that promise to transform retirement into an opportunity and a 'second chance' for self-development and social success" (Katz and Laliberte-Rudman 2005:149). Other studies have examined the role of advertisements in shaping the cultural identities of older people as potential consumers of a variety of goods and services. Williams et al. (2007) showed how a marketing strategy for margarine using images of older people evolved over a 7-year period. They found a shift from an initial emphasis upon the agedness/longevity of the characters toward a later emphasis upon the exercise of choice and engaging in activities not usually associated with old people. This shift in focus, the authors suggest, "may apply particularly to the baby boomer generation" (op cit.:17).

Older people's "complex consumption" is not confined to purchasing leisure goods and services. A broad array of financial services have become available such as reverse mortgages, long term care insurance, investment portfolios, and so forth – many of which address later life income security (Brennan and Ritch 2010). Ekerdt and Clark (2001) have explored the role of retirement financial planning advertisements in shaping the meaning(s) of retirement. They found that most of the advertisements conveyed an image of retirement in positive terms, as an emancipatory life stage of active leisure, achieved by self-reliant, financially sophisticated men. Exactly how, if at all, such advertisements shape expectations and interpretations of later life is of course difficult to gauge, but the companies that commission them are counting on the fact that they can and they do.

Older People as Marginalized Consumers

Arguably most advertising and related market research are geared toward selling goods and services to people with the money to buy them. It is a field which tends to emphasize the better off among the older population (Roberts and Zhou 1997). Research in marketing, leisure, and tourism studies and related social research has followed such trends and studies of consumption and consumer behavior among "poor old people" are consequently uncommon. This lack of research is partly the result of, and partly a contributor to the more general assumption that older people are still largely a residual group. For example John Vincent writes:

> Older people's access to consumption opportunities is limited, as is that of disabled people, by the physical structure of retailing. Out of town supermarkets effectively discriminate against noncar users. Not only are older people less likely to drive or to have a car; but the alternative outlets, the corner shops and city center stores are being driven out by competition. There are other retail outlets in addition to shops. Mail order and telephone shopping, for example, can facilitate consumption choices by older consumers. However, these remote systems lose much of the valued social contact which local shopping can facilitate, and older people tend to have less access to the latest communications technologies (Vincent 1999:151).

Such assumptions are made with little reference to empirical observation or interrogation of older people themselves. Such research that has been carried out suggests that these assumptions of marginality significantly underplay the significance of shopping and leisure consumption as sources of

positive well-being among older pensioners (Szmigin and Carrigan 2001). In one study conducted in two London, England shopping centers particular focus was given to those groups of elderly persons "stranded in council estates" and displaying signs of "disability, poverty, and loneliness" (Miller et al. 1998:79). The authors observed that although assumptions "that the elderly [sic] are largely a nostalgic and sentimental community whose ties lie firmly attached to the traditions of their own childhood and that they would therefore ideally prefer a sepia tinted image of 'olde worlde' shopping" (Miller et al. 1998:83) were supported in the focus group discussions (in a context that drew attention to the members' collective agedness and limited means) when the individuals from these focus groups were accompanied on their shopping trips – where the focus was on the activity of shopping – the evidence suggested that shopping was in fact associated with a "sense of enjoyment" and that these particular elderly people "showed a marked preference for large supermarkets because of their desire for bright modern looks and access to the large gamut of new produce" (op. cit. 1998:84). Similar assumptions can be discerned in studies of casino gambling, where the perceived "vulnerability" of older gamblers is belied by empirical research. As one study observed "there was no evidence to support the idea that casino gambling activities threatened these older adults in any way" (Hope and Havir 2002:195). For most people, it seemed that they were operating within clear financial limits – and in the process, having fun.

Noteworthy too are the results of research conducted in non-Western "middle income" countries. Although limited in number, such studies suggest that active consumerist attitudes and habits exist among significant numbers of older people. In a survey of older consumers in Malaysia, Ong and Phillips observed that "contrary to the common image of older persons as 'invisible consumers' … older consumers in Malaysia are in many ways 'canny consumers' who know what they want and how to get it" (Ong and Phillips 2007:113). Related research conducted in China (a country with the largest number of mature consumers in the world) also indicates that older consumers share many similarities in consumer choice and participation with the younger generation, with a general preference for "foreign" rather than "domestic" products and similar levels of overall consumption (Yang et al. 2005).

As noted, social science researchers have tended to cling to the assumption that modern developments in leisure, shopping, and the "new" consumerism are "dangerous" or "bad" for more peripheral and marginal groups, risking excluding them still further (Miller et al. 1998:88). Such evidence as has been gathered suggests that this is not the case. The preference of many, if not most older people, is generally to enjoy the opportunities that shopping, leisure, and lifestyle consumption offer. These findings signal an important point for the sociology of consumption – namely the role that consumption plays not only in reproducing and refashioning identities and lifestyles but also in offering opportunities for sharing, for socializing, and for having fun. And in the process, the oppressiveness of chronological age-based identities may be lightened.

Difference, Diversity, and Inequality Among Older Consumers

While we have been at pains to demonstrate that later life has become a site of complex consumption and that older age groups appear to be as active consumers as much as any other age group, it would be a mistake to ignore the differences between groups of older consumers. These differences are reflected both in market segmentation and diversity of lifestyles as well as in socio-economic inequalities. As with any age group, differences in late life income and resources create different constraints on people's capacity to consume and exercise active consumer choice (Peterson 2007). Many of these differences do not emerge specifically in later life. Some reflect continuing inequalities associated with education, ethnicity, and gender that persist over the life course while others reflect discontinuities arising from the contingencies of life in late modernity.

While there exists a considerable body of literature addressing income inequalities in later life (Price and Ginn 2006; Scharf 2009), much less has been written about inequalities in consumption. Since marriage conceals much of the gender imbalance in lifetime earnings and pension entitlements, household expenditure data tell us little about how gender affects men and women's individual choices. Changing rates of divorce, remarriage, separation, and widowhood across cohorts and over time affect the composition of later life households, making it likely that the influence of gender on consumption will vary as a complex function of age, period, and cohort. Given current differences in longevity, the longer women live, the more likely they are to live alone and households headed by single older people spend consistently less than married households. Ethnicity compounds the effects of gender. Older black and Hispanic women are twice as likely to be poor as older black and Hispanic men and older white women and *5 times* as likely to be poor as older white men (Street and Wilmoth 2001:131–2).

Income poverty and consumption poverty are not of course identical, and income poverty generally exceeds consumption poverty for all age groups. Among the over 65-year-old U.S. population, just over 16% are income poor but only around half that number are consumption poor. Some 6% are both income and consumption poor. Within this most marginalized group, according to Fisher and his colleagues, a disproportionate number are "women, widowed, high school drop outs, Blacks, and renters" (Fisher et al. 2009:765). Although detailed research into the sources and consequences of such consumption differentials in later life is lacking, the limited spending power of such groups seems likely to lead significant numbers of old, widowed, and black women into the enforced status of "flawed consumers" (Bauman 1998:38). However, even in circumstances of poverty, later life identity construction and social relatedness through consumption remain possibilities, as the British research study already mentioned has shown.

New Directions for the Study of Aging and Consumption

One of our intentions in writing this chapter has been to revisit Goldstein's prediction, made over 40 years ago, that in the future older people would play a more significant role as "important consumers." Our conclusion is that older people have indeed become more active participants in consumption and consumerism, moving in the words of one recent book "from passive to active consumers" (Jones et al. 2008). What are the consequences of this shift for the sociology of later life? What directions does it suggest for future research and crucially what remains unexplored and unrecognized?

The theme of consumption (and leisure) has been present since the origins of social gerontology, but it has always operated in the background. Like many related areas, it has been obscured by the more dominant focus on health, poverty, and social care. The relative lack of attention to consumption is equally evident in the sociology of old age, where its absence also reflects a broader neglect of the topic within sociology as a whole (Zukin and Maguire 2004). That it is now receiving attention is not only a reflection of the growing importance of later life within consumer society but also a consequence of changes in intellectual orientation within sociology itself. This is not just a consequence of the demographic weight of the number of retirees in the population, nor is it connected solely to the rising standards of living of retirees – though both are important. The significance of consumption in later life is also the story of consumption as a key cultural field within society, creating new sources of distinction as well as new forms of collective identity (Hechter 2004). It is here that aging constitutes an important aspect of the development of consumption. Much has been written about the impact of the aging of the baby boom cohorts in the more prosperous nations in the world as they move from middle age to retirement. What is often overlooked is the role played out by the distinct "generational habitus" (Gilleard and Higgs 2005) exhibited by these new cohorts of retirees in the development of consumption and consumerism.

Many of the important tropes of modern consumer lifestyles have their origins in the "generational schism" of the late 1960s with its focus on identity, self-expression, and social differentiation. What has sustained and developed this new "generational habitus" are the new and enlarged markets for fashion, leisure, and domestic technologies and the declining costs of leisure that have contributed to the shift from consumption to mass consumerism. Any development in the field of consumption and later life must take into consideration the historical emergence of this new consumerist habitus within earlier youth-oriented cohorts and their various subcultures. If people in later life continue to participate in and extend the scope of consumerism within retirement, it is important that research integrates the emerging "cultures of aging" into the core assumptions of both social gerontology and the sociology of aging.

As we have noted several times, there is still a dearth of sociologically informed quantitative and qualitative work on almost all aspects of consumption and consumerism in later life. What work has been done often throws up unexpected results – particularly when older people are not treated as if they are outside the practices shared by the rest of the population, or when consumerism in later life is not treated as confined to the practices of a small and privileged elite within the retired population. More research into the consumer practices and preferences of older people is needed – not in order to promote strategies for further market segmentation but to challenge assumptions that consumption in later life remains a marginal or risky activity that older people cannot afford to engage in.

A focus on the cultures of consumption in later life can also develop a unique perspective in relation to the contradictory representations of agedness in what is, in many parts of the world, a very age sensitive and in some ways "ageist" society. The fact that aging consumer societies remain strongly orientated toward the idea of youth rather than old age has meant that part of the engagement of older people with consumer culture is through the denial, refusal, rejection, or reconstruction of "old age" as a dominant structural identity. As noted earlier, market research has made clear that agedness does not attract sales. Resistance to old age is more common, and consumer products that offer such age-proofing sell. The target for such "antiaging" products is typically the middle-aged consumer, but sales of antiaging products and procedures are rising among both younger and older age groups. Studies of "age-conscious consumption" suggest that later life consumer choice can sometimes focus upon maintaining a "nonaged" identity (Hurd Clarke et al. 2009). Such explorations of consumer choice indicate both the emancipatory potential of consumption alongside the perceived imperative to choose not to be old; or perhaps more accurately to choose to be old in a new and improved manner. Breaking the taboo that such studies of "age conscious" consumption are trivial and inconsequential provides considerable scope to explore the identity work of older consumers of clothing, fashion, and self-care products in the presentation of self as aging in the right way, taking account of the potential significance of health status and gender.

An area for future research that also deserves more exploration is the role of consumption in shaping and sustaining social relationships in later life. Household consumption, for example, is not principally individualized consumption. Mature couples' consumption preferences serve many functions, which may reflect and reinforce their sense of identity and solidarity or which may create and widen schisms within the partnership. Buying and exchanging presents across the generations may provide a less evident means for sustaining the engagement of older people in cultural and technological developments that are "taken up" first by their children or grandchildren, as for example, when adult children buy their parent a mobile phone. Tours, travel, and visits to the shops may offer opportunities for older people to socialize with friends and share and develop their recreational pleasures. The state provision of consumption-oriented benefits to older people – such as free or subsidized transport – may extend such opportunities across a wider segment of the older population, as may "senior" discounts on eating out, personal care, and shopping. Consumption may also involve buying memories and memorabilia that link past and present – maintaining or constructing continuities with one's earlier adult life. Digitalized media now make it possible to "rejuvenate" old records and old movies, for example.

In short, it is important to recognize the significance of consumption in understanding the new dynamics of later life, the changes in the organization of the life course and the significance of age as an organizing principle for determining status and position within society. As complex consumption overshadows basic household expenditure and leisure time exceeds the time required for self and household maintenance and outside employment, older people's participation in consumption and consumer society is growing in size and significance. Earlier socialization into the consumerist habitus of mass consumer society is evident for each successive birth cohort since the 1930s while the mass media provide increasing opportunities for people of all ages to be exposed to developments in lifestyle culture and technology. Such a combination of cohort and period effects suggest that the old age of first modernity will be progressively undermined by a more contingent, conflictual, and effortful later life. Studies of later life consumption are important in charting this process of change.

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Part VII
Social Vulnerabilities and Aging

Chapter 24
Planning for Old Age

Debra Street and Sarah Desai

For many individuals, planning for old age is somewhat analogous to generals' propensity to fight the last war. What is to be planned for, and when, depends on how typical experiences of old age are perceived, whether an individual expects to fit within the typical mold, and which goals for later life seem to have been attainable in the recent past. The looming "silver tsunami" of Baby Boomer retirees, who transitioned to adulthood during expansive educational opportunities, maturing welfare states and booming economies, reflects a challenge for aging societies now confronting very different contemporary socioeconomic conditions. From the mid to late twentieth century (the Baby Boomers' temporal frame of reference for what to expect in old age) most individuals' eventual retirement in developed countries was taken for granted and pension systems appeared relatively stable. However, both prospects – universal retirement and secure pensions – are far less certain for cohorts contemplating old age at the outset of the twenty-first century.

The choices and risks associated with later life planning reflect opportunities and behaviors constrained by particular national social arrangements, employment markets, and welfare states. In fact, Ulrich Beck (1992, 1999) characterizes modern nation states as *risk societies* that reflect cultural standards for tolerable and intolerable risk at different points in the life course, including the risks associated with old age. Just as individuals adapt personal goals and plans in response to changing conditions, welfare states enact and adjust social policies in nation-specific ways that are consistent with meeting needs of aging populations, maintaining cultural standards of acceptable risk and responsibility (Beck 1999), and reflecting the ideological currents of the time (see Hacker 2006; Béland and Gran 2008). The interplay between structure and agency and cohort-specific experiences of aging through time make consideration of planning for later life a moving target. Broad social and cultural change, the political context of modern welfare states, evolving family structures and health institutions, and transformed labor and investment markets shape the opportunity structures and constraints that individuals planning for later life must consider in their assessments of how best to plan for their futures. The influences of social networks within which individuals are embedded and make decisions add another layer of complexity to the mix.

The idea of planning for a good life in old age is universally appealing but conceptually imprecise. Certainly, no one sets out to accomplish bad outcomes in old age, although many people experience them. What a good old age might entail encompasses a range of diverse outcomes across many life domains. Further, a "good enough" old age – a period at the end of the lifecourse savored

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as enjoyable and satisfying – could vary so widely across individuals that there is no widespread agreement among sociologists about what or how to study planning, nor among individuals about what exactly is to be planned for, beyond doing one's best to secure adequate income and avoid frailty and ill health. One candidate outcome associated with planning for a good old age is the psychosocial notion of expressing generativity in midlife that reflects individuals' sense of responsibility toward other generations, lives invested with meaning, and optimism about the future of humanity, leading to ego identity vs. despair in old age (Erickson 1959; McAdams and St. Aubin 1998). The actual expression of life-enhancing midlife generativity may (or may not) be tightly linked to identifiable planning processes for old age.

For the purposes of this chapter, we characterize planning for old age as the range of activities individuals deliberately pursue with a goal of creating desired outcomes in later life. Such planning could involve a range of strategies, from picking a career to becoming parents, from buying a vacation home for future use to investing in the stock market, from purchasing long-term care insurance to exercising regularly, from changing careers to pursuing a hobby, and from having cosmetic surgery to simply making new friends. We highlight a selection of sociological literature that bears on issues associated with individual planning for old age, particularly the well-developed body of research on retirement planning, both at the level of national pension systems and for individuals. However, sociological research that focuses explicitly on planning for old age more generally (and the activities and processes associated with it) is relatively sparse. This is not surprising, given an array of factors that make theorizing and empirical research on planning for old age particularly challenging. Among the challenges are the following:

- Hyper focus on economic aspects of financial planning for retirement, to the exclusion of research on other important aspects of planning for later life.
- Evolving meanings of retirement and old age in youth-dominated cultures.
- The challenge of linking contemporaneous individual preferences and behaviors to outcomes that will not be experienced for decades, if ever.
- The sheer scope of activities that could be planned in ways that impact later life experiences (and unplanned counterpart activities that also influence how individuals experience their lives at advanced ages).
- The pace of social and policy change associated with aging societies.

Social scientific literature that bears on planning underscores how a variety of activities associated with daily life in younger adulthood are major contributors to outcomes in old age, regardless of whether individuals consciously or explicitly include later life goal-oriented planning in their decision-making calculus. For example, while research on goal-setting by young adults indicates that setting goals in the first place is a predictor of the speed and efficiency of achieving positive outcomes in early adulthood, research in this vein typically treats planning and associated outcomes as processes of transitions to early and middle adulthood, rather than an explicit effort to plan for old age (Clausen 1991; Reynolds et al. 2007). While early life decisions set the path toward a range of possible outcomes in later life, members of different cohorts experience similar transitions under different conditions that structure how and what they can reasonably plan (Shanahan et al. 1997). Membership in a cohort that enters their employment years during periods of high labor demand, like current Baby Boomers, represents luckier timing than for cohorts who make such transitions when unemployment is high, as do young adults in 2010. Planning can do only so much to compensate for such socio-historical differences that shape cohort possibilities and constraints. We touch on several areas beyond retirement income where planning for later life is important and discuss potential areas for future sociological research that incorporate shifting meanings and expectations associated with old age, early twenty-first century risks associated with aging, and identifying pathways for individuals in different social positions toward good lives in old age.

Planning

Planning for old age falls within the scope of processes that cognitive psychologist Kathleen Galotti (2002) characterizes as making "decisions that matter." The complexities associated with real-life planning are monumental. Along with selecting a goal (among competing ones) having various levels of "goodness," gathering (often complex) relevant information, structuring decisions to account for the different criteria and options that could maximize the likelihood of goal achievement, making a decision about what set or sets of options to pursue, then finally evaluating progress and strategies associated with goal attainment that might signal need for readjustment (Galotti 2002). Planning and pursuing goals under the complexities of real world experiences is fraught with multiple influences, signaling the need to study planning in multiple dimensions and across levels of analysis. Despite the complexities, individuals often do exert planful competence (Clausen 1991; Shanahan et al. 2003), including deliberate actions to address predictable risks of later life, such as low income, social isolation, and declining health.

While psychologists and economists focus predominantly on individuals, more sociological approaches emphasize that planning does not occur in a social vacuum, but rather is structured by the particular arrangements that shape expectations and experiences of old age within specific societies. There are both individuals who do not plan much and desired outcomes that are unplanned, no matter what level of analysis sociologists consider. Welfare states, other social institutions, and organizations are implicated in the ways individuals try to optimize future outcomes. The institution of retirement, the dominant marker for old age in developed countries for much of the twentieth century, requires a predictable income stream to support it. Pension systems in modern welfare states are an essential structural piece of the old age planning puzzle; consequently pension issues dominate the research literature. This underscores two issues that link sociological research and planning for old age. First, the age of eligibility for public pensions is the ubiquitous social science proxy used to distinguish old age. Second, social gerontologists regard income *adequacy* as an essential component of managing in later life, and it is a centerpiece of their research and theorizing about planning for it. Despite a relative dearth of explicit analytic attention to planning for later life outcomes more generally, a rich body of sociological literature documents later life outcomes for different groups associated with the mixed economies of retirement income systems. In fact, research is often restricted to analysis of the retirement decision or saving for retirement as proxies for whether any planning has occurred at all.

Planning for Retirement and Later Life Income Security

Pension systems are important structuring institutions, and the expansion of public pension systems throughout the mid-twentieth century steadily improved the stability and value of retirement income, leading to normative expectations of a tripartite lifecourse of education, work, and retirement (Kohli 1986). Retirement systems, for the first time, gave ordinary workers the right to "stop work before wearing out" in what John Myles (1989) called *old age welfare states* (Myles 1989). By 1980, however, most developed countries had outrun the postwar expansion that marked the "golden age" of welfare states (Esping-Andersen 1999) and the normative (for men) tripartite mid-twentieth century life course became blurred by the end (Mutchler et al. 1997). Women's employment exploded, welfare states retrenched, transitions between work and retirement became less crisp, and employers scaled back or changed the rules of the game for occupational pensions (Guillemard and Rein 1993; Shuey and O'Rand 2004). Disrupted domestic labor markets, modifications in employee benefits, transformations in welfare states (Quadagno, Chap. 20), and other social

institutions have undermined confidence in the predictability of prospects for retirement as an institution and for conditions of later life more generally.

Sociologists in the 1980s and early 1990s researched how occupation and pension benefits influenced labor exit, noting that by the mid-1990s the decades' long trend toward early retirement for men reversed. Early retirement research had focused mainly on men's experiences, but women's unprecedented surge into paid work soon attracted analytic attention. Women's shorter average work histories, differential entitlement to pension benefits, and the early influences of the transformation from defined benefit to defined contribution pensions inspired researchers to investigate how retirement-related processes were different for women (see, e.g., O'Rand 1996; Ginn et al. 2001). Growing diversity in aging cohorts and variations in later life experiences for different race and ethnic groups also began to attract research attention in the 1980s and 1990s.

Income security in old age varies internationally, depending on the size and structure of public pension systems and routine access to private retirement income (see, e.g., Ginn et al. 2001; Gran 2008). In the United States, later life income security typically requires access to private pensions, individual savings and wealth to top up income received from Social Security. Women, members of minority demographic groups, unmarried people, and individuals with lifetime low wage employment are less economically secure (Angel et al. 2007; Harrington Mayer and Herd 2007; Shuey and O'Rand 2004; Street and Wilmoth 2001). Over the past 30 years, employers have replaced defined benefit pensions and their guaranteed retirement income with defined contribution savings plans that shift savings and investment risk from large institutions onto the shoulders of individuals (see Schulz and Borowski 2006; O'Rand 2003; Shuey and O'Rand 2004) at a time when individuals appear to be ill-equipped to handle the risk of uncertain investments in volatile markets.

Baby Boomers entered a workforce that seemed to hold the promise for secure retirement at ever younger ages, so early sociological research on aging often focused on predictors of "early" and "on time" retirement. By the early 1990s, research had evolved to account for the ways that discernible shifts in particular institutional realms – such as women's labor market participation, changing family forms, and the transformation of occupational retirement systems – influenced current and future retirees. For example, researchers documented patterns of the pace and timing of dual worker couple retirement (Henretta et al. 1993; Elder and Pavalko 2003; Moen 2003; Behringer et al. 2005). However, the pace and timing of retirement transitions in previous decades seems an unlikely roadmap for increasingly variable and dynamic transitions now and in the future. In the aftermath of the financial market collapse, more men than women have lost jobs and the relatively uninterrupted trend toward increased equity in pension savings in private financial markets ended in fall 2008. Older workers are remaining employed, postponing anticipated retirements to stabilize their pension prospects. Such secular circumstances, and others, work their way into younger adults' expectations and planning for old age. A need to systematically study and document how planning might contribute to a good old age in life domains that extends beyond knowledge about income security becomes even more important when economic uncertainty abounds.

Why Is Planning so Difficult to Study?

With the exception of research on retirement planning, planning for old age writ large is difficult to observe contemporaneously (see Pearlin 2010:211) and usually studied post hoc under the broader umbrella of sociological research on outcomes in old age. There are myriad reasons. Modern societies are dominated by youth culture, fear of aging, age denial (e.g., Blaikie 1999; Calasanti and Slevin 2001), differences in individual planning horizons and propensities, the rapid pace of social change that alters expectations, and structured inequalities that influence the capacity to choose goals and plan in the first place. For some people, whether because the struggle to keep their heads

above water in current circumstances precludes planning, or because some individuals are not very planful in the first place, old age is simply another experience that unfolds in its own way—"old age is just something that happened to me."

Sociologist David Ekerdt observes potential for an opposite trend, what he calls "foreshortening of the lifecourse." A steady drumbeat of media messages reminds adults that they must "do" something now to make retirement happen later. He argues that retirement has "colonized adulthood" (Ekerdt 2004:5) by penetrating the consciousness of even very young adults with the need to plan. This foreshortened lifecourse could lead to foresight in planning for later life, or the specter of planning for the end over an entire adult lifecourse may provoke anxiety and create perverse outcomes rather than instill peace of mind (Ekerdt 2004).

Planning for a Different Time

What old age and retirement might mean in individual futures has always been and remains something of a moving target (see, e.g., Achenbaum 1978; Cole 1992; Ekerdt 2010; Hardy 2002; Phillipson 1998; Quadagno 1988; Weiss 2005), with the position of future goalposts moving faster than individuals can readily incorporate into planning. Change in nearly all institutional realms is so brisk – from education, to families and work (see Harrington-Meyer, Chap. 17), to social policies, to the state of the economy – that perceiving the structural landscape for old age a decade in the future, never mind several, makes planning a daunting task. Traditionally, old age in the United States was conveniently marked by the 65th birthday – the age when individuals could retire with full Social Security benefits. Even that is changing. The age for entitlement to full Social Security retirement is increasing gradually, to 67 for individuals born in 1960 or later (Social Security Administration [SSA] 2010). Sixty-seven-year-old Americans, not 65-year-olds, will soon be the administratively (and social scientifically) "old," and the United States is not alone in recently increasing national retirement ages. The phrase "sixty is the new forty" has invaded popular culture and media reports on aging, spawning websites with the slogan emblazoned on gifts, greeting cards, and t-shirts. Yet in the current recession, older workers who have lost their jobs are the age group most likely to be long-term unemployed (BLS 2010), take jobs at substantially lower pay, and perceive age discrimination in their efforts to be reemployed (NYT 2009). Despite popular support for the program, confidence in the future of Social Security benefits has dwindled since the 1980s (Quadagno 1996) and many younger Americans doubt whether Social Security benefits will be available at all when they hope to retire (Gallup 2010). Logically, this *may* make individual planning more salient than ever for younger workers (even if they are wrong in their policy prognostications), but it does not necessarily mean that most younger workers *can* or *will* behave planfully.

For researchers who tracked savings for prospective retirees (often taken as the most tangible evidence of planning for old age), the ramifications across life domains of the loss in value when financial markets plunged in 2007 and 2008 are still unfolding, although there has been a chilling effect on plans to retire (EBRI 2010). Adding fuel to the retirement savings loss fire, the sub-prime mortgage collapse hit individuals who had planned to cash out soaring home equity for income in later years. From a sociological perspective, it is not just that individuals have less, on average, to fund their retirements. These shocks manifest differently for individuals in different structural locations and undoubtedly change planning orientations. Some individuals were scarcely affected; others experienced an unexpected and profound change in life course trajectories that required adjustment across institutional realms of family, work, and retirement.

Individuals who planned carefully by saving and investing for old age and retirement over the past few decades could have wildly different outcomes for similar efforts. An individual who retired in early 2007 could have converted assets into retirement annuities, sold a home and downsized at

the peak of the housing market, creating a comfortable income stream for old age. The downturn of housing and equities markets less than a year later meant that precisely the same kind of planning portfolio and behavior could yield very different outcomes, for no other reason than because retirement conversions were a few months apart. By late 2008, growing numbers of prudent planners realized that the collapse of the value of retirement savings or housing assets – the largest single asset for most American families (U.S. Census Bureau 2001) – jeopardized retirement plans.

Only 16% of workers who responded to the *2010 Retirement Confidence Survey* (Employee Benefits Research Institute [EBRI] 2010) were very confident that they would have enough money to retire comfortably. On average, the value of retirement investments for *Retirement Confidence Survey* (hereafter *Confidence Survey*) respondents declined across the board from 2007 to 2010. The percentage who said they expected to work past 65 increased from 11% in 1991, to 19% in 2000, to 33% by 2010 (EBRI 2010:28). Workers who said they were saving at all for retirement declined from 65% in 2009 to 60% in 2010 and half of workers reported they were "not too" or "not at all" confident they could accumulate enough savings for retirement (EBRI 2010). Twenty-seven percent of working respondents had savings and investments (excluding value of primary residence and defined benefit pension) of less than $1,000, up from 20% in 2009. In 2002, half of respondents to the *Confidence Survey* reported having investments and savings of $25,000 or less, which declined to 48% by 2007. By 2010, however, nearly two thirds of respondents reported their savings and investments were worth less than $25,000 and nearly 30% of workers said they would delay retirement, mainly because they could not afford to (EBRI 2010). The link between retirement and old age experiences, the emerging contours of future public pensions and private retirement systems, an uncertain employment market during the preretirement years, combined with the volatility and individual risk of retirement investments, make understanding the right steps for planning for later life difficult to discern.

What to Plan for Old Age?

Uncertainties aside, some processes that lead to desired or negative outcomes in old age are neither inevitable nor immutable, making better theoretical and empirical understanding of the opportunities and constraints different groups encounter in planning for old age a fertile area for sociological research. The emphasis and importance placed on planning in different sociological frameworks varies across theoretical and research approaches and is often implicit in the models rather than explicitly analyzed. Taken for granted in most sociological work on later life outcomes are differing propensities to plan or save, based on assumptions of individual behavior borrowed from economics. Economists generally take an individualist stance and explain planning for old age using one of two broad theoretical approaches. One emphasis is the life-cycle saving hypothesis that posits that individuals borrow, save, and dissave to smooth consumption over the life course (Ando and Modigliani 1963). The other emphasis is the theory of planned behavior, which assumes that norms, attitudes, and perceived control will increase the likelihood of planning and that successful planning experiences contribute to future planning behavior (Ajzen 1991).

Sociologists have not yet fully articulated planning for old age into sociological theories or empirical work (see Dannefer and Uhlenberg 1999; Marshall 2000; Hitlin and Elder 2007a, b). Rather, sociology of aging and the life course has tended to analyze a range of outcomes associated with aging rather than focusing on particular choices individuals make in the moment and how processes unfold as they prepare for their futures. One influential research track in that vein explores successful (Rowe and Kahn 1997 1998) and/or productive aging (Bass et al. 1993; Bass and Caro 2001), deploying a rich array of quantitative datasets (cross-sectional and longitudinal), indicators,

and statistical analyses to demonstrate the associations between individual characteristics and positive late life outcomes. The influential Rowe and Kahn (1997:439) definition of *successful aging* includes "avoidance of disease and disability, maintenance of high physical and cognitive function, and sustained engagement in social and productive activities." Researchers in the *productive aging* tradition have elaborated the benefits of continued engagement in productive activities (including caregiving, volunteering, civic engagement, and employment) for improved physical and cognitive functioning and greater life satisfaction (e.g., Burr et al. 2002; Ekerdt 2010; Morrow-Howell et al. 2001; Morrow-Howell et al. 2003; O'Reilly and Caro 1994). Although criticized because the term *successful* overly pathologizes routine aspects of aging (Kane 2005) and *productive* aligns with economic activity (Herzog et al. 1989), the *successful/productive aging* research stream provides empirical evidence that social activities enhance later life.

The theoretical importance of planfulness in these frameworks is apparent, even if not elaborated: optimal goals can be "attained through individual choice and effort," emphasizing the importance of planning for later life (Rowe and Kahn 1998:37). Successful and/or productive outcomes associated with aging are highly correlated with SES indicators (making retirement planning that contributes to higher SES important), but outcomes are not entirely dependent on them. *Successful/productive* aging frameworks are concerned with later life outcomes that result from individual choices (similar to economic theories), tend to be relatively decontextualized, and focus on outcomes emphasized within neo-liberal ideological frameworks (Estes and Mahakian 2001; Katz 2000; Taylor and Bengtson 2001). Compared to its *successful aging* cousin, *productive* aging is more attuned to opportunities and constraints – more sociological – that influence individual capacities to succeed or produce (Taylor and Bengtson 2001), but processes of planning for old age are central analytic concerns for neither theoretical approach. Researchers highlight positive outcomes for individuals who age optimally within the conceptualizations of each framework, but how or when it is important to plan or the ways social location and life course together influence capacities to plan are generally not incorporated into the models.

McLaughlin and her colleagues (2010), analyzing data from four waves of the Health and Retirement survey, determined that the constraints of successful aging models are so stringent that only 11.9% aged successfully and that rates of successful aging were declining over time. Their findings point to a fundamental flaw in paradigm that otherwise has attracted widespread attention and yielded influential empirical insights. An overwhelming proportion of older Americans fail to age successfully, at least when stringent operational definitions of variables are used (McLaughlin et al. 2010). Whether it is through bad planning, lifestyle choices, cohort-specific life course constraints, or bad luck that individuals fail to hit successful aging markers, it would be implausible to imagine that merely 12% of later lives are "good" ones. Factors such as birth cohort, age, gender, race, ethnicity, and life experiences influence beliefs about what constitutes success in terms of aging (Holstein and Minkler 2003; Jackson et al. 1993; Phelan and Larson 2002). This highlights an obvious criterion for meaningful sociological conceptualization of good lives in old age and how individuals could plan for those: definitions must connect in some tangible way with lived experiences of individuals in different cohorts and what people do and value in their own lives.

From a more experiential, critical, and social relational stance, sociologists skeptical of the productive/successful aging paradigms envision a good life in old age more pragmatically, as individuals making the most out of what is available in the later years, given the contextual circumstances of aging they experience (see, e.g., Holstein and Minkler 2003; Kane 2005; Phillipson 1998; Street et al. 2007). This includes individuals adapting to social losses alongside physical and cognitive declines often associated with aging. While the capacity to age successfully or productively is not available for every individual, accomplishing a good life in old age – getting the most out of life as it comes – is more widely obtainable, particularly if social institutions like workplaces and welfare states also make planful adjustments to help individuals meet their needs. Research on planning that promotes skills in habituation (Kastenbaum 1980) to identify and enact processes that

foster adaptation, tend social relationships, and create and/or preserve an array of evolving capacities that enhance well-being and happiness in later years, (despite the age-related onset of limitations most individuals will almost inevitably experience) has received relatively less attention (but see Holstein and Minkler 2003).

Challenges in Planning for Old Age

Women and men enhance or undermine opportunities for good old age through an almost endless range of activities, from accomplishing training or education that leads to lucrative employment, whether they avoid smoking, embrace healthy diets and exercise, or decide to form families or life partnerships, and to be childfree or raise a family. Mundane activities bear inexorably on the outcomes in later life, and while the quotidian choices of individual behavior represent agency, they are not planning for old age (see Hitlin and Glenn 2007a; Pearlin 2010). What distinguishes planning for old age in particular from either planning in general (which has a future goal orientation, but not necessarily one associated with old age) or the minutiae of everyday choice is the goal of the activity, its intended consequences.

Conceptually, planning for old age captures a series of tensions: between human agency and the constraints social structures impose on individual lives; between plans and actions associated with short-term goals and contemporaneous choices vs. strategies enacted for the longer range; between current and delayed consumption; and, between the relative shares of responsibility for the state, employers, and individuals in planning and providing for old age. Culturally and ideologically, planning for old age in modern societies involves deliberate action to accomplish something many younger individuals fear – growing old – and that many individuals want to deny – being old. Understanding what characteristics, expectations, risk perceptions, and opportunities inspire some individuals to plan for old age, and what exactly they plan for, presents a series of puzzles for sociologists of aging and the life course. As mentioned earlier, sociological research on these planning puzzles has usually been linked to outcomes associated with either retirement (income or transition planning) or health promotion for later life.

Over the past 3 decades, a substantial body of social science research has focused on how working-aged individuals in developed countries like the United States plan to avoid or minimize poverty and poor health, two of the major risks associated with old age. The dominant stream of research associated with planning for old age has treated one outcome – having sufficient financial resources in retirement, whether from pensions, individual savings, or wealth – as the implicit proxy for successful planning, if not successful aging. Consequently, analysis has often focused quite narrowly on economic issues at the expense of noneconomic ones, with well-developed bodies of literature in behavioral economics, cognitive psychology, and sociology centered on individual determinants of investment and retirement income planning. Sociologists have generally been more attentive than researchers in other disciplines to the ways that social inequalities are structured and expressed in the sources and amounts of later life incomes for different demographic groups, but economic outcomes are still the most usual proxy for successful planning. A second stream of sociological research has explored more directly the processes of retirement planning and decision-making for individuals and within families under changing conditions of work and retirement. How individual workers decide, and how spouses and partners together negotiate work/life transitions are also important topics of sociological research (Henretta 1992; Moen 2003; Szinovacz and DeViney 2000). A third research trajectory associated broadly with individual planning for old age (although more usually couched in terms of health behaviors rather than "planning") explores the role health behaviors and healthy lifestyles (another set of deliberate activities) play in later life healthfulness (see Ferraro, Chap. 29; Haber 2003; but also see Holstein 1998; Minkler 1999).

Even so, planning *qua* planning for old age, beyond issues associated explicitly with work-to-retirement transitions (Kim and Moen 2001) and retirement income planning, is seldom the focus of sociological research on preparations individuals make for their futures (although see Denton et al. 2004 and Moen et al. 2005 for exceptions). Planning that pays off for health and income security provides a material foundation that permits individuals to savor later life across multiple dimensions. Because highly valued but less tangible goals for old age – like happiness, life satisfaction, and well-being – are subjective, the role planning may play in their pursuit is intrinsically even more difficult to theorize, operationalize, and observe than the planful components of economic security or health behavior. This, no doubt, is why several sociologists observe that agency is more often asserted or assumed than analyzed empirically in life course research (Hitlin and Elder 2007a; Marshall 2000; Pearlin 2010; but see Denton et al. 2004; Hitlin and Elder 2007b; McMullin and Marshall 1999). Although planning and agency are not precisely analogous conceptually or in ways that could be operationalized for research, life course agency (Hitlin and Elder 2007a) operates, in part, through planning that individuals can accomplish within the opportunity structures they encounter.

Cultural roadmaps provide age-related guideposts for sequencing adults' education and employment transitions (Settersten and Hagestad 1996), but simultaneously invoke several planning black boxes of their own. Age norms evolve in ways that are neither entirely predictable nor synchronized across important life domains. Further there is really no age normative guidepost for when in the adult life course deliberate planning for later life should begin, although recently the dominant message is sooner rather than later (Ekerdt 2004). Cohort membership and social location also mediate individuals' perceptions of risk (Shuey and O'Rand 2004) and influences planning for an increasingly diverse aging population. The onset and types of later life planning must also differ across and within groups, with individuals of different demographic characteristics incorporating different types of strategies, goals and priorities (Angel and Angel 2006; Angel et al. 2007; Calasanti and Slevin 2001; Ginn et al. 2001; Holstein 1998), and time horizons (Ekerdt and Hackney 2002; Denton et al. 2004; Hitlin and Elder 2007a; Moen 2003). For some individuals, planning seldom happens at all (Denton et al. 2004). Although the ideal age for planfulness for later life lacks a normative age marker – except, perhaps, in the aspirations of financial planners – there is an age-based pattern bolstered by both logic and evidence that, as adults get older, the salience and propensity to prepare for later life increases.

Structured Inequalities and the Life Course Lens

As life course theorists have emphasized, later lives are the sum of prior statuses, earlier choices and past experiences (Elder 1994, 1998; Elder and Johnson 2003), whether enacted as planful for old age, or not. A tenet of life course research is the variation in individual capacities (and by extension, later life chances for a good life) structured by earlier opportunities and constraints, including choices individuals make (see, e.g., Lutfey and Mortimer 2006; Roberts and Bengtson 1999; Settersten 2003). Life chances are determined by family statuses and origins; gender, race, and ethnicity; the communities where people grow up and grow old; by educational and employment experiences expressed over adult lifetimes; and the socioeconomic and historical circumstances of the time. A strength of sociological approaches for studying old age is the capacity to take into account the way opportunities for planning and choice for individuals are socially structured by cohort and social location. One gap, however, is that the actual processes of planning are rarely modeled in research, but rather are implicit in the models and inferred from outcomes (Marshall 2000; Dannefer and Uhlenberg 1999; Hitlin and Elder 2007a). This is likely because planfulness overlaps with the "problem" of agency in life course research, and is most often treated as the residual that is not explained within analysis of normative patterns (Marshall 2000).

In general, sociologists using the life course framework have indirectly taken some aspects of planning for later life into account through outcomes research. The largest body of literature using a life course framework has focused on *cumulative advantage and disadvantage* (hereafter CAD) as a mechanism by which structural opportunities and risks bestowed by initial social location magnify advantage and disadvantage, translating into later life inequalities (Dannefer 1987, 2003; DiPrete and Eirich 2006; O'Rand 1996, 2003; Ferraro 2007). Advantaged structural locations – high levels of education, employment in benefit-rich employment sectors, high income jobs – provide some individuals with better arrays of choices and capacities to exercise life course agency and plan. Typically, CAD analyses demonstrate categorical differences in SES, gender, race/ethnicity, and other social markers that reflect structured (dis)advantages in early life and manifest in tandem across multiple life domains. Most evidence in the CAD framework demonstrates that individuals with greater income, wealth, and education face circumstances offering more choices and fare significantly better in old age than their less educated, less wealthy, lower income counterparts (see, e.g., O'Rand 1996; Willson et al. 2007; Ekerdt 2010; Burge and Street 2010) . CAD approaches can highlight intergroup differences within cohorts (Dannefer 2003), but the varying capacities for agency that influence intragroup variation are rarely explicitly analyzed (Marshall 2000; Hitlin and Elder 2007a).

Ferraro and his colleagues (2009) have recently explicated *cumulative inequality* theory (hereafter CI) that extends and refines attention to the accumulation of risk and opportunity across multiple life course domains. CI emphasizes that later life variation may arise from disadvantage (higher levels of exposure to risk) or advantage (more exposure to opportunity) in one life domain, but that neither advantage nor disadvantage in one domain is inevitably associated with advantage or disadvantage in another. While research in the CAD tradition focuses on the structured bifurcation and accumulation of advantage and disadvantage over the life course, processual permutations associated with the accumulation process are seldom specified (DiPrete and Eirich 2006; but see Willson et al. 2007). By contrast, the CI approach gives more analytic weight to *potentially* asynchronous (dis)advantage and to choice/human agency across life domains. Using CI, Ferraro and his colleagues argue that life course trajectories are shaped by "the accumulation of risk, available resources, and human agency" (Ferraro et al. 2009:423).

Theoretically, within the CI framework individuals may be structurally disadvantaged in earlier life or one particular life domain, but can potentially compensate by exercising agency – planning and implementing plans – in another. An individual may experience low SES over the life course, yet simultaneously compensate in another life domain. A low income elder may experience substantial well-being and happiness in non-SES domains through planning and behaviors that capitalize on advantages in their psychosocial domain – perhaps by nurturing family relationships or developing a large network of friends for social support. Outcomes across every life domain need not vary in the same direction (Ferraro et al. 2009; Ferraro and Kelley-Moore 2003). Although CI shares with CAD an analytic capacity to examine the opportunity structures for later life income security or healthfulness, CI redirects attention to inequalities experienced differently across life domains. Large pensions or great wealth do not necessarily guarantee good health or well-being. Consequently, CI's attention to distinctive accumulations of advantage and disadvantage represents a recent theoretical innovation in sociology of aging and the life course that may offer more analytic attention to human agency and, by extension, planning processes. This offers a theoretical and analytic approach that departs from dominantly deterministic or economic views of later life outcomes.

Middle-range perspectives like exchange theory (Dowd 1975) provide viewpoints that received more attention in earlier decades of research on the sociology of aging, but which could potentially be retooled to offer additional analytic traction and alternative lenses into planning processes. For example, rational choice or exchange perspectives emphasize actions that weigh the costs and benefits of interpersonal relationships, where issues of time, money, and concern come into play (Silverstein 2006). Exchange theory assumes a certain calculus of reciprocity, including interpersonal

investments early in life with the expectation of returns in old age, which may be construed as "planning." For example, having a large family or sending children to expensive private schools could be interpreted as a fallback plan to protect oneself from social isolation or financial fragility in old age. For the most part, however, current behavior is not treated as planning for the future. Rather these "investments" represent a collection of subtle and time-specific cultural expectations about how others one provides for – emotionally or materially – will interact with someone in the future. While it does not make sense to interpret attending every one of a child's soccer games as "planning" in the same way as contributing to a 401k, from an exchange perspective attention to children is a type of investment. These investments, like financial ones, may not have predictable returns due to the pace of social change. Whether a set of current expectations about old age, likely to be affected by social change, can be considered as deliberate planning is an open question, but also a potential starting point using exchange theory concepts and models for research on planning for later life.

Planning for older ages represents an evocative example of gaps and frictions between individuals' life courses and the practices and processes influenced by a range of social institutions. *Structural lag* – the gaps between individuals' contemporary experiences and the inertia of institutions and organizational forms designed to meet the needs and normative expectations of earlier times (Riley and Riley 1994) – makes planning difficult. To optimize life chances and plan effectively, individuals need to enrich their contemporaneous lives across a range of domains and over time. Predictability and stability make planning easier, because it is clearer what needs to be done, and when. Especially during periods of rapid socioeconomic change, for example, the current recession in the United States and abroad, gaps between what individuals need and wherewithal to accomplish those goals become more apparent. Economic turmoil has highlighted the extent of risk and fragility of planning for later life. Recent changes in welfare states suggest that the risks individuals must plan for will increase rather than decline (Esping-Andersen 1999; Phillipson 1998; Estes and Mahakian 2001). Current institutional forms, socioeconomic opportunities, and the expectations and needs of individuals are desynchronized within the structures of the social programs, institutions, and organizations that do not yet take new preferences and risks into account. Yet the ingredients for a good old age – having adequate resources to meet needs (and some wants), relatively good physical and mental health, the capacity to engage in meaningful activities and to enjoy social relationships, enough help when it is needed, a modicum of happiness – are timeless. An ongoing challenge for sociologists is to enrich systematic understanding about how the complexities of twenty-first century institutions endow life courses with capacities for planning for old age, and how those capacities are deployed across different groups.

Where Next?

The large body of sociological research that emphasized retirement and income planning to the exclusion of other planning considerations is understandable for several reasons. The sheer size of national expenditures on state pensions throughout the developed world and the thirst of investment markets for the vast pools of capital that pension and retirement savings provide represent one impetus to pension planning research. Although not without its data challenges, the relative ease and ubiquity of obtaining quantitative indicators have also made issues surrounding pensions and retirement income among the easiest topics associated with planful aging to analyze. Patterns in pension planning and retirement saving can be assessed readily using standard metrics of program participation, scope of coverage, monetized portfolio or benefit value, all data routinely collected in several high-quality, nationally representative datasets. Exclusively economic models of later life planning employ well-developed theoretical frameworks and reflect the economic colonization of so many aspects of human experience. Another reason for this focus arises from the "usual science" pursuits

of sociologists, given the attention that SES inequalities receive in life course research. For example, Veenhoven (2006) argues that the discipline is so problem-focused that sociologists seldom pay attention to the distribution of important life experiences, like happiness, in their research repertoires. Yet happiness, and figuring out ways to enhance it, might be the quintessential planning goal for old age.

Studying how retirement became institutionalized and widespread in western democracies spawned a wealth of theorizing on the welfare state, but often failed to connect the macro processes that institutionalized retirement to the micro level experiences of individual women and men. Nonetheless, macro and comparative research at the end of the "golden age of the welfare state" provided a lens through which sociologists could explore how societies shaped the experiences of women and men in time and place. Less available were studies that explored how timing, linked lives, human agency, and lifelong development, the other tenets of life course research, unfolded for individuals planning under the umbrella of the broader political economy.

Researchers in the CAD tradition and life course research pioneered studies that exploited the rich data in several longitudinal data sets to understand how advantage and disadvantage structured planning potential for individuals in different groups. Recent developments of CI theory (Ferraro et al. 2009) and the reflexive planning model (Denton et al. 2004) offer rich analytic platforms for sociologists to more fully incorporate the role human agency plays in planning processes within the structural contexts of different life domains. The challenge for CI, as for CAD research in particular and life course research more generally, will be to settle on conceptual and operational definitions for planning and exploiting longitudinal data sets that can live up to the potential of the theoretical framework. The challenge for the reflexive planning framework will be to extend its analytic reach to larger, more representative populations.

What is a good old age and how can individuals plan to attain them in the future? These are at once philosophical questions, a series of processes and accomplishments, and a set of puzzles that sociologists have yet to adequately define, operationalize, and study. There is no firm agreement on what "good" old age is, what exactly successful aging looks like, or how planning is implicated in the outcomes. This has, so far, left little choice but to study what is most readily understood and measured – often income and occasionally health status, because those are the variables for which we have the best indicators over the longest periods of time – as the proxies for the planning outcomes.

While some workers appear to be very planful in terms of preparation for old age (through retirement savings at least), others have few tools with which to plan. Ekerdt and Hackney (2002) found that, even among workers who had pensions, many did not know when they would become eligible for benefits or the value of their pension income on retirement. These earlier findings are reinforced by current data from the latest *Retirement Confidence Survey* (EBRI 2010). Its executive summary offered bullet points that compared 2010 respondents to respondents in earlier years of the survey:

- Preparations [for retirement] are still eroding (fewer saving for retirement)
- More people have no savings at all (27% have $1,000 or less)
- Clueless about savings goals (most do not know how much they need to retire)
- Expecting to work longer (EBRI 2010)

The *Retirement Confidence Survey* is one barometer of how Americans perceive prospects for retirement, and the main conclusions of the report are that planning for retirement is more disrupted than it has been in decades. Similar effects associated with economic insecurity may also be manifested in other life domains. Alternatively, planning in other life domains may inoculate planners against some consequences of economic disadvantage or uncertainty by magnifying advantage in other facets of life. This suggests fertile ground for sociological research on planning for later life more broadly, with potential for both empirical advances and theoretical ones.

Old age is the historically contingent culmination of individual lives in particular times, viewed from the perspective of planning through the lens of expectations formed in the present for an unknown and (to a large extent) unknowable future. From this vantage point, individual decisions early in life (such as whether to form a family, pursue higher education, or settle for a second-best job) or cohort-related circumstances within strained political economies (e.g., entering the job market or losing employment during a deep recession, rehousing "boomerang" kids, experiencing failure of a retirement investment) represent critical turning points in earlier adulthood that create life course discontinuities and differentiate subpopulations whose transformative early experiences vary. Research has started to document ways time is expressed differently in partnered women's and men's life experiences (Moen 2003), but little yet about how such temporal experiences systematically influence the onset of planning for old age, whether setbacks at critical junctures in the life-course inspire or frustrate planning, nor how much planning involves a series of individual choices or the depth and influence of consultations with others (nor who, besides spouses and partners, those other social relational influences are).

Do young families consider their own old age when they contemplate having children, and if so how and which families? How do parents decide to weigh the trade-offs between investing in the education of their children and cultivating their own retirement prospects? Do individuals with family histories of disease or disability (chronic or otherwise) plan for old age differently from others whose contextual backdrops differ? Such variations in family circumstances and individual experiences all have plausible influences on the capacity to plan, underscoring the potential for turning points associated with planning for old age in one domain of life to be quite separate from, and perhaps to magnify or mitigate risks in another. However, research that could test processual turning points or adjustments in life trajectories associated with deliberate planning for old age remains a task for the future.

One challenge for future sociological research on planning for later life involves reclaiming the analytic import of the structural realities within which planning occurs, often attributed to error terms in economics, but from a sociological perspective the social status and relationships that give meaning to later life. Surely, economic security and good health are important outcomes, attributable both to good planning and good luck over the life course and in old age. Being able to distinguish which process is in play, what matters most (luck or planning, structure or agency) and when, are important potential contributions of future sociological research. The systematic and predictable inequalities associated with income insecurity and poor health in later life are well documented by sociologists. But systematic insights into other less tangible or easily measured components of daily life that may also arise from planning for old age are not.

What exactly needs to be planned for old age? The possibilities are vast and evolving quickly in the twenty-first century. Planning happens more easily when the future seems predictable, yet unpredictability seems to be the watchword for the foreseeable future. For retirement to persist, an income stream for material support is necessary, so saving and investing for that possibility remains an important planning priority. However, instability in financial markets and the potential for policy changes in public retirement systems could have different planning outcomes for individuals in different cohorts or structural positions. Some may read the uncertain fiscal tea leaves as an imperative to save as much and as early as possible. Others may interpret the possible benefits of planning in a very different way, presuming that change is so rapid and outcomes so uncertain that too much planning makes little sense at all. Others may want to plan for future income security but lack the resources necessary to do it effectively because of competing current demands or inadequate income; some may have plenty of resources but lack a sense of urgency or desire to plan, preferring current over delayed consumption. It may be that financial planning seems fraught with peril, but other life domains offer more leverage for planning that could yield predictable outcomes. Setting and acting on goals that optimize social relationships and tweak conditions in nonfinancial realms of life may be the arena for planning more activities for future old age. The laundry list of planning

orientations, other life domains and possible later life outcomes, and how individuals might plan (or not) within them is long. A few broad areas for additional research on the way planning may influence later life outcomes include the following:

- How to look and feel in old age: whether an individual attempts to roll back the appearance of aging by such activities as coloring hair or having cosmetic dentistry or surgery; whether to embrace the potential outcome of generativity and achieve ego identity or to pursue activities that stave off a sense of old age and mortality; preserving health and mobility to the extent possible.
- Where to live in old age: planning to move closer to adult children who have moved away, to downsize into a smaller house in the same community, to be a snowbird or a sunbird, to move into an age-segregated retirement community, to age in place.
- When old age is experienced: continuing as many roles from younger adulthood for as long as possible, avoiding activities associated with aging and old age; resisting stereotypes associated with aging.
- Who matters in later life: maintaining social relationships with friends and family, preserving contacts with the broader community, making new friends in new settings, anticipating care giving and receiving relationships and planning for those.

These and many more outcomes may be positively affected by planning, or negatively impacted by its absence. However, knowing when and for whom planning matters most requires data that go far beyond indicators of income and health status. Understanding the role planning plays in these later life processes requires research that considers how inequalities in several facets of life may interact to mitigate some inequalities and magnify others.

One recent example of how casting a broader planning net could be studied is an empirical project by Margaret Denton and her colleagues (2004) who developed a *reflexive planning* framework to study planning for old age in a small convenience sample of midlife and older Canadians. They note that as uncertainty increases around the ability of the welfare state, financial markets, and families to meet individual needs during later life, people reflect on their life situation and make choices accordingly. While four-fifths of individuals in the sample engaged in reflexive planning, a small group lived day-by-day, with little thought about the future. *Planners* in the study had a positive outlook and a strong sense of agency, in contrast to individuals who coped *day-by-day* and had a fatalistic perspective and weak sense of agency. Those who avoided planning were not simply disorganized or spontaneous. Most of the nonplanners were divorced or separated women with low incomes and few resources available for planning. Social structural factors interfered with the luxury of planning for later life (Denton et al. 2004). This research underscores the connections between lived experiences and structural constraints, how adaptation to current circumstances shapes planning and the interpretation of contemporary experiences, and could be extended to many realms of later life experiences and different cohorts of individuals.

Survey research can identify outcomes that may be associated with planning, but is so far poorly suited to understand processes of goal-setting, decision-making, and planning for old age across an adult lifetime. This argues for several different approaches to pry open some of the black boxes associated with planning for later life across multiple life domains. Exploratory studies that encompass the life experiences of diverse groups would be an important first step, including multimethod approaches used to explore the complexities of planning in real world circumstances (see, e.g., Moen 2003 and Denton et al. 2004). Quantitative components of such research with validated metrics for assessing planning activities could foster comparison across group experiences of planning if appropriate measures beyond income and health status can be devised. Qualitative research of processes associated with planning is also essential to build theory and empirical confidence that the range of activities associated with planning – or not – for old age are systematically identified and investigated. Qualitative studies of planning for different demographic groups, on varied life

trajectories and at different turning points and transitions across the adult life course, could offer a grounded approach for theory-building, a foundation for broader study, and better insights into planning processes beyond the current focus on health and retirement. Such research would offer insights into processes associated with planning for older ages across successive cohorts, diverse groups, and multiple life domains, to build confidence that larger, more generic national studies have merit and utility for the discipline.

At the beginning of the twentieth century, contemplating routine survival into old age accompanied by a period of leisure at the end of life was beyond the imaginations of most individuals. Economic progress, social and cultural changes, increased life expectancies, and a set of structuring institutions moved potential old age beyond the realm of imagination to realization. But the current pace of social change and the restructuring of social institutions requires reimagination of old age for this century. There is substantial potential for sociological research to explore more carefully and creatively how planning might influence later life outcomes beyond the important considerations of income and health. Processes and outcomes surrounding those two material foundations of good old age have been carefully researched by sociologists over the past several decades, although economic turmoil and health care reform will keep social science research on planfulness for health and income security important areas of study. Understanding how planning directs and redirects life course trajectories that influence social support and friendship, outlooks on life, sense of fulfillment and happiness – the very things each of us would plan for old age if we could – are understudied areas that provide fertile ground for future sociological research.

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Chapter 25
Responses of the Long-Term Care System to Recent Natural Disasters

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The number of people affected by disasters has grown steadily since the mid-1970s. The number of deaths due to natural disasters world-wide between 1970 and 2006 is estimated at nearly 2.8 million (EM DAT 2009). Recent natural disasters include the tsunami in South Asia, and major earthquakes in Haiti, Japan, Pakistan, China, and Turkey. In the United States, four powerful hurricanes struck Florida in 2004, and Hurricanes Katrina and Rita caused major destruction in the Gulf Coast states in 2005. These events highlight serious and fatal health consequences following major disasters. In the United States, more than 45 million people live in the coastal region of the Atlantic and Gulf Coast, which are exposed to considerable risk of hurricanes (U.S. Census Bureau 1997); the risk of hurricanes has increased by nearly 40% in the past 15 years, due in large part to rising sea temperatures (Pew Center on Global Climate Change 2009). More than 12% of the population of U.S. coastal states will be aged 65 and above by 2025. Large heavily populated areas of the United States are also at risk of major earthquakes, including much of the West Coast, the Central Mississippi River Valley, and the coastal Southeast (U.S. Geological Survey 2009). The growing numbers of natural disasters, as well as the threat of man-made emergencies, underscore the importance of improved planning at the individual and community levels to address the disaster preparedness and recovery needs of older people and their families.

In the United States, the population aged 65 and above will increase to 82 million by 2050, from 35 million in 2000. About four million older people in the United States live in nursing homes or residential care facilities (Association for Homes and Services for the Aged 2009; Centers for Disease Control 2008). The vast majority of older people live in the community. Many of the negative consequences of natural disasters for older people are due to exacerbations of chronic diseases, which disproportionately affect older people (Fernandez et al. 2002; Miller and Arquilla 2008). Over 70% of people aged 80 and older have a disability; over 40% need help to perform basic activities of daily living (U.S. Census Bureau 2002). Effects of Hurricane Katrina underscored the need to improve preparedness for older people, both those living in the community and those in long-term care residential facilities. Hurricane Katrina devastated many communities in the Gulf Coast in August of 2005. Over 1,300 people died, the majority being older people (Simerman et al. 2005). The response to a disaster by emergency management organizations, public health agencies, and medical providers depends in large part on advance planning. This planning must consider the needs of special populations, such as frail older people and disabled individuals (Johnson et al. 2006; Saliba et al. 2004; U.S. Office of Inspector General 2006). There is considerable consensus among public health experts and researchers that medical systems and emergency management in the U.S. and in many other countries are not prepared for public health disasters (Johnson et al. 2006; Miller and

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Arquilla 2008). Their lack of preparation is particularly acute regarding needs of older populations (Fernandez et al. 2002; Johnson et al. 2006; Miller and Arquilla 2008; Saliba et al. 2004; U.S. Office of Inspector General 2006).

In this chapter, we first describe preparedness challenges and opportunities affecting nursing homes. Next, we consider the preparedness needs of organizations that provide health and other supportive services to older people living in the community. Our focus in the first two sections is on long-term care organizations in the United States. Next, we focus on preparedness responses and needs of older individuals. In that section, we broaden our lens to include experiences and studies conducted in a number of counties following recent disasters, including Turkey, China, and Japan. We consider responses and perspectives from a life course perspective. Some researchers view disasters as a combination of populations and potentially destructive natural or man-made events, where the combination involves a socially produced condition of vulnerability (Hoffman and Oliver-Smith 1999). Such conditions arise, for example, when large cities grow in areas that are subject to intense hurricanes or massive earthquakes. A disaster creates an immediate need to respond to new and unique conditions. Individuals' responses to such rapid change are influenced by their conceptual frameworks, which are a function of their life experience (Hoffman and Oliver-Smith 1999). Thus, disasters may be symptomatic of strategies societies use to adapt in the context of their social, economic, and built environments (Hoffman and Oliver-Smith 1999).

We turn next to implications for research and practice. To help guide future research, we present an integrated model of long-term care preparedness, The Socio-Ecological Model of Individual and System Preparedness in Long-Term Care. This model applies elements of the socio-ecological model of health to disaster preparedness, including individuals, families, neighborhoods and communities, and political perspectives. Next, we consider how the life course perspective applies to preparedness for older people. Then, implications for practice are considered, including needs for communication and training.

Definition of Disasters and Emergencies

Most studies examining preparedness use the terms "emergency" and "disaster" interchangeably, to refer to life-threatening unexpected events (e.g., Laditka et al. 2008a). These events can encompass a relatively localized "emergency," such as a tornado, or a more massive "disaster," such as Hurricane Katrina. We recognize that the government, communities, social service, and health care organizations play a role in preparing older people for local events affecting a small number of individuals, such as a house fire. However, in this chapter, we use the terms emergency and disaster to refer to widespread events that disrupt community infrastructure over a broad geographic area. This definition of an emergency or disaster is consistent with well-recognized published guidelines (Task Force of Quality Control of Disaster Management 2002). The terms "emergency" and "disaster" relate to the sociology of aging in that these are categories of events for which individuals and society can help older people and the organizations that serve them to prepare, where that preparation includes advanced planning for major unexpected widespread disruptive events and their aftermath.

Disaster Preparedness and the Special Needs of Older Populations

The special needs of older populations in disaster preparedness need to be considered by practitioners, policymakers, and planners, to enhance geriatrics disaster training and education. The Bioterrorism and Emergency Preparedness in Aging Committee, formed in 2002, addressed these

areas by developing and disseminating education and training materials to improve preparedness for older people residing in the community and in residential facilities (Johnson et al. 2006). The Bioterrorism and Emergency Preparedness in Aging Committee consisted of members of the National Association of Geriatric Education Centers. Six of the 46 Geriatric Education Centers in the U.S. took the lead in this initiative. The Bioterrorism and Emergency Preparedness in Aging framework conceptualizes the special needs of older populations as stemming from: (1) compromised immune systems, which make older people more susceptible to stress induced by extremes of temperature or biological agents; (2) failure of major body systems such as renal failure, and comorbidities such as diabetes, which put older individuals at higher risk of adverse outcomes following a disaster; (3) declines in functional and cognitive status, limitations in mobility, and loss of vision and hearing, which result in special communication needs and additional preparation time required by older populations; and (4) other factors related to lower socioeconomic status, racial and ethnic disparities, social isolation, disability, and ageism (Johnson et al. 2006).

Preparedness in Nursing Homes

More than 1.5 million older Americans reside in nursing homes (Centers for Disease Control 2008). Despite a declining prevalence of disability, their number will grow due to population aging (Laditka 1998). In this section, we extend the discussion introduced by Laditka et al. (2008b, 2009). Nursing homes are vulnerable to many wide-spread disasters, including hurricanes, earthquakes, floods, outbreaks of infectious disease, terrorism, prolonged loss of power, as well as other challenges involving ice, snow, fire, or wind. Disasters raise particularly difficult challenges for preparedness, because these events substantially disrupt infrastructures of emergency response and regional economies, often affecting the availability of electrical power, communications, gasoline and other fuels, transportation, food, medicines and other supplies, and staff (Laditka et al. 2008b, 2009). Relatively little research examined disaster preparedness in nursing homes before Hurricane Katrina.

The four hurricanes that struck Florida in a 44-day period in 2004 – Charley, Frances, Ivan, and Jeanne – prompted a recently published study of 291 nursing homes. Researchers found that major concerns were transportation and long lasting power outages (Hyer et al. 2009). There was evidence that transportation agreements were not upheld; generators were not adequate to support air conditioning and laundry services. A number of studies were conducted in the aftermath of Hurricane Katrina. One identified perceptions about disaster preparedness among nursing home administrators in South Carolina in the period immediately before and after Hurricane Katrina (Laditka et al. 2007a). Although South Carolina was not directly affected by Katrina, nursing home administrators in the state followed the events surrounding Katrina closely because South Carolina is at risk for severe Hurricane damage. Administrators expressed concerns about their ability to care for evacuees from other nursing homes in the event of a disaster, and about their lack of appropriate transportation (Laditka et al. 2007a, b). In a response to a brief survey of administrators immediately following Hurricane Katrina, the majority of respondents said that they were rethinking their preparedness plans for transportation, supplies, staffing, and communication (Laditka et al. 2007a). In a study of nursing homes primarily in Mississippi that sheltered nursing home residents evacuated from areas with the most damage from Hurricane Katrina, nursing home administrators also raised concerns about communication, transportation, supplies, and staffing (Laditka et al. 2008a). Laditka and colleagues (2008b) found reports of long-term mental health needs among both residents and staff following Katrina. Administrators said that nursing homes were not included in community preparedness planning (Laditka et al. 2008b).

Administrators of nursing homes in New Orleans who evacuated or sheltered affected individuals following Hurricanes Katrina and Rita said major challenges were lack of appropriate transportation,

staffing shortages, and a perception of abandonment by state and federal response agencies (Dosa et al. 2007). A study of hospitals in New Orleans serving older patients in skilled nursing facilities and hospice units found that loss of power, shortages of staff and supplies, and extreme heat were major challenges following Katrina (Gray and Hebert 2007).

Another study following Hurricane Katrina focused on responses of 38 staff in four nursing homes in Mississippi that sheltered frail evacuees (Laditka et al. 2009). Staff emphasized the need to provide emotional support to evacuees as well as physical care. Many staff said caring for evacuees was difficult because they were anxious and in poor physical condition after the evacuation. A major challenge in caring for evacuees was communicating with evacuees' families: landline and cell phones did not operate for weeks following the hurricane; further, families were spread by the evacuation (Laditka et al. 2009). Staff also stressed challenges associated with preventing dehydration, lack of food and personal hygiene supplies, and staff exhaustion. At the same time, many described caring for evacuees as "a blessing," saying the experience helped them to bond with residents, evacuees, and other staff. Staff emphasized the importance of teamwork, community help, and the need to have a well-organized disaster plan, extra supplies, and dependable staff (Laditka et al. 2009).

A recent study examined emergency evacuation plans for about 2,100 nursing homes in the U.S. (Castle 2008). Although most facilities were relatively well prepared to shelter in place, most did not include plans to evacuate. Summit meetings of key stakeholders, including leaders in long-term care, transportation, emergency management, federal and state agencies, and nursing homes, were convened in 2007 to discuss challenges and opportunities in disaster preparedness for nursing homes (Hyer et al. 2006). Participants recommended enhancing transportation and communication resources, improving coordination between nursing homes and local emergency preparedness systems, refining disaster preparedness guidelines, and conducting emergency drills (Hyer et al. 2006).

Taken as a whole, research and recent meetings of key stakeholders identified a number of common problems faced by nursing homes following disasters: loss of power; lack of sufficient or appropriate transportation for evacuation; wide-spread disruption of communication systems, with breakdowns in landline and cell phone service; lack of food, water, gasoline, medications, and other medical and general supplies; and lack of adequate staff (Dosa et al. 2007; Hyer et al. 2006; Laditka et al. 2007a, 2008b, 2009; Saliba et al. 2004). Findings suggest that nursing homes receive substantially less support than hospitals from local, state, and federal response agencies, and that this shortcoming affects them before, during, and following disasters (Brown et al. 2007; Dosa et al. 2007; Hyer et al. 2006; Laditka et al. 2008b). For example, state and federal laws do not require that nursing homes receive priority for power restoration following a disaster (Brown et al. 2007).

Summary of Disaster Preparedness Lessons Learned from Nursing Home Studies

There were a number of important "lessons learned" from nursing home-related research conducted following Hurricane Katrina. Laditka et al. (2008b) adapted six of the training and practice domains described by The Bioterrorism and Emergency Preparedness in Aging Committee (Johnson et al. 2006) to describe care, practice, and policy implications for nursing homes and other residential facilities serving older people. The six domains described by Laditka et al. (2008b) are: (1) maintain core functions, i.e., the ability to maintain normal day-to-day operations following a disaster, with a focus on ensuring that there are sufficient supplies for residents and families of staff and their pets; (2) respond to needs of a diverse group of stakeholders, e.g., provide culturally sensitive care to residents; (3) apply geriatric-specific protocols in patient and resident care, including triage and

medication management; (4) address mental health needs of residents and staff, recognizing that older people and staff are vulnerable to depression after a disaster and may have long term mental health needs; (5) ensure transportation is available if evacuation is needed, and that transportation services meet the special needs of older people (e.g., heating, cooling, accommodate wheelchairs); and (6) ensure communication systems are in place with backup systems for landline and cell phones and the internet. Laditka et al. (2008b) also introduced two new preparedness domains for long term care populations: (1) ensure that needs of nursing homes are addressed in community preparedness planning, e.g., lifelines such as power are restored promptly; and (2) recognize nursing homes provide valuable health care resources to the community, including oxygen, trained health care personnel, and supplies. The preparedness concepts in the domains described by Laditka et al. (2008b) can be extended to or adapted for many types of residential communities for older people, including independent living communities, assisted living communities, and continuing care retirement communities. These preparedness domains can also be applied to health and social services agencies providing care to older people living in the community, which are described in the section that follows.

Preparedness Among Agencies Providing In-Home Care to Older People in the Community

In this section, we turn to preparedness among agencies providing care to older people in their homes, drawing on the discussion introduced by Laditka et al. (2008a). More than eight million vulnerable older Americans receive long term care services in their homes (Hughes and Renehan 2005). Support for home care will grow, as a continuing response to the Supreme Court's 1999 Olmstead Decision (United States Supreme Court 1999). Most recipients of home care are over age 75 and live alone. These older adults are at high risk of rapid physical decline, mental disorientation, emotional trauma, and death; few would be able to care for themselves during and after a disaster. Thus, agencies providing care in the home serve as a critical component in the long-term care continuum.

Home health agencies and personal care agencies provide a broad array of medical and support services for older people in their homes. Home health agencies provide more highly skilled nursing care, whereas personal care agencies provide basic assistance with bathing, dressing, meal preparation, and similar activities (Hughes and Renehan 2005). The federal Centers for Medicare and Medicaid Services requires home health agencies to have disaster plans. No specific rules govern the types or regularity of training or the content of those plans. Most states require home health agencies to be certified to obtain Medicare reimbursement (Hughes and Renehan 2005). Improving federal and state regulations could substantially enhance preparedness among home health agencies. Home health agencies can also seek accreditation from the Joint Commission or the Community Health Accreditation Program. Since 2006, the Joint Commission standards require home health agencies to conduct one disaster drill per year (Joint Commission 2007).

No federal regulations govern disaster preparedness for personal care agencies. Preparedness among these agencies varies substantially by state. We provide one case example using South Carolina. Most personal care agencies in South Carolina have a contractual agreement to provide services to clients enrolled in the Community Long-term Care Program. This is a Medicaid home- and community-based waiver program serving approximately 12,500 clients who qualify for both nursing home placement and Medicaid (Pande et al. 2007). Case managers are employed by the Community Long-term Care Program. Case managers are required to ensure that clients of personal care agencies have disaster plans (South Carolina Department of Environmental Control, SC DHEC 2005). Case managers develop an "emergency preparedness checklist" and an "emergency telephone

list" with clients and/or designated caregivers (SC DHEC 2005). Clients' needs are assessed when they are enrolled in the Program, and updated every 30 days (SC DHEC 2005). Nurse consultants evaluate clients and identify those who should have priority status during disasters. With clients' permission, names are shared with emergency agencies.

Research examining disaster preparedness in agencies providing services to older and/or disabled clients in their homes is sparse. Until recently, almost all studies have been limited to narrative reports about the impact of a disaster on clients of home care services (Riddix and Dellar 2001) or ways home health care nurses can help clients to prepare (Sienkiewicz et al. 2007). There are few empirical studies in this area. Using qualitative methods, researchers evaluated how five home health agencies in Orleans Parish, Louisiana, responded to Hurricane Katrina (Kirkpatrick and Bryan 2007). All of the agencies had preparedness plans. However, the breakdown of communications was widespread due to the loss of landline and cell phone operability. Results showed a lack of coordination among government and home health agencies (Kirkpatrick and Bryan 2007). The researchers recommended additional drills to train agency staff, better ways to identify clients who are reluctant to evacuate, enhanced communications and transportation, and early evacuation.

Another recent study examined preparedness among health care and personal care agencies in South Carolina (Laditka et al. 2008a). Telephone interviews were conducted with administrators of 16 agencies providing in-home personal care to 2,147 clients, and five agencies providing in-home health care to 2,180 clients. For agencies in both categories, findings suggest a lack of preparedness: in identifying clients at high risk and assisting them in planning, providing written materials and/or recommendations for clients, training staff, and coordinating disaster planning and response across agencies (Laditka et al. 2008a). Although home health agencies were better prepared than personal care agencies, a number of home health administrators commented that they were unsure how well their plans would work. Most administrators said that better coordination and/or more preparedness training is needed. The findings support incorporating disaster planning in certification requirements for home health agencies, and developing additional educational materials for administrators and staff and for clients (Laditka et al. 2008a).

Older Adults' Experiences and Responses to Disasters

In this section, we focus on responses to disasters and needs of older people. Responses are considered using a life course perspective, building on the recent review by Shenk et al. (2009). We include studies conducted in the United States and in other countries.

Coping Approaches

From a life course perspective, memories and previous experiences help shape how older people experience and cope with disasters (Krause 1987). Disasters often evoke one or more coping strategies. Two broad coping styles used by older adults have been identified: emotion-focused coping and problem-focused coping.

In emotion-focused coping, older people often turn to activities or emotional states that keep them from directly confronting stressful events (Yeung and Fung 2007). In this strategy emotional support, humor, and disengagement are often used by older people to mediate responses to stressful events. Some responses may be positive. For example, older adults may help others affected by the disaster. This response can distract older individuals from their own problems, and provide a greater sense of

emotional control (Heller et al. 2005). Emotion-focused coping can also lead to negative responses. For example, one study suggested that talking about an earthquake caused older people to relive the disaster experience and resulted in increased stress (Alea et al. 2004).

Problem-focused coping involves efforts to reduce and alleviate stressful situations (Yeung and Fung 2007). An example of problem-focused coping is improved preparation for another disaster among people who have experienced a previous disaster (Ecevit and Kasapoglu 2002). Findings in this area are mixed. A lifetime of experiences with life changes – including but not limited to disaster-related changes – may enable older adults to better cope with change (Heller et al. 2005; McMillen et al. 1997; Norris and Murell 1988). Some research suggests that experiencing a disaster prompts older people to recognize the need to prepare (Heller et al. 2005). In one actual experience, however, older people who experienced an earthquake and recognized a need to prepare for a future earthquake did relatively little to prepare (Heller et al., 2005). A recent study examined preparedness among 547 older people in Florida who responded to a survey while visiting an ambulatory Veterans Administration clinic (Cherniack et al. 2008). Nearly 84% reported that they had lived in a hurricane prone area of Florida for more than 10 years; about 31% reported experiencing 5–10 hurricanes, nearly 38% reported experiencing more than 10 hurricanes. Yet, most respondents did not understand common warning terminologies, e.g., "hurricane watch" or "hurricane warning," or what steps to take if they heard these warnings and only 56% had an evacuation plan. About 30% said they had an electric generator, but of these, only 46% said they knew how to operate it (Cherniack et al. 2008). These findings suggest that preparation for hurricanes was lacking even among an older population with substantial disaster experience.

Level of Coping Self Efficacy

According to Bandura (1997), coping self-efficacy is defined as self-reported ability to cope with the effects of a disaster or trauma. Individuals can often recognize their relationship to the environment, and thus anticipate future adaptive responses. Through this process, older people consider possibilities for their future, and attempt to control their future life course. This approach can help define the older person's feelings, thoughts, motivations, and behaviors. Levels of coping self-efficacy are related to the individual's personality and life experience. Those with high coping self-efficacy have better abilities and are more likely to cope effectively with stresses during and after a disaster (Bandura 1997).

Psychological effects: Negative psychological effects of disasters can include anger, fear and shock (Yeung and Fung 2007), sadness (Alea et al. 2004), and emotional numbness and social isolation (Ecevit and Kasapoglu 2002). Depression following disasters varies depending on individual characteristics. For example, among older people who survived the Loma Prieta earthquake in San Francisco, greater exposure to the damage and destructive effects of the earthquake increased depression overall, and exacerbated depressive symptoms of older people with depression (Nolen-Hoeksema and Morrow 1991). Although often negative, psychological effects after a disaster can be positive. Positive effects include personal growth and reassessment of life priorities (McMillen et al. 1997). Surviving such an experience sometimes causes survivors to articulate community needs, and can help to inform improvements in infrastructure, services, and policy (McMillen et al. 1997).

Social support: During and after disasters, social support is provided through formal groups and structures and informal systems of family, friends, and neighbors. Organizations and the community provide resources and services. Support is also needed to address emotional needs. Social workers often fulfill essential roles following disasters, thanks to their skills in providing information and services to older individuals in the community (Javadian 2007) as well as in long-term care facilities

(Laditka et al. 2008b, 2009). In many instances, older people have been living in the disaster area for a longer time (Goto et al. 2006), and have established better social networks than younger residents, factors that can help older people to cope following disasters (Kato et al. 1996). As suggested in our review of recent research on nursing homes and organizations providing services to frail older people in the community, establishing strong community linkages and networks well in advance of a disaster is an important characteristic of organizations that respond more successfully to disasters (Laditka et al. 2008b, 2009). An analogous benefit may accrue to older individuals who have strong social networks.

Life experiences and responses to disasters: As a whole, evidence suggests that older people have greater coping abilities than younger adults. Some research attributes stronger coping abilities to more life experiences (Melick 1985), and experiences with coping with stressful events (Heller et al. 2005; Thompson et al. 1993). A lifetime of experiences with many life changes may help some older people cope with disasters reasonably well (Norris and Murrell 1988; Thompson et al. 1993). Many older adults have experienced a previous disaster (Kato et al. 1996), and may therefore be more confident in their ability to manage a new one (Phifer and Norris 1989). There is evidence that older persons who experienced a disaster previously may experience less stress after another disaster (Goto et al. 2006; Melick 1985; Phifer and Norris 1989). There may be analogous beneficial effects of having experienced a lifetime of lesser emergencies, challenges, and traumatic events, as they can help to prepare the individual for new challenges even if they might be unexpected. Studies of older persons' emotional health have identified individual characteristics that promote successful adaptation, variously described as resilience, mastery, self-efficacy, or emotional vitality (Hendrie et al. 2006). Analyzing data from the Berlin Aging Study, Baltes and Baltes (1990) proposed that accumulated life experiences for some older persons result in "wisdom," the ability to exercise good judgment about important but uncertain matters, which enables successful adaptation. It seems likely that those older persons who have developed this ability to make good judgments in the face of uncertainty would be better adapted to deal with disaster experiences successfully.

Implications for Research and Practice

The Socio-Ecological Model of Individual and System Preparedness in Long Term Care

Drawing on previous research at both the organizational and individual levels, we offer an initial theory of preparedness for older people in long term care. A useful starting point for conceptualizing a framework of preparedness for long term care is the Vulnerability Perspective (Blaikie et al. 1994). Thomas and Soliman (2002) adapted the Vulnerability Perspective to examine factors that contributed to death among older people in heat waves the United States during a 20-year period. As adapted by Thomas and Soliman (2002), the Vulnerability Model suggests that the progression of vulnerability is influenced by "root causes" such as limited resources, "dynamic pressures" such as lack of local institutions, and "unsafe conditions" such as lack of preparedness to cope with disasters and hazards (Thomas and Soliman 2002, p. 27). The Vulnerability Perspective offers a framework for how various external factors, such as social, economic, and political institutions increase or decrease vulnerability to disasters among certain groups of people. The model suggests that personal characteristics such as age, gender, and level of disability interact with the external environment and organizational systems to affect the ability of individuals and organizations serving older people to plan for disasters, and to

recover from them. According to this model, risk arises as a combination of vulnerability and hazard; that is, the interaction of these factors increases individuals' susceptibility to risk.

Building on the Vulnerability Perspective, we suggest a framework for conceptualizing preparedness for older people, The Socio-Ecological Model of Individual and System Preparedness in Long Term Care. The model extends the Vulnerability Perspective framework by incorporating domains of preparedness identified in previous studies of disaster preparedness among organizations providing health, medical, residential, and other supportive services to older people (Cherniack et al. 2008; Dosa et al. 2007; Hyer et al. 2006, 2009; Johnson et al. 2006; Kirkpatrick and Bryan 2007; Laditka et al. 2007b, 2008b, 2009; Saliba et al. 2004), and older adults' experiences and responses to disasters (Shenk et al. 2009). Figure 25.1 shows a simplified version of the model. Using this model, the older person's risk can be viewed as a function of vulnerability plus individual characteristics, and organizational and system level preparedness factors. As shown in Fig. 25.1, risk for older people is at the center of the model. Risk is affected by three sets of factors, represented by three ovals, extending out from the center in the following order: (1) individual characteristics, such as health status, mobility, education, location of residence (e.g., rural or urban, coastal or noncoastal, earthquake prone or nonearthquake-prone), disability status, income, access to transportation and information/resources, ability to communicate, social support (e.g., presence of a spouse and/or adult children), and life course experiences; (2) organizational characteristics, including staff number and type, type and number of older people served by the organization, location factors analogous to individual location characteristics, training, communication resources, and transportation resources; and (3) system factors, including health care resources, emergency systems resources, technology resources, transportation network, and communications network. Thus, the model incorporates domains previously identified as important in long-term care preparedness studies at the individual, organizational, and system levels. These factors interact to affect risk among older people from natural or man-made disasters.

Many older people live alone, some with limited resources and few social contacts. Many will not be able to engage in active information gathering during a disaster (Slaughter et al. 2005). An integrated theory of disaster preparedness in long term care will anticipate this need for information, strengthen multilevel communication efforts, and provide specific recommendations for the preparedness needs of older adults at the individual, organizational, and system levels, integrating an understanding of the life course perspective.

Although the Vulnerability Perspective framework and the Socio-Ecological model provide useful conceptual frameworks for disaster preparedness, these models have limitations. They are not causal models. Further, they do not allow researchers to identify certain factors and characteristics that play more (or less) prominent roles in preparedness for older people. It would be useful for future research to identify linkages among sets of factors and causal pathways and to determine factors and characteristics that play a key role in preparedness for older individuals. These steps will help to develop an integrated theory of preparedness in long-term care. We suggest that an integrated theory should present the current state of knowledge regarding such preparedness, depict areas in which revisions of current knowledge, practice, or policy may be desirable, inform future research into emergency preparedness among organizations serving older populations, and lay out directions for future research in the field.

Implications for Life Course Research

The strength of the life course perspective lies in its ability to integrate the context of individuals' lives, including the current phase of life with its previous experiences and consequences, the time and events both before and after the point being studied, and the ways in which the individual's life

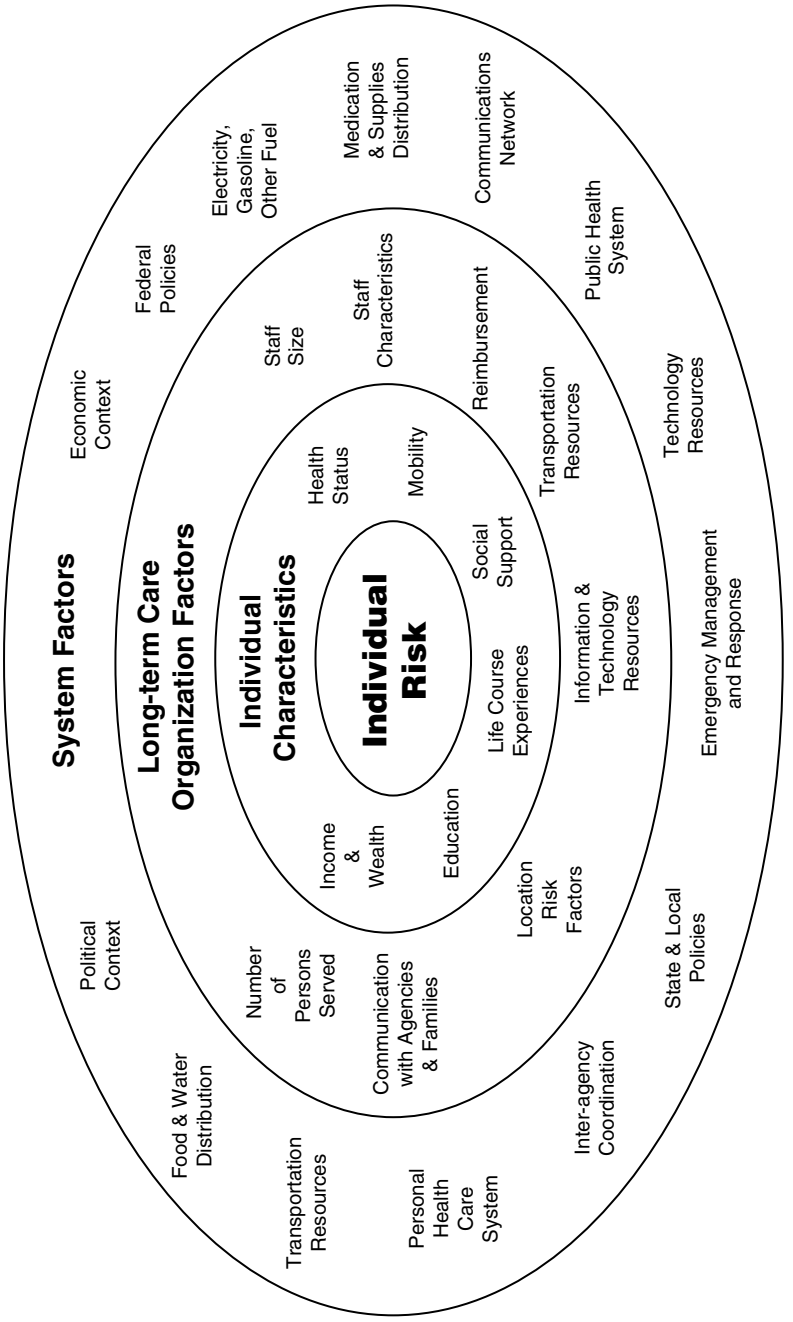

Fig. 25.1 The socio-ecological model of individual and system preparedness in long-term care

is intertwined with others (Shenk et al. 2009). The past helps to shape the individual's orientation to the present and the future so that life before the experience of the disaster and life after the disaster exist in the context of the individual's personal experiences and environment. Thus, there is interplay between biography and history, or self and society. The biography of the older adult interacts with the historical encounter of the disaster experience. It is from this interaction that the life course perspective extends itself to conceptualization and understanding of individual action.

Central to the concept of disaster studies are the obvious effects a disaster brings, including vulnerability, loss of lives, and destruction or loss of material possessions. Following a disaster, everyone is likely to experience losses and be affected. However, more severe and longer lasting adverse effects occur among those who belong to the most vulnerable groups. This includes those with lower socioeconomic status, those most affected by health disparities associated with race or ethnicity, individuals with limited social support, and those with limited ability to access resources to rebuild and recover. Among older adults, their frailty and vulnerability may often be compounded by misconceptions about their abilities and needs. Older people can be further victimized by oversimplified generalizations about their abilities to respond in the event of a disaster.

The experiences of disasters by older adults influence the rest of their lives and the consequences are likely to bring behavioral changes. Their life orientations and intrinsic features can also set them apart from other disaster victims. As noted earlier, previous experiences with a disaster can improve confidence in their ability to manage the situation; longer length of residence in the disaster area may have led to development of stronger social networks (e.g., Kato et al. 1996). The number of years lived with the range of experiences they are likely to have encountered can make older adults emotionally stronger and more mature in handling the stresses of a disaster encounter (e.g., Heller et al. 2005). The emotional competency that derives from these intrinsic features is often affected by the physiological changes that aging often brings. Though older adults are often viewed as vulnerable and frail, these characteristics are countered by the heightened emotional stability they possess (e.g., Hendrie et al. 2006). Given these skills, older people can often serve as sources of information for disaster preparation and recovery.

The best way to mitigate the unfavorable outcomes of a disaster experience is to be prepared. Although researchers have identified many negative effects of disasters, the interpretation of the encounter varies across individuals. Capitalizing on strengths of older adults as expressed in the richness of their lifetime of experiences can make a significant contribution to disaster research. Disaster studies can help to inform life course research. Disaster research provides a vivid example of how the life course perspective can help us to understand the complexities of interactions of history and memory and of individuals' experiences within a historical context. The challenge is to balance strengths and vulnerabilities of older adults as survivors of disasters who can aid in preparing for future disasters.

Disaster and Emergency Communication Needs

Preparedness communication is a key factor in disaster preparedness (Kreps et al. 2005). Unfortunately, preparedness information may not reach older adults or their families, due to limited access to information, confusing communication of messages that are not well designed for their intended audience, and poor understanding of these messages by older adults (Cherniack et al. 2008). At all ages, people increasingly are turning to the internet for information about health risk and disease. Facing a pending disaster or emergency, many older people rely on the internet to provide accurate, current, and easily understood information. A recent study evaluated the readability and suitability (e.g., content, layout, cultural appropriateness) of 50 top websites with information about disasters and preparedness aimed at the general public in the U.S. (Friedman et al. 2008).

The researchers found that most websites required a high reading level, nearly grade 11, and were rated difficult or very difficult. Most were rated as either below average or adequate in suitability. These results suggest that there is a need for web-based preparedness resources that can be more easily understood.

Public and governmental health organizations, and organizations providing long term health care and support services, can help prevent excess morbidity and mortality among older people by communicating about the need for preparedness and its desired characteristics, and about disasters that are predictable in the short term. Community, public health, and organizational responsibilities may include helping older people to prepare for unexpected events, helping them to shelter-in-place or assisting with evacuation and/or transportation to shelters if necessary, and helping them to recover from disasters (Johnson et al. 2006). In all of these areas, clear, targeted messages will result in better attention to the information, and a greater probability of understanding the need to take action when required (Kreuter et al. 1999).

Preparedness Training Needs Among Students of Health Administration and Health Professions

There is an urgent need to enhance disaster preparedness training for students of public health, gerontology, health administration, nursing, social work, and other health-related fields. One recent study used a train-the-trainer process and experiential learning to teach doctoral students to serve as preparedness educators for students of public health and health administration (Laditka et al. 2007a). After reviewing preparedness instructional materials, students worked in small groups of 3 or 4 students to develop teaching materials for master's level students. The results of eight paired Likert scale questions on pre and postassignment surveys showed significant and meaningful improvement in students' perceptions. The results showed markedly improved knowledge about disaster preparedness for vulnerable groups, and in the students' confidence in their ability to develop and teach disaster preparedness (both $p<0.05$) (Laditka et al. 2007a). This type of experiential approach can be adapted by faculty to incorporate a "stand alone" assignment in a course for students, including students of public health, health administration, gerontology, social work, and nursing. It can also be adapted to train leaders in the private and public sectors, as well as health care professionals, to train health care and public health workers and volunteers to plan for disasters and respond to them.

Additional Areas for Future Research in Long-Term Care Preparedness

A growing number of studies have examined preparedness in nursing homes, in response to the aftermath of Hurricane Katrina. In the past 20 years there has been a huge growth in other residential options for older people in the United States, including assisted living facilities, continuing care retirement communities, and retirement communities. To our knowledge, no research has examined preparedness plans in these long-term care organizations and communities in which most residents are older. Thus, little is known about procedures and processes to help these older people during and after disasters. The eight training and practice domains described by Laditka et al. (2008b) could be adapted for research in these residential facilities and communities. In another area, research has not typically distinguished between reactions to natural disasters and reactions to man-made disasters. Reactions to the latter, particularly terrorist events, may differ qualitatively from reactions to natural

disasters. They may also result in different life course effects, including, for example, enhanced feelings of patriotism or vulnerability, either of which could influence behaviors throughout the ensuing life course.

Research that explicitly examines cohort effects in preparedness would also be useful. Results of a recent study using nationally representative data for Vietnam era veterans ($n = 7{,}914$) from the 2001 National Survey of Veterans illustrates the usefulness of considering cohort effects in disaster preparedness among older populations. Brooks et al. (2008) compared the treatment of posttraumatic stress disorder and that for other mental health conditions of veterans of the Vietnam War era who served in Vietnam and those who served elsewhere, stratifying the analysis by age (<60, ≥60). Most mental health measures were significantly poorer among veterans who served in Vietnam than those who served elsewhere; veterans who served in Vietnam were also significantly more likely to receive treatment for posttraumatic stress disorder (Brooks et al. 2008). A cohort effect was observed: the negative effect of service in the war zone on mental health measures was substantially worse among those who experienced the war at younger ages; they were dramatically more likely to be treated for posttraumatic stress disorder than were those who experienced the war at older ages (Brooks et al. 2008). These findings highlight the complex interplay of cohort, age, and shared life-altering experiences. There may be similar differential disaster-related effects.

In addition, research has examined the role of race and ethnicity in vulnerability to disasters in the U.S. (for a review of earlier studies, see Fothergill et al. 1999). Most of these studies have been conducted after Hurricane Katrina (e.g., Chen et al. 2007; Elliott and Pais 2006; Lee et al. 2009; White et al. 2007). Taken as a whole, there is substantial evidence that African Americans are disproportionately adversely affected after a disaster, compared with non-Hispanic whites (Chen et al. 2007; Elliott and Pais 2006; Lee et al. 2009; Mills et al. 2007; White et al. 2007). Further, there is evidence that African American women may have the greatest vulnerability for long-term mental health problems after a disaster (Chen et al. 2007; Mills et al. 2007). The experiences of African American women following Hurricane Katrina are the focus of a recently conducted study (Laditka et al. 2010).

Conclusions

In this chapter, we described challenges and opportunities of disaster preparedness in organizations providing long term care for older people. A life course approach was used to consider older adults' experiences and responses to disasters. We also proposed a framework for long-term care preparedness. We encourage researchers, policy makers, practitioners, and administrators to continue to improve knowledge of how to help older people prepare for disasters, and to recover from them. Older adults bring a lifetime of experience to disasters. Their special needs and coping styles need to be addressed in disaster planning and recovery. It is important to recognize the vulnerabilities and special challenges that older adults experience following a disaster. At the same time, the history and memories of older people can prepare them to draw valuable lessons from past disasters and challenging experiences, and often also to cope with present disasters. Public health and community professionals who specialize in preparedness, together with administrators of organizations that provide health and social services to older people, would benefit from incorporating the valuable perspectives of older individuals in disaster planning.

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Chapter 26
Elder Mistreatment

Sonia Salari

Quality of life has emerged as a strong theme in the study of sociology of aging and life course. Victims of elder abuse and neglect experience low quality of life, along with a greater risk of morbidity and mortality (CDC 2009; Dong et al. 2009; Lachs et al. 1998). Evidence suggests elder mistreatment has existed historically in various forms (Pillemer and Wolf 1986), and current estimates suggest between one and two million older Americans suffer physically, psychologically, and/or financially at the hands of a trusted caregiver, spouse, or other family member.

At the societal level there has been increasing awareness and response to elder abuse and neglect over the past three decades. In the 1970s, public attention focused mostly on child abuse and neglect. The 1974 Child Abuse Prevention and Treatment Act (CAPTA) included an official definition of mistreatment and a mandatory reporting requirement for suspected child abuse. During this time, the first federal domestic violence shelter for victims of intimate partner violence (IPV) was established in California. The decade was also known for the beginning of the deinstitutionalization movement, where disabled persons were integrated more heavily into community life. Institutional settings were widely considered abusive. In 1975, Adult Protective Services (APS) legislation was funded under the Title XX Social Security Act, with an eye toward mandatory reporting standards. APS units were created in states to investigate reports of maltreatment of vulnerable adults (Fulmer et al. 2002). Later that decade, Claude Pepper chaired the widely publicized House Select Committee on Aging hearings and coined the term "elder abuse" (Bonnie and Wallace 2003).

The 1980s are commonly cited as the decade of greatest public attention to the problem and prevention of elder abuse and neglect. Initially, funding was sparse and research seemed stunted by methodological difficulties. Initially, policymakers and APS workers saw no harm in simply adapting child abuse patterns and solutions to the plight of the abused older person. Pillemer (2005) has critiqued early decades, when elder abuse "knowledge" was not empirically tested and tended to involve repeated claims describing elder abuse victims as highly dependent on overburdened caregivers. Eventually, the repeated claims came to be accepted as truth, with the perspective influencing policy programming. Improvement began in the late 1980s when the Amendments to the Older American's Act, adopted in 1987, defined elder abuse categories (physical, sexual, emotional/psychological, neglect, self-neglect, abandonment, and financial exploitation) (Teaster 2004). The first large-scale incidence study was published by Pillemer and Finkelhor (1988) using surveys from the Boston Metropolitan Area. Early investigators devoted enormous efforts toward establishing the abuse prevalence, and bringing the dialog into the sights of national funding agencies (Wolf and Pillemer 1989). By the late 1980s, the late Rosalie Wolf introduced the *Journal of Elder Abuse and Neglect*, which is still the premier journal for the study of mistreatment in later life.

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Over the past three decades, experts have come to understand the challenges to studying later life mistreatment, and they acknowledge research, policy, and practice in the field lags decades behind other areas of family violence, such as child abuse and IPV (Dong et al. 2009; McNamee and Murphy 2006). By 2003, the National Research Council reported no major foundation had identified elder mistreatment as a priority and federal funding for this problem had been modest at best (Bonnie and Wallace 2003). Since that time, small-scale federal efforts have funded incidence studies and there has been some progress developing accepted definitions.

Recent trends in elder mistreatment knowledge have focused on determining prevalence from a variety of sources which include bureaucratic reports from organizations such as APS. APS substantiated reports of elder abuse in 50 states show most cases took place in domestic settings (89.3%) and victims were typically female (65.7%), Caucasian (77.1%), and disproportionately over the age of 80 (42.8%). Self-neglect was the most frequently reported form of mistreatment (Fulmer et al. 2005; Teaster et al. 2006) and has been shown to be a significant predictor of mortality (Dong et al. 2009). Limitations of bureaucratic measurement include the need for consistent definitions across states and the reliance on reports to authorities, leaving much of the incidence unmeasured. APS units have defined *vulnerable adults* as those who are mistreated or in danger of mistreatment, without the ability to protect themselves due to advanced age or functional disability. Victim age categories vary across states, so groups 18–59 with disabilities, those 60 (55 or 65) and over have all been used – making cross-state comparisons challenging (Teaster 2004).

Social science research has attempted to determine prevalence through primary health care interviews, telephone surveys (Bonomi et al. 2007; Laumann et al. 2008), caregiver self-reports, and content analysis of television and print news stories (Malphurs and Cohen 2002; Salari 2007). Limitations include the biases of media and self-reports related to victimization or perpetration, and variations based on operational definitions. The National Research Council developed a definition of elder mistreatment as "intentional actions that cause harm or create serious risk of harm … to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder or failure by a caregiver to satisfy elder's basic needs to protect … from harm" (Bonnie and Wallace 2003:1). These guidelines provide a helpful framework but tend to leave many facets of elder mistreatment unmeasured.

The social construction of elder abuse and mistreatment has expanded in recent decades with a widespread recognition of new categories such as self-abuse and neglect. In addition, material abuse has ballooned in recent years, as evidenced by the reports listed in the National Council of Elder Abuse (NCEA) daily news feed listserv. Evidence suggests greater rates of financial exploitation are related to new vulnerabilities, such as identity theft and investment scams. The recent economic downturn has worsened the rate of material abuse suffered in later life (Metlife 2009). Attention to nonfamily perpetrators now includes strangers who target community dwelling elderly persons as well as negative treatment one might receive in institutional settings. Recently, the "victim's rights" movement has spilled over to survivors of elder abuse, recognizing the need for age-appropriate support services and shelters.

The social construction of elder mistreatment is related to cohort aging and period effects. The current generation of older persons has been socialized to keep hardships to themselves and family life private. Many of the violent or traumatizing incidents have remained hidden, with a high rate of under reporting. Elderly victims of detected mistreatment have a small group of devoted advocates such as researchers, human service personnel, medical staff, and those in law enforcement. Survivors of abuse are often left in precarious positions, as the available support services may not be age appropriate or responsive to the needs of an older person. As the Baby Boom cohort ages, significant increases are expected in the number of vulnerable elders, which is likely to be dealt with more publically. A stronger advocacy lobby is expected to develop to effectively mobilize forces to prevent and respond to violence.

Researchers now understand that child abuse models of dependency are not appropriate to explain elder victimization. However, in order to raise awareness and address the service and policy needs of this population, the scholarship will need to move beyond the focus on individual and family dynamics alone, and recognize the role of the larger community and sociological forces.

Ecological Iceberg of Elder Mistreatment

My experience in the field includes domestic violence victim advocate, university professor (taught courses in aging, public policy, and family violence), and researcher in the area of family violence (Salari 2007, 2009; Salari and Baldwin 2002) and elder mistreatment (Salari 2002, 2006). Based on these roles, I envision an ecological framework which examines the micro (individual), meso (family), exo (community), and macro (societal) level conditions influencing the social construction of elder mistreatment. The first two levels have received a great deal of attention in the literature, namely the individual and family culture perspectives. The vulnerabilities of victims (health, cognitive functioning, isolation, and gender) and the psychological characteristics of perpetrators are considered the *individual* level. *Family* dynamics include maladaptive dependency, violence socialization, unbalanced reciprocity, and poor coping skills. The two macro-level influences have been neglected. Fewer perspectives have focused on *community norms* about the nature of public and private relationships or the effects of the *economic and social structure* as they relate to elder maltreatment. All four ecological levels can be recognized and combined within an "iceberg" framework, where the unmeasured incidence is acknowledged, realizing the true size and shape of the phenomenon (under the surface) are difficult to envision. The social construction of mistreatment is likely to change with cohort aging over time (Fig. 26.1).

Why is there so much unmeasured elder mistreatment? Elderly persons have greater potential isolation than other age groups because they may be homebound and not be expected to appear for

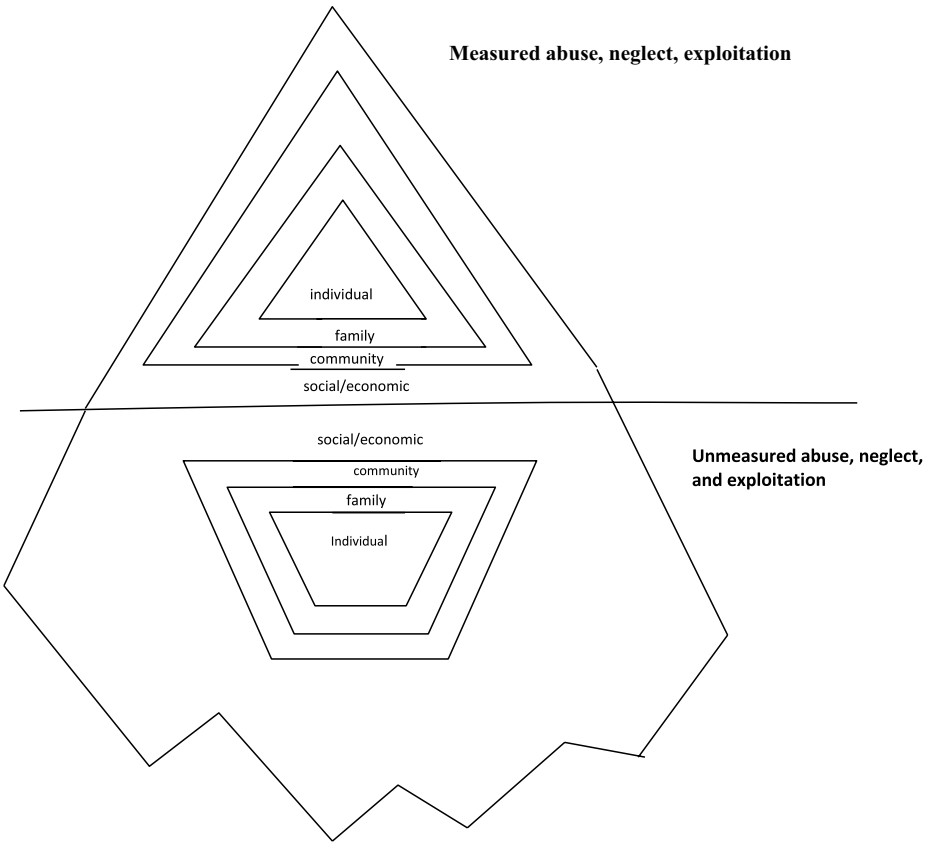

Fig. 26.1 Ecological iceberg of elder mistreatment

work, school, or other regular social obligations. Abused elders with physical evidence of injury are less visible to authorities and service personnel. Detection of abuse is further hampered by factors such as disability, cognitive limitation, depression, technological challenges, and perceived stigma. These characteristics make elderly individuals more vulnerable in families with abusive perpetrators. Relatives who abuse may be overburdened with caregiver responsibilities, or may be manipulative and dependent on the victim and exploit the situation. Abusive spousal behaviors are another source of potential threat to well-being. Intimate partner perpetrators range from psychologically aggressive and isolating to homicidal, and may be motivated by the perceived need for power and control.

Community culture and public vs. private family norms exist to either encourage intervention or turn a blind eye to violence. Denial is a powerful force in individualistic societies where family interactions are considered private business. Under these conditions, the mechanisms of power and control used by members are known only internally and not open to public intervention. In the case of elder mistreatment, the power and control mechanisms may take the form of physical abuse, neglect, psychological maltreatment, and/or financial exploitation. Norms of individualism increase potential for self-abuse and neglect to occur in the home – without a chance of community intervention. Social structural and economic conditions influence the well-being of communities, families, and individuals. Larger influences such as gender oppression, ageism, racism, public policy, and access to resources cannot be ignored with regard to the social construction and experience of mistreatment in later life.

Theoretical and Empirical Perspectives of Elder Mistreatment

Elder mistreatment is not caused by one easily identified element or characteristic, so theoretical perspectives guide our understanding of the potential conditions and outcomes, without definitive proof to support one viewpoint over the other. It is likely that the perspectives described here only begin to explain the true causes and relationships associated with known patterns of abuse and neglect, but much remains unmeasured. The *social-ecological model* supports the notion of individual, interpersonal, and societal factors linking elder mistreatment to "broader social issues," such as the economy and aging services (Dahlberg and Krug 2002; Wolf 2000). Rosalie Wolf (2000) expressed enthusiasm for this framework in her later essays. This section will loosely follow this ecological model to help organize the theoretical literature in the field and identify areas in need of further research.

Individual factors include historical, health, and biological indicators that potentially put a person at greater risk for involvement in violence. An example might include psychological issues related to trauma, mental health, or substance abuse problems. Other issues may include vulnerabilities related to disability, cognitive function, age, race, and gender. For victims, repeated exposure to physical and psychological trauma has been linked to responses, such as learned helplessness, where the sense of empowerment has been lost and individuals must re-learn independent thinking patterns to leave an abusive situation (Walker 2009). Personality types and the need for power and control are individual traits related to perpetrator motives. The intimate partner relationship that previously had little or no aggression, but developed "late onset of abuse" could signify changes related to functional disability or cognitive disease state in the perpetrating individual. Alzheimer's disease has been known to decrease normal inhibitions and increase aggressiveness (Steinmetz 2005).

Family, spousal, and caregiver relationships involve a variety of dynamics and patterns related to quality of life outcomes. Steinmetz (2005) points out that most forms of abuse are defined by the relationship between the abused and the abuser (such as IPV or child abuse). However, elder abuse has only age as a defining characteristic and the relationship can vary.

Social Learning Theory posits those with negative experiences in childhood imitate the behavior they witnessed and continue the cycle (Wolf 2000). This "intergenerational transmission" of abuse is learned within the family unit so that neglecting, angry, or violent reactions are based on previous behaviors or witnessing. Children who grow up under these circumstances might be expected to abuse their children or even aged parents. With few other skills for coping with frustration, family members are sensitized to violence which is condoned in the family culture. Support for this model was found when severely neglected elders treated in emergency departments were more likely to tolerate the lack of care they received at home if they were abused or neglected as children (Fulmer et al. 2005). Wolf and Pillemer (1989) dispute the validity of social learning theory, because elder abuse perpetrators are not necessarily from abusive homes themselves. In addition, this perspective discounts the fact that humans have "free agency" to make their own choices about their behavioral conduct in the family setting.

The overburdened caregiver perspective attributes greater risk of elder abuse and neglect to the overwhelming stress felt by adult children or other relatives who care for a dependent elderly person (Steinmetz 2005). Exchange theory suggests abuse potential increases with a perceived imbalance of reciprocity. Relationships are considered ideal when the benefits outweigh the costs. A dependent older person may balance the relationship by giving financial gifts or emotional support (Wallace 2005: Wolf 2000). Laws of distributive justice suggest that later-life disabilities could tip the scale – causing the older person to lose status or experience abuse, neglect, or exploitation in the family (Pillemer and Wolf 1986).

Another at-risk relationship involves abusers who are dependent on the older victim, such as an adult child or grandchild who is substance abusing, mentally ill, or manipulative. In a twist on the exchange theory perspective, Pillemer, Wolf, and others using control groups, found abused elderly were not more dependent than their nonabused counterparts (Pillemer 1986; Pillemer and Finkelhor 1989). In addition, abusers were actually more likely to be dependent on the elderly person and the aggression may represent attempts by someone with few resources to gain power (Pillemer and Wolf 1986), and/or abuse may be a symptom of addiction or mental illness (Pillemer 2005; Wolf and Pillemer 1989; Wolf 2000).

Spousal or IPV can be exhibited as either a continuation of previous abuse or a pattern with late onset. The CDC (2006) defines IPV as occurring between two people in a close relationship, which is perpetrated by a current or former spouse or dating partner. Regardless of age, spousal or partner violence has been described as the most common form of family violence (Gelles and Strauss 1988), and mid- and later-life abuse may closely resemble violence in younger age categories. Physical size and strength differences, as well as access to resources, influence the IPV violence outcomes between men and women. Women are more likely seriously injured or killed in an IPV event and recent research has focused specifically on the plight of older women. Consequences of IPV can include health problems, depression, trauma, suicidal ideation, disability, and death.

A recent telephone interview survey of 370 women aged 65 and over found 26.5% reported a lifetime prevalence of IPV. Physical or sexual abuse (or both) was reported by 18.4% of the sample and 21.9% reported psychological abuse. Narrowing the timeframe of recollection, 3.5% of women reported IPV in the past 5 years and 2.2% in the past year. Of those with IPV experience, there exists an overlap of exposure, with most women reporting more than one type (Bonomi et al. 2007). IPV is not limited to female victimization in later life, and at least one major survey found wives more often perpetrated (36%) compared to husbands (22%) in partner abuse (Pillemer and Finkelhor 1988).

Not all IPV is equally harmful or potentially deadly. Johnson's research over the past 15 years has helped make distinctions recognizing the most harmful categories (i.e., homicidal). These distinctions serve as a guide to researchers, service professionals, law enforcement, and policymakers who can respond accordingly with appropriate use of public resources. Johnson (2008) describes *intimate terrorism* as an intense pattern of "coercive control" with a campaign that isolates and

endangers the victim. Intimate terrorists are most likely to be homicidal, compared to other types of perpetrators. In my content analysis study of mid- and later-life intimate partner homicide suicide (IPHS) events ($n=403$), intimate terrorists could be identified among some perpetrators in the fatal events. For example, a perpetrator (65), upset about a break up, came to his former girlfriend's (54) workplace and chased her, fatally shooting her in the back and face. He then killed himself nearby. Before the incident, the victim had been threatened and stalked. Her daughter said "He was obsessed with her. He would not leave her alone" (Salari 2007).

In contrast, *situational couple violence* is mutual conflict that escalates into only minor aggression, without either party exhibiting coercive control or risk of homicide. *Violent resistance* is usually perpetrated in self-defense by victims, as they contemplate leaving the abusive relationship. This form of "fighting back" should be recognized as part of the leaving process – with implications for law enforcement. Distinctions are important, so that danger can be assessed, and resources can be allocated wisely to punish the most dangerous perpetrators.

The duration of IPV is relevant to later-life abuse. Late onset violence in those with a long history together might suggest a change in the organic brain functions of the perpetrator or may reflect an aggressive response to caregiver burden. In contrast, long-term IPV known as "spouse abuse grown old," describes partners together over time with continuous levels of abuse in the relationship. The dynamic tends to be cyclical with an increase in frequency of "tension," "crisis," and "calm." The calm phase eventually disappears, leaving the repeated high stress tension and the acute battering stages (Walker 2009). The CDC (2006) warns that long-term IPV can be particularly harmful to victims both physically and psychologically. Repeated trauma over time may lead to *Post-Traumatic Stress Disorder* (PTSD), which is associated with elevated anxiety, fear, depression, and difficulty coping. It is not uncommon for victims to become passive with an inability to see a viable way out. This explains the common pattern where a victim exits several times before they go permanently (Walker 2009).

Social networks are key to the abuse survivor. Unfortunately, the family and friends who once supported the victim tend to drop out as they become frustrated with the inability to make a permanent break from the abuser. Victim advocates are beginning to recognize that the abuse victim usually understands best how to manage terminating the relationship. Danger of serious injury or death escalates when victims are attempting to leave or have left an intimate terrorist. Perpetrators manufacture isolation over time, by interfering with family relationships and cutting victims off from potential social supports. In my IPHS research, neighbors sometimes commented that they did not know the deceased couple, even after living next door for 25 or 30 years. One neighbor believed the husband (85) would not allow his wife (81) to socialize. She commented, "I tried to talk to her; she would smile and then turn her face. She didn't dare" (Salari 2007:448).

Extended kin networks from the family of origin may serve to prevent violence or serve as a buffer between a perpetrator and a victim. Perpetrators who perceive they are being monitored by the victim's family members may resist using violent control tactics. A colleague and I (Salari and Baldwin 2002) examined over 4,000 dyads from the National Survey of Families and Households and found that injurious aggression was more prevalent in those couples who had little contact with the woman's family of origin. Those who are motivated to perpetrate family violence will often wage a campaign to isolate their victims from family support networks so that violence or financial exploitation can go undetected. Another point to consider, we must acknowledge, not all extended family networks are protective. Those with a culture of violence and oppression against women may condone abusive behavior and encourage dominant displays of power and control, even within kinship units.

Elder mistreatment perspectives that consider community level influences are sparse. Communities are involved in the experience of violence, through the degree to which they see family violence as a public vs. private matter. Do the members of the community feel comfortable intervening in domestic disputes or providing mediation? Or, do they turn a blind eye to the perpetration?

Some Native American tribes perceive elder abuse as a community problem with the need for community solutions (Maxwell and Maxwell 1992). In more individualistic societies, having laws against violence is not enough if there is no enforcement and perpetrators have no costs associated with harmful behavior (Dahlburg and Krug 2002). Levinson's (1989) study of 90 nonwestern societies found family violence was not universal and the structure of the society served to promote or prevent abuse. Societies with low divorce rates and greater gender equality had low levels of family violence. In addition, family aggression was minimal in societies with norms of public intervention, where extended family and neighbor networks felt it was their *obligation* to mediate in a dispute. Rules against abuse may exist in society, but lack of enforcement can cause serious harm. Perpetrators who abuse and are not punished may scoff at laws when they are only symbolic. Fewer negative repercussions make vulnerable family members "safe" targets for a family system or individual who is abusive. To apply this philosophy to elder abuse, the problem becomes critical as you add vulnerabilities of older victims with complications of aging and disease, cognitive and physical limitations, generational differences in norms of reporting, and ageism. The solution would involve public recognition of family vulnerabilities that encourage mediation, shelter, and enforcement of effective punishments for abuse perpetrators. In addition, community solutions must balance the needs of choice and autonomy with safety and security. Adult abuse victims have the right to self-determination and the right to be free from mistreatment.

In addition, to violent family relationships, there can also be elder mistreatment that occurs in institutional settings. Goffman's work found total institutions have goals which strip residents of their self-identity and require adaptation strategies for psychological survival (see Salari 2006). Institutional abuse at the hands of licensed professionals in health care facilities and nursing homes is now labeled as "malpractice" (Fulmer, Paveza, and Guadagno 2002). All forms of abuse and neglect can also take place in an institutional setting, and facility workers have been known to perpetrate serious crimes against residents. Prevention efforts have included the new requirements of criminal background checks on facility employees, which is only effective if potential employees have previously been *convicted* of abuse crimes. The vast majority of sexual predators are not convicted – so background checks may only serve a false sense of security.

The majority of the theoretical perspectives to date focus on individual (micro) and family level (meso) dynamics to help us understand what makes some vulnerable to abuse and neglect, while others are at lesser risk. Community norms and larger social and economic influences have been largely left out of the explanations. What happens to victims and perpetrators when law enforcement is ineffective, discriminatory, or lacking altogether? Is elder mistreatment worse in periods of economic downturn? How do policies play a role in prevention and treatment of abuse and neglect? Once victims are removed from dangerous situations in families, are they in a better place? Do communities have appropriate services and shelters for an older person? How does the social construction of mistreatment change with new cohorts entering later life? The future of aging and life course scholarship in this area needs to include greater attention to investigations of the larger sociological influences on quality of life in old age.

Types of Elder Mistreatment

Types of elder abuse have been identified to include physical, sexual, emotional/psychological, and financial exploitation. Neglect can sometimes include abandonment and can be perpetrated against oneself. Suicide is the most severe form of self-abuse, and is common among elderly white men. *Physical abuse* refers to the infliction of pain or injury, in the form of bruises, burns, fractures, lacerations, abrasions, hair loss, and injury to sexual organs (Wallace 2005), Result may include health problems, psychological harm, disability, or death. Some definitions of physical abuse

include the use of chemical (drug-induced sedation) and physical restraints. *Sexual abuse* includes nonconsensual sexual contact. Persons who are physically or cognitively incapacitated and/or unconscious are unable to consent and are at increased vulnerability to sexual attack. The lack of ability to communicate may exacerbate the trauma of the attack and hinder adequate reporting. Traditional rape kit testing has often been omitted for elderly victims of such attacks (Burgess and Hanrahan 2006).

Emotional/psychological abuse often accompanies physical and other types of abuse. It is commonly described as infliction of mental anguish. Weiss (2003) introduced a more intense interpretation of "psychological abuse" to describe something different from a bad relationship, a fight, a hot temper, or poor communication skills. Psychological abuse is defined as a "campaign" to harm another. Perpetrators have "bad empathy," where they zero in on their victim's vulnerabilities and use weaknesses against them to cause harm. Normal relationships attempt to shelter loved ones from harm and criticism. An example is infantilization, the psychological mistreatment aimed at older persons that attacks their independence and adult status by subjecting them to treatment normally reserved for children (Salari 2006).

Material abuse/financial exploitation. The greatest wealth in American society is typically accumulated by mid- to later-life, which increases vulnerability to financial exploitation. Modern crime perpetration includes identity theft and breaches to financial privacy. Older generations were socialized during a time when cultural norms prescribed free exchange of Social Security numbers and financial information, so strangers were often entrusted with vital account information. A recent survey of APS reports found financial exploitation (unauthorized use of resources) to be the third most common category of investigated and substantiated reports (Teaster et al. 2006). Recently, the 2006 amendments to the Older American's Act officially defined exploitation as fraudulent, illegal, unauthorized, or improper act of a caregiver or fiduciary that uses the resources of an older individual for monetary or personal benefit, profit or gain, etc., depriving the older person of rightful access to or use of benefits, resources, belongings, or assets (OAA 2006). There is an estimated $2.6 billion annual loss from financial elder abuse (Metlife Study 2009), and it seems to be increasing over time. People who are financially hurt by the current economic downturn are experiencing a desperate state – increasing perpetration and/or targets of exploitation. Those with considerable wealth (e.g., Brooke Astor) are also vulnerable to abusive family or nonfamily perpetrators (Ramnarace 2009), who may feel entitled to take inheritance early.

Neglect can be active (an action) or passive (a failure to act) on the part of a caretaker. It includes failure to care (feed, clothe, bathe, diet, supervise), misuse of medications (including overmedication to sedate), and a failure to seek medical care when needed (Wallace 2005). Pressure sores are considered a sign of neglect and are usually preventable with regular movement. According to a national survey of APS, caregiver neglect is the second-most substantiated case (21%) (Teaster et al. 2006). A recent study of adults recruited through the use of four urban emergency departments found older adults diagnosed as neglected are sicker, have fewer financial resources, and less support in the home (Fulmer et al. 2005).

Abandonment is defined as a caregiver's leaving a dependent elderly person alone and no longer providing care for him or her (CDC 2009). Prevalence of this form of mistreatment, sometimes called "granny dumping" is actually not very high among reported APS cases, but may receive disproportionate publicity. Newsweek (1991) stated 38% of hospitals sampled had reported at least one case of elder abandonment, and hospital staff sometimes empathized with overburdened caregivers.

Self-abuse and neglect. Self-neglect is actually the most often substantiated allegation of maltreatment according to APS reports (Teaster et al. 2006). However, not all states include it as an official form of elder mistreatment. Older American's Act amendments of 2006 define "self-neglect" as an adult's inability, due to physical or mental impairment or diminished capacity, to perform essential self-care tasks such as obtaining food, clothing, shelter, medical care, goods and services to

maintain health, mental health or safety, and manage one's own financial affairs (OAA 2006). Hoarders are sometimes included in the self-neglect category, as they have a compulsion to collect animals and/or save items to the point of excess – often creating dangers to health and fire safety. Reported elder self-neglect and abuse are significantly associated with an increased risk of mortality (Dong et al. 2009).

Self-abuse can include intentionally using too much medication, or perhaps even suicide – which obviously causes harm to older victims. It is important to realize that suicidal self-abusers can also be harmful to other people. Murder suicides involve both fatal domestic violence and suicide, and Malphurs and Cohen (2002) argue these events are disproportionately perpetrated in later life and increasing over time. Sometimes the primary motivation of the perpetrator is homicide and in other instances it is suicide, where the suicidal person makes a decision to commit homicide first. IPHS is among the most tragic forms of family violence, and in later life there is more often primarily suicidal motive, when compared to younger age categories (Salari 2007, 2009).

Research Methodology and Challenges to Estimates of Prevalence

Research methodology in the area of interpersonal violence has been challenging because detection in caregiver and family relationships is elusive and known cases may just represent the "tip of the iceberg" (Branch 2008). Underreporting is a persistent limitation plaguing studies of elder mistreatment. Rarely do perpetrators admit on a survey that they abuse vulnerable people. Current generations of elderly people are likely to keep victimization to themselves for a variety of reasons (CDC 2009). In addition, victims may feel protective of adult child or grandchild perpetrators and remain guarded about disclosing bad experiences or enduring stigma of "airing dirty laundry." For those living with abuse, humiliation, or fear of retaliation may factor into their lack of disclosure. Older victims remain hidden as they are less likely to seek shelter, make fewer calls to police, and rarely bring legal actions against perpetrators, compared to younger counterparts. Elderly individuals may also find it difficult to report or disclose abuse due to fear of potential institutionalization.

Elderly persons who are "shut in" may be more severely isolated and hidden from professionals in the medical and social services field who could detect and prevent their abuse and neglect. In addition, mental and physical disabilities may intensify the vulnerability in later life. It is possible for older persons to be mistreated without cognitive awareness of the situation. On the other hand, Steinmetz (2005) describes another problem where some elderly persons perceive that they are abused, but instead are actually suffering from paranoia. Cognitive limitations often create difficulty securing informed consent, thus making a high-risk population a challenge to study. Some researchers find it troubling that much of the work in this area depends on reports from health and human service professionals who work with vulnerable populations, rather than victims and families themselves (Pillemer 2005). These ethical issues have implications for Institutional Review Boards as well as potential funding sources (Bonnie and Wallace 2003; McNamee and Murphy 2006).

One of the most persistent difficulties surrounding elder mistreatment research has to do with the definition of mistreatment, including who can be a perpetrator (family, institution, strangers, self). What is the age range for victims (disabled adults 18–64, elders 55 and over, 60+, 65)? What type of abuse or neglect is counted in the prevalence report (physical, psychological, sexual, neglect, abandonment, exploitation)? Prevalence studies have varied widely in these definitions – making a definitive estimate nearly impossible. Even from a policy and practice perspective, there are state-by-state differences in definitions and responses to elder abuse (Teaster 2004). State units have taken a lead in detection, response, and enforcement, but confusion exists when comparing patterns in reporting and outcome (Bonnie and Wallace 2003). Federal attention has mandated reporting and provided some consistent definitions, but not everyone is satisfied with the standards developed. In

addition, APS reports represent only the most severe forms of mistreatment reported to authorities, and actual cases are undercounted (Steinmetz 2005).

Prevalence estimates vary based on the types of mistreatment included and the method of measurement. Wolf's (2000) review article estimated between 4 and 6% of elders experienced domestic elder abuse, neglect, and financial exploitation. The National Research Council estimated those 65 and over who had suffered mistreatment by a caregiver or close contact between 0.5 and 10% (Bonnie and Wallace 2003). The most common ranges are measured between 4 and 10% (Costa 1993).

Pillemer and Finkelhor's (1988) widely cited stratified probability sample of community elders aged 65 and older in the Boston Metropolitan area ($n = 2{,}000$) suggested an overall prevalence of 3.2%, but the study was limited to physical (conflict tactics scale), psychological (insulted, sworn at, or threatened), and neglect (deprivation of assistance) types but did not include others such as sexual abuse, financial exploitation, self-abuse, and neglect. Adding those, the estimate is expected to be higher.

A recent random digit dialing nationally representative phone survey of 5,777 older adults found the following past year prevalence of mistreatment: physical 1.6%, emotional 4.6%, sexual 0.6%, potential neglect 5.1%, and current financial exploitation by family 5.2%. Lifetime financial exploitation by a nonfamily member was estimated at 6.5%. Proxy reports were not helpful to identify mistreatment (except for financial exploitation), and they call for alternative methods to capture the abuse rates of those with severe cognitive and physical disability (Acierno et al. 2009).

In another recent study, the National Social Life, Health, and Aging Project (NSHAP) interviewed 3,005 community-dwelling, cognitively aware individuals aged 57–85 in 2004. Respondents were asked directly if there was anyone who insults them or puts them down (verbal), anyone who takes their money or belongings without their permission or prevents getting when they ask (financial), or anyone who hits, kicks, slaps, or throws things at them (physical mistreatment). Findings suggest that verbal mistreatment was the most common form reported (9%). The verbal abuser was most often someone other than an immediate family member (56%), a spouse or intimate partner (26%), or last, an adult child (15%). For financial mistreatment, the highest reported category of offender was someone other than a family member (56%), followed by an adult child, and – rarely – a romantic partner or spouse. Physical mistreatment was the least-frequently reported type (1%). Of those who reported physical abuse, nonrelatives were most often perpetrators (55.6%), followed by an adult child (24.8%), and lastly, an intimate partner or spouse (19.6%).

Interestingly, reports of financial mistreatment were higher among African-Americans compared to their white counterparts, but Latinos reported less financial and verbal mistreatment than others. Running counter to the "vulnerability" hypothesis that suggests more frailty would lead to greater victimization, these authors found respondents in their late 50s and 60s reported higher rates of elder mistreatment than did older persons. Results must be taken in context, as older persons over the age of 85, those in nursing homes, and the cognitively impaired were not included in this study (Laumann et al. 2008).

Outcomes of elder maltreatment can range from psychological distress (PTSD) to loss of life. The CDC points out that physical injury from abuse can lead to premature death or make existing health problems worse (CDC 2009). Several researchers have pointed to the mortality risk of elder mistreatment. Lachs et al. (1998) reported results of a 9-year observational cohort study of 2,812 community dwelling older persons published in the *Journal of the American Medical Association*. They found risk of death among reported and corroborated elder abuse (odds ratio 3.1) and self-neglect (odds ratio 1.7) led to shorter survival after adjusting for demographics, disease, social networks, cognitive status, and depressive disorders. Dong and colleagues 2009 found self-neglect had an alarming mortality risk within the first year after the report. Elder abuse reports were associated with a 40% increased risk of overall mortality – including cardiovascular mortality.

Medical examiners rarely consider elder mistreatment as a cause of death because it is difficult to assess. There is a call for greater training of forensic specialists in the area of geriatric medicine (Dyer et al. 2008) to recognize abuse and neglect – as it differs from accidents, medication side effects, disease, or results of aging. Elder abuse forensics is estimated to be about where child abuse detection was three decades ago and IPV was 10–15 years ago (Dyer et al. 2008). In one extreme instance, dozens of victims in several institutions were killed by a nurse who injected them with lethal doses of medication, but none of these cases were recognized or reported by medical examiners. Attitudes about nursing home deaths among a focus group of forensic specialists indicated disturbing ageism, as nursing home residents were considered a "waste of their time … because most … would die eventually anyway" (McNamee and Murphy 2006).

The most severe form of family violence involves multiple fatalities at once – the commonly known murder-suicide or IPHS. Patterns of IPHS in later life show a primary motivation toward suicide for the older man, who makes a decision to simultaneously kill his wife or partner (who is usually unaware of her fate). The consensual suicide pact is very rare (1% in middle aged couples and 4% of elderly). The CDC definition of "mercy killing" is also typically not the motive, as consent on the part of the terminal or hopeless patient is required (see Salari 2007). As a researcher, I have found that some of the mystery of studying family violence is resolved in these cases. Incidents are countable; we know that fatal domestic violence and self-abuse have happened on the scene. There is no potential harm to human subjects – and it does not depend on the ability of the victim to answer questions with credible information. There are variations that allow the researcher to "make distinctions" (See Johnson 2008) between perpetrator/victim relationships. So, for example, some IPHS perpetrators seem focused on homicidal acts, with intimate terrorist qualities and others who are primarily suicidal, with a decision made to kill their partner or ex-partner before they suicide. These distinctions provide us with a chance for more targeted prevention efforts (Salari 2007). From a societal perspective, IPHS incidents seem to take on different patterns across cultures. For example, those countries with restrictive gun control laws have fewer IPHS incidents. In the events, other methods are used, such as carbon monoxide poisoning – but the incident is more likely a suicide pact, rather than one where a partner is caught off guard with a fatal gunshot.

Modern Developments in Research and Policy

What is the prototype for elder mistreatment and why does it matter for policy? Wolf (2000) explained that the typical image of a functionally impaired older person with a well-intentioned, but overburdened, caregiver (similar to the child abuse model) influenced legislation in more than three quarters of the states. Reduction of caregiver burden and stress was a major focus of many of the interventions, and some have argued, older persons were often infantilized, including potential civil rights infringements (Pillemer 2005). Once empirical studies included comparison groups, Wolf and others became convinced the dependency child-abuse model was not appropriate and needed to be modified for the specific experiences of older persons. The "family stress theory" (Wallace 2005) or "situational model" were not supported by the evidence, and elder abuse seemed more similar to domestic violence models than to child abuse. Dependency had a different relationship than expected – with dependent, mentally ill, and/or substance-addicted family abusing older persons (Pillemer 2005; Wolf 2000).

The 1990s were significant because large datasets were used to quell the earlier emphasis on "sandwich generation" stress. Logan and Spitze's (1996) well-known work determined it was rare for the middle generation to be in the position of caring for both elders and dependent children at the same time. Until age 75, older persons give significantly more downward support than they receive and then it equalizes. Modern researchers tend to acknowledge that dependency and stress

may be a strong contributing factor – but not the only family elder-abuse dynamic. Steinmetz identified the *perception* of the caregiver's burden was more important than actual level of dependency. Gaining or maintaining control was a primary motivation for this type of abuse perpetrator (Steinmetz 2005).

During the 1990s, technology changed the landscape of safeguarding personal information and property. Widespread use of the internet increased identity theft and financial scams on vulnerable persons who became targets of sophisticated financial schemes by both kin and nonkin perpetrators.

Legislatively, the Americans with Disabilities Act helped bring freedoms and open public places to those with assistive devices. In 1992, Congress passed and funded the Older American's Act Title VII Chap. 3 for prevention of abuse, neglect, and exploitation. Vulnerable Elder Rights Protection included provisions for state legal assistance and Long-Term Care Ombudsmen programs. This legislation was aimed at curbing institutional mistreatment of elderly and disabled persons with assistance and advocacy.

With the murder of Nicole Brown Simpson, public attention was focused on IPV. IPV research made theoretical progress, as Johnson and colleagues identified distinctions among types of victims and perpetrators – with the recognition that not all were the same or deserved the same response (see Johnson 2008). The 1994 Violence against Women Act focused on the needs of violence survivors and represented a step toward public recognition that social structure, funding for shelters, and training of law enforcement and prosecutors play an important role in violence prevention and treatment. Initially, the new legislation focused mostly on the perspectives of younger victims.

Since 2000, family violence, including elder mistreatment, has been viewed as a public health and human rights issue – evident in work from the World Health Organization (WHO), Centers for Disease Control and Prevention (CDC), and *Journal of the American Medical Association* (special issue 5 August 2009). Progress has been made regarding a widely cited definition of elder mistreatment, as well as more inclusive estimates from APS. Recommendations of the National Research Council urged scholars to focus on more studies, and included methodological and logistical suggestions needed to create a solid research base addressing elder mistreatment (Bonnie and Wallace 2003).

The 2000 and 2005 reauthorizations of VAWA included attention to the plight of the older and disabled woman. There was a greater recognition of the special needs of these violence survivors, who might require an alternative physical environment and greater sensitivity training among police personnel and courts. As Baby Boomers age, domestic violence shelters with provisions for an aging population will be required. It is unlikely that an older victim would choose to escape abuse if she would be placed in a dormitory setting with a number of young children, staircases, and other barriers to good quality of life. The VAWA reauthorization act of 2000 provided $5 million per year to STOP grants and training programs encouraging law enforcement, prosecutors, and court officers to recognize, address, investigate, and prosecute instances of elder abuse, neglect, exploitation, and violence against individuals with disabilities, including domestic violence and sexual assault against older or disabled individuals. By 2005 reauthorization, there was an expansion to $10 million per year FY 2007–FY 2011 for domestic-violence programs that deal with domestic and dating violence, sexual assault, and stalking against victims age 50 or older (National Coalition against Domestic Violence 2006).

During the decade since 2000, there has also been a large emphasis on "Victim's Rights," which is reflected in the VAWA reauthorizations. There is new concern over how older and disabled survivors are treated during the process of the report, sheltering, protecting, and prosecuting. What happens to victim's rights in the process of criminally punishing perpetrators? Unfortunately, much of the problem of family violence policy is that it focuses on sheltering survivors, but not getting to the root of the problem … stopping the perpetrators. Abusers are often smart, "slippery," and manipulative, so professionals often advise against couple's counseling, where the therapist may be

drawn into the dynamic. Individual counseling for each party is recommended instead (Weiss 2003). As a Victim's Advocate, I often saw a victim escape, and another woman would take her place as the focus of a specific abuser. Perpetrator programs were developed for abusers to talk about their perspectives, learn anger management skills, and attempt to reform. In small doses, this can be effective if they take responsibility for their actions and commit to change. However, once the judicial system began assigning perpetrators to these programs in mass numbers they often did not accept responsibility and the programs were overwhelmed and ineffective (U.S. Department of Justice 2003).

The majority of states do not maintain an "abuse registry" to track alleged elder abuse perpetrators (Teaster et al. 2006). Savvy perpetrators are free to target new victims and move around from state to state to stay ahead of law enforcement. VAWA enacted laws for computerized systems for "full faith and credit" that assure protective orders are enforced across state lines. It seems that similar programs could be applied to combat perpetration of elder mistreatment across the nation.

The 2006 amendments to the Older American's Act Title VII include services and allotments for detection, assessment, intervention, investigation, and response to elder abuse. Responses include public education/outreach about financial exploitation, elder abuse shelters and safe havens, multidisciplinary elder-justice activities, services to underserved populations, and development of accountability measures. Several definitions were provided, including "elder justice" which includes efforts to prevent, detect, treat, intervene in, and respond to elder abuse, neglect, and exploitation, and to protect older individuals with diminished capacity while maximizing their autonomy and self-determination. An older individual has recognized rights, including right to be free from abuse, neglect, and exploitation (OAA 2006).

APS has undergone a transformation over time, to more adequately respect the right of older persons to shape their own lives. Those who are being abused or neglected by others may refuse services and intervention. There is a greater concern that disrupting the family system, even if it is abusive, may cause more harm to the older victim than good. If intervention is undertaken, it is often considered the state's responsibility to improve the situation for the elderly victim and many service providers agree that it may be difficult to accomplish with limited resources. Currently, social service agencies that focus on protection work to investigate the abuse and most often provide referrals to helpful resources in the community. Refusal of services to remedy hoarding and medical neglect creates controversy. Of reported APS cases of abuse, 11% of vulnerable adults refused services (Teaster 2004).

APS is currently limited in its ability to function effectively, due to the economic downturn and a lack of adequate funds to keep up with the demands created by mandatory reporting laws (Fulmer et al. 2002). Certain types of elder mistreatment have been exacerbated by the recent widespread economic instability. Older persons were already the age group most at risk of material abuse, but the crisis conditions seem to have increased their vulnerability. In order to prevent widespread losses, the banking industry has taken an interest in monitoring the spending and withdrawal patterns of older account holders to identify and combat financial abuse – include the freezing of assets when exploitation is suspected. Law scholars have pointed to abuse potentials in guardian and conservator arrangements with the acknowledgment that some vulnerable adults are unable to make decisions in their own best interest.

Elder abuse is defined, counted, and treated differently depending on the specific laws of each state. According to a comparison done between 1986 and 2000, reports to APS agencies of elder/adult abuse increased from 117,000 to 472,813 (Teaster 2004). By 2003, 50 states (plus Guam and Washington, DC) reported a 19.7% increase with a total of 565,747 reports. Despite these substantial increases in reports, states have faced budget shortfalls in the difficult economic conditions, which have often led to program reductions (Teaster et al. 2006). This trend is dangerous, considering that many APS agencies are performing on a bare bones budget and must refer clients out to community services.

Discussion and Future Agenda

Family violence has been recognized as a major cause of injury and a serious threat to public health (CDC 2009; WHO 2010). The consequences of violence and neglect for the elderly are serious because of the greater potential for damage to skin, organs, and bones, as well as the longer recovery time, compared to younger victims (WHO 2010). Elder mistreatment is severely under-reported, and attempts at a more accurate count are thwarted by methodological issues related to measurement, disclosure, cognitive ability, consent and proxy status.

Elder mistreatment literature has developed over the past 30 years, but many of the early review articles focused on the methodological dilemmas, variation in definitions, and the quest for an accurate count, with little attention to theory construction. Some aspects of the phenomenon that are known and a great deal that is still unclear. The ecological iceberg conceptualization recognizes that there are micro, meso, exo, and macro systems that can be measured and that an entire mass that exists below the surface that eludes detection. It is unclear what size or shape represents the lower level of the iceberg, but multiple levels of influence exist in those layers. The theoretical perspectives to date tend to dwell on the micro-level role of individuals and family dynamics, with less attention focused on the larger community, the economy, and the social structure.

A great deal of mystery surrounds the incidence and nature of elder abuse and neglect at these macro levels. Community and cultural beliefs about the public vs. private nature of intimate partnerships and family relationships play a role in the social construction of what is perceived as abuse and what is disclosed to outsiders. What is the role of community intervention? What happens when there is no access to shelters? If laws exist to prohibit mistreatment, what happens with a lack of enforcement? How do vulnerable elderly persons fare with societal oppression against women or minorities, or in a poor economy? When public services for victims are cut back, what is the consequence to public health and abuse prevention?

Social construction of elder mistreatment varies across conditions and cultures. These issues are not only relevant to the United States but have vast global significance. Older people in the developing world have great vulnerability, especially when they are impoverished. According to the WHO (2010) the risk of property seizure and abandonment of older widowed women is greater in countries with severe gender oppression. Other conditions of hardship may exist where healthcare, food, and medicine are rationed to the old. For example, in the recent 2010 earthquake in Haiti, nursing home residents were originally passed over with food and water supplies. The title of the Associated Press article said it best "Abandoned, 85 elderly Haitians await death: nursing home residents, barely a mile from the center of the aid effort, left waiting." Several of the elderly residents of this nursing home died of dehydration and lack of food, and those who survived described being visibly neglected and robbed of their money and possessions as they lay injured in the street (De Montesquiou 2010). Economic and social conditions play a role in whether mistreatment is detected, perpetrators punished, and victims sheltered. The macrosystem is the stage where social problems are identified, policy is made (or neglected), and the rules are then enforced – either effectively or ineffectively.

In the United States, substantiated reports to APS seem to give us a good idea of the nature of abuse, but there is an enormous rate of under-reporting. It is important to recall that the APS reports represent only the most severe cases, and in reality there is more of a continuum. Elder abuse cuts across SES levels, but access to resources might help an individual escape harm without the use of public services. Shelters house those with no other options for escape, and the residents do not represent a cross-section of the abused population. Few older victims use shelter services, possibly because of cohort differences in help-seeking behaviors. Recent policy changes suggest more attention is needed to make services appropriate for the needs of elderly clientele.

Family violence at any age is a human rights issue and it significantly reduces the quality of life. Whatever the rate, it is clear that we need an understanding of why older persons are targeted and

how family members and other abusers isolate victims. Advocacy movements and public awareness campaigns are important factors for change. Several recent studies have helped to ease paralysis in the field, and provide a greater understanding of prevalence and undercount, so that a new focus can be placed on federal funding, theoretical advancement, and policy recommendations. Future cohorts including the Baby Boom Generation will have a differing social construction of elder mistreatment and the societal responses necessary for prevention. Based on previous activism exhibited by this cohort, one might expect greater attention to transparency and victim advocacy.

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Chapter 27
Crime, the Law, and Aging

Duane Matcha

While much has been made for older American's decreasing rates of poverty, improved health status, continued connection to the worlds of work and community service as well as continued strong family relations, their relationship to the criminal justice system as victims and perpetrators of crime remains less well known. Although research explores facets of this relationship, such efforts generally draw little attention because of older American's limited involvement as either perpetrators or victims of crime.

What we know is that the relationship between older Americans and the criminal justice system is multifaceted. For example, while much has been made of the difference between the reality and perception of criminal victimization of older Americans. Similarly, older Americans are victims of various forms of abuse at the hands of family members or care providers that are occurring within a variety of environmental locations ranging from independent living arrangements (Fisher and Regan 2006; Lachs et al. 2006) to institutional settings such as nursing homes, assisted living facilities (Wood and Stephens 2003), and prisons (Stojkovic 2007). Conversely, older Americans are also perpetrators of crime. Although the United States in not experiencing a "geriatric crime wave," older Americans do commit crimes and are being incarcerated. According to Feldmeyer and Steffensmeier, arrest rates of older Americans between 1980 and 2004 increased in the categories of simple assault, drug law violations, and OBT (Other But Traffic) (Feldmeyer and Steffensmeier 2007). In other categories, arrest rates have remained stable or declined during that period of time. Nevertheless, state and federal prisons continue to experience an increasing percentage of older inmates. The increasing number of elderly inmates and their attendant consequences such as higher costs of incarceration and extensive health problems raises serious questions regarding the future of the prison system.

What are the implications of crime by and against older Americans? It is within this context that issues such as age-related treatment within the criminal justice system as well as long-term cost of incarceration exist. If older Americans are identified as a "special category" of criminal offenders, what are the consequences? Should age-segregated prisons be constructed to ensure the safety of older-aged prisoners? Additionally, the number of older women in prison raises issues of specific care as well as their marginalized position within the larger prison population (Krabill and Aday 2005).

Victimization of older Americans elicits similar policy questions. Here, questions of the social and physical environment within which the elderly lives and functions become central; creating a safer living environment, monitoring impediments to mobility, and improving access to services necessary for independent living. More specifically, does knowing the risk factors for victimization among older Americans provide sufficient reason for the establishment of age-specific services to

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limit their impact? What, if any, criminal justice policies are essential if older Americans are more likely to die or experience medical problems as a result of victimization?

Such policy questions underscore the impact of age as a social category in the criminal justice system. Although the sociology of aging has been interested in crime relative to the aging population for decades, more recent efforts have attempted to diversify the focus. While interest was initially on the victimization of older Americans and their fear of crime, recent research has broadened its efforts to disaggregate older Americans and explores the impact of race, sex, and social class on victimization as well as reasons for perpetrating crime. More recent research within the sociology of aging also addresses multilayered issues such as the social, medical, ethical, and economic consequences of incarceration of older Americans. These efforts are forcing a deeper thinking of the implications of the aging process and its relation to criminal activity.

While the role of older Americans in the criminal justice system is understood as being victim or perpetrator, their role within the broader American legal system is less clear. This lack of certainty is grounded in the ongoing debate over what obligations society defines as necessary toward older Americans. Given that demographic projections indicate continued expansion of the elderly population throughout the first half of the twenty-first century, the ramifications of legal uncertainty regarding what rights older Americans should have is problematic.

This chapter begins with an historical overview of aging and the law, then transitions to coverage of aging and crime. The application of an historical context throughout provides the means by which changes and challenges can best be understood. In the second section, elderly victimization focuses on the ongoing debate over perception vs. reality of crime against the elderly as well as the extent and consequences of elderly abuse. In the third section, the role of the elderly as the perpetrator of crime and its consequences are addressed. Finally, the last section examines how crime and the law have framed the lives of older Americans to the present and prognostications for the future.

Aging and the Law

The law represents the foundation upon which social contracts are created and enforced. As Cohen states: "The law affecting the elderly is a reflection of how society regards older people, the relationships that exist between and among generations, the views people have about growing old, and the passage of time in another age" (Cohen 1990:184). Questions concerning the role of older Americans relative to the legal system offer insight into the extent that chronological age impacts the legal process. As Eglit notes, "age bias is obviously present in the interactions that, in the aggregate, make up the American legal system" (Eglit 2004:5). The concern of the legal system is the balance between creating public policy that endows a specific population with necessary services and public policy based on equality across the population.

Some 3 decades ago, Cain (1976) addressed the relationship between age and the law. Beginning with definitions of age (chronological, functional, and social) as well as the emergence of aging within the field of law, he focused much attention on the post-World War II period in which "laws have contributed to the creation of a distinctive status for the elderly" (Cain 1976:356–7). Although the focus at the time was that of mandatory retirement, he argued that the emergence of laws that provide the legal basis for programs designed for the elderly had inadvertently reinforced their dependence on those who interpret and administer the programs. As a result, he suggested that "a major challenge facing gerontologists is to move beyond advocacy for particular measures to a perspective which calls for consistency and coherence of status, for programs which can be comprehended and managed more fully by the elderly themselves" (Cain 1976:366).

Similarly, Kapp examined the relationship between aging and the law by assessing the type of law and its relevance to an aging population. The importance of this approach is found in his

exploration of the influence of law on the elderly, particularly in terms of government intervention. The fundamental question addressed by Kapp is whether the elderly enjoy equality or special treatment as a result of the law. In terms of equality, the Americans with Disabilities Act and the Age Discrimination in Employment Act are examples in which older Americans are treated the same as other age groups. On the other hand, laws based on special treatment of the elderly include Social Security, Medicare, and government housing for the elderly (Kapp 1996, 2006).

While the debate continues over whether the elderly receive equality or special treatment under the law, it is important to understand the changes that have occurred in the law over the past 30 years. In the mid-1970s, equality under the law did not exist for older Americans. Mandatory retirement rules forbade older Americans from remaining on the job, regardless of their qualifications as chronological age was the primary characteristic defining when a person could or could not work. In the first decade of the twenty-first century, mandatory retirement rules are virtually nonexistent although age discrimination remains a constant struggle for some mature workers. Similarly, equality under the law is assumed under the Americans with Disability Act. However, if application of the law within the criminal justice system is generally viewed as an accommodation of older, rather than younger, criminals, its application becomes viewed as special treatment of the elderly.

As a result of the need for accommodation of older criminals and victims within the criminal justice system, the legal debate is primarily over special treatment under the law on the one hand, and age bias on the other. In terms of special treatment, legal questions regarding the right of the elderly to receive a disproportionate share of government funding and continued protection under the law in entitlement programs such as Medicare and Social Security have become of primary importance. These programs return us to the heart of the argument over social contracts that involve intergenerational transfers of funds from younger to older generations. The long-term issue is whether American society is willing to increase the transfer of funds from younger generations to older as well as the youngest generation that is truly important. Although the elderly population will increase as a percentage of the total population, it is also true that the youngest generation will decrease as a percentage of the total population. In 2000, the total dependency ratio of 51 was comprised of a child ratio of 33 and an elderly ratio of 19. By 2050, the total dependency ratio is expected to reach 61 and be comprised of a child ratio of 28 and an elderly ratio of 33 (United Nations 2004). Furthermore, the argument that programs such as Medicare advances the health of the elderly at the expense of younger generations is evidence that the problem lies not with special treatment of the elderly, but rather with social policy unwilling to provide commensurate health coverage to others generations of Americans.

Relative to crime and the law, the creation of a separate justice system for older Americans does not garner overwhelming support from the public (Preston 2003). However, Rothman and Dunlop suggest that as legal issues of a growing older-aged population increase, "it is important to understand how courts, as an institution, judges, and court administrators perceive this development and what policies or practices they should be developing to address it" (Rothman and Dunlop 2006:32). Addressing the role of the court, Manning, Carroll, and Carp report that "older judges may show greater affinity to plaintiffs in age bias claims" (Manning et al. 2004:16).

Equal treatment of older Americans under the law is also problematic. As Preston and others report, efforts to require prison compliance with the ADA have met with some resistance. Although prison inmates regardless of age are covered under ADA regulations if they are disabled, older prison inmates may face additional hardship (Preston 2003). According to Morton, some prisons require inmates to pay for medical care visits. While the reason for inmates to participate in the cost of medical care may be understood as a method to control utilization rates, the result may have a deleterious impact on older inmates. The problems of copayment programs for older inmates include difficulty paying for services that they are more likely to be in need of. If they are unable to pay for medical services, they are less likely to seek treatment, thus exacerbating the medical condition (Morton 2001).

The question of special vs. equal treatment of older Americans under the law remains central to the discussion of aging, crime, and the law. While special treatment is generally decried as favoring older citizens over the needs of other age groups, equal treatment, as presented by Morton (2001), can result in bias against the elderly. Thus, questions of the impact of equal treatment are of similar importance as questions of special treatment as they relate to older Americans.

Victimization of the Elderly

This section examines the perceptions and realities of older Americans as a victim of criminal activity. The question of perceived victimization is followed by the changing nature of crime against older-aged Americans. Finally, an historical analysis of elder abuse offers evidence of continued physical, social, and financial trauma experienced by older Americans at the hands of friends, family, and strangers.

Perceptions and Realities of Victimization

Thirty years ago, older Americans identified fear of crime as their most important problem (Harris 1976). Research throughout the 1980s and 1990s in the United States has consistently reported that fear of crime among older Americans is not as pervasive as predicted earlier (Yin 1982; LaGrange and Ferraro 1987; Ferraro and LaGrange 1992; Ferraro 1995). Hale in an international review of the fear of crime offers the following assessment that presents a more complex portrait: "Fear of crime is influenced by a general sense of vulnerability, by signs of physical and social decay in the neighborhood and by lack of community cohesion or inter-group conflict" (Hale 1996:131).

In part, the problem between reality and perception of crime is the result of research efforts that are not always measuring what they purport to measure (Ferraro and LaGrange 1987). As Ferraro points out, concepts such as *fear* and *perceived risk* must be understood as identifying fundamentally different experiences (Ferraro 1995). As a result, Ferraro argues that "perceived risk is correlated with both official crime risk and fear; actors are more afraid when they sense a greater likelihood of potential criminal risk" (Ferraro 1995:120). Furthermore, as Yin points out, fear of crime is influenced by ones age, sex, and perceived health status; in other words, the most vulnerable (Yin 1985). The elderly are likely to know the perpetrator of the crime, more likely to defend themselves, and to report a crime. Furthermore, while we now know that initial research findings regarding elderly concerns of crime were inaccurate, questions remain. For example, Ferraro and LaGrange question why the public and mass media continue to believe that the elderly are fearful of crime when in fact they generally are not (Ferraro and LaGrange 1992). It is this effort to engage in a deeper understanding of the relationship between aging and criminal victimization that will move gerontologists in new research directions.

Although research has consistently demonstrated that older Americans are much less likely to be victimized, the perception continues to frame the relationship between aging Americans and crime. The reality of victimization by age is shown in Table 27.1. Statistics from the U.S. Department of Justice demonstrate that older Americans experienced 9.1 violent crimes per 1,000 persons in their age group in 1973. By comparison, younger Americans experienced violent crime rates that were 9 times greater. The differential in violent crime rates between older and younger Americans has continued throughout the remainder of the twentieth century and into the first decade of the twenty-first century. For example, in 1983, the violent crime rate against older Americans decreased to 5.9 per 1,000 persons aged 65 and above while rates among younger age Americans vacillated. By 1993,

Table 27.1 Violent victimization rates by age, 1973–2005 (violent crimes included are homicide, rape, robbery, and both simple and aggravated assault)

Violent crime rate per 1,000 persons in age group							
	Age of Victim						
Year	12–15	16–19	20–24	25–34	35–49	50–64	65+
1973	81.8	81.7	87.6	52.4	38.8	17.2	9.1
1974	77.5	90.6	83.5	58.6	37.5	15.5	9.5
1975	80.3	85.7	80.9	59.5	36.9	17.8	8.3
1976	76.4	88.8	79.7	61.5	35.9	16.1	8.1
1977	83.0	90.2	86.2	63.5	35.8	16.8	8.0
1978	83.7	91.7	91.1	60.5	35.8	15.0	8.4
1979	78.5	93.4	98.4	66.3	38.2	13.6	6.2
1980	72.5	91.3	94.1	60.0	37.4	15.6	7.2
1981	86.0	90.7	93.7	65.8	41.6	17.3	8.3
1982	75.6	94.4	93.8	69.6	38.6	13.8	6.1
1983	75.4	86.3	82.0	62.2	36.5	11.9	5.9
1984	78.2	90.0	87.5	56.6	37.9	13.2	5.2
1985	79.6	89.4	82.0	56.5	35.6	13.0	4.8
1986	77.1	80.8	80.1	52.0	36.0	10.8	4.8
1987	87.2	92.4	85.5	51.9	34.7	11.4	5.2
1988	83.7	95.9	80.2	53.2	39.1	13.4	4.4
1989	92.5	98.2	78.8	52.8	37.3	10.5	4.2
1990	101.1	99.1	86.1	55.2	34.4	9.9	3.7
1991	94.5	122.6	103.6	54.3	37.2	12.5	4.0
1992	111.0	103.7	95.2	56.8	38.1	13.2	5.2
1993	115.5	114.2	91.6	56.9	42.5	15.2	5.9
1994	118.6	123.9	100.4	59.1	41.3	17.6	4.6
1995	113.1	106.6	85.8	58.5	35.7	12.9	6.4
1996	95.0	102.8	74.5	51.2	32.9	15.7	4.9
1997	87.9	96.3	68.0	47.0	32.3	14.6	4.4
1998	82.5	91.3	67.5	41.6	29.9	15.4	2.8
1999	74.4	77.5	68.7	36.4	25.3	14.4	3.8
2000	60.1	64.4	49.5	34.9	21.9	13.7	3.7
2001	55.1	55.9	44.9	29.4	23.0	9.5	3.2
2002	44.4	58.3	47.6	26.4	18.2	10.7	3.4
2003	51.6	53.1	43.5	26.5	18.6	10.3	2.0
2004	49.7	46.0	43.2	23.8	18.0	11.0	2.1
2005	44.0	44.3	47.1	23.7	17.6	11.4	2.4

Note: because of changes made to the victimization survey, data prior to 1992 are adjusted to make them comparable to data collected under the redesigned methodology. Estimates for 1993 and beyond are based on collection year while earlier estimates are based on data year. Because of changes in the methods used, these data differ from earlier versions. For additional information about the methods used, see *Criminal Victimization 2005*
Original source: rape, robbery, and assault data are from the National Crime Victimization Survey (NCVS). The homicide data are collected by the FBI's Uniform Crime Reports (CUR) (Supplementary Homicide Reports) from reports from law enforcement agencies
Source: U.S. Department of Justice 2009. Office of Justice Programs. Bureau of Justice Statistics

the violent crime rate against older Americans remained steady at 5.9 per 1,000 persons. However, violent crime rates among younger Americans increased significantly. Among 12–15-year-olds, there were 115.5 violent crimes per 1,000 persons in that age category. Similarly, teenagers aged 16–19 experienced 114.2 violent crimes per 1,000 persons in that age category. Ten years earlier, the

respective rates were 75.4 and 86.3. By 2006, violent victimization rates declined for all age categories. Among older Americans, the rate of violent victimization declined to 2.4 per 1,000 persons in that age category. Similarly, the rates among younger citizens declined to 44.0 for those aged 12–15 and 44.3 for teenagers aged 16–19 (Bureau of Justice Statistics 2009).

While the elderly are less likely to be a victim of crime than other age groups, there are particular crimes such as burglary and being the target of con artists that older Americans are more likely to experience. Older Americans, particularly men, are also more likely to be robbed in private locations whereas assaults against older women are most likely to occur in a private location. In addition, the use of a gun was more likely to be used against older men during a robbery and against women during an assault (Bachman et al. 1998). LaGrange and Ferraro (1987) and others (for example, Yin 1980; Hirschel and Rubin 1982; Chu and Kraus 2004) address a range of consequences that crime can have on elderly victims. Consequences include increased medical care, greater likelihood of death, and limited mobility because of injury, longer recuperation periods, as well as increased social isolation (Peguero and Lauck 2008). It is this vulnerability that makes crime against the elderly much more problematic. Because most elderly are on fixed incomes, are more likely to experience health problems, and are limited in their choice for residential location, the fear of losing money and property that potentially cannot be regained through time and work makes the loss much more difficult for older victims.

Victims of Elder Abuse

A particularly devastating area of elderly victimization is that of elder abuse. In this case, the perpetrator of the offense is generally the spouse although adult children and other family members also rank as likely perpetrators. Although the United States was in the forefront of the developed world in identifying elder abuse, the extent of the problem remains relatively unknown. Data from the National Center on Elder Abuse (1997a) indicate a 150% increase in the number of reported cases between 1986 and 1996 and that the number of reported cases is significantly underreported.

According to the National Center on Elder Abuse (1997b), the primary sources of reporting elder abuse were health care and service providers followed by family. Further complicating the reporting process is the variation in state level legislation regarding the reporting and investigation of suspected elder abuse (Jogerst et al. 2003). Brinig et al. (2004) also found that state laws regarding elder abuse are not uniform in their content or application by social service agencies. These discrepancies facilitate the continued growth of elder abuse.

According to Carp, there were 206,000 substantiated cases of elder abuse in 1991 (Carp 2000). However, if the belief that there are 14 cases of elder abuse that exist for every one that is reported, then there were over 2.8 million cases of elder abuse in 1991. By 1999, there were 242,430 investigations of domestic elder abuse (Brinig et al. 2004). Wolf estimated that some 4.5 million "persons ages 60 and over living in domestic settings were abused, neglected, or exploited" (Wolf 2000:8). A nationally representative study of elder mistreatment reported that "1 in 10 NSHAP respondents answered positively to questions on verbal mistreatment, and 3.5% said that they had suffered financial mistreatment" (Laumann et al. 2008:S252).

According to the National Center on Elder Abuse (1999), neglect is the primary cause of mistreatment of the elderly (55.0%), followed by physical abuse (14.6%), financial/material exploitation (12.3%), emotional (7.7%), all other types (6.1%), unknown (4.0%), and sexual (0.3%). Although availability of data on elder abuse in institutional settings is limited, Wolf cites Pillemer and Moore (1990) who reported over one third of nursing home personnel in one state witnessed an incident of physical abuse and over 80% witnessed a case of psychological abuse in the previous year (Wolf 2000).

The consequences of elder abuse on its victims are many but are not clearly understood. According to Wolf, efforts to sort through the impact of aging, abuse and other factors are difficult (Wolf 2000). Research findings do suggest that abuse has a deleterious effect on the physical well-being of the victim resulting in increased mortality rates. Additional research by Fisher and Regan found that elderly victims who experienced psychological/emotional abuse "reported significantly more health conditions, on average, than did women who had not been abused in this manner" (Fisher and Regan 2006:207).

The recent past offers lessons for the future of elder abuse and its victims. As the demographic shift continues throughout the first 3 decades of the twenty-first century, elder abuse and its consequences will remain an underlying crime against older Americans. Efforts to standardize data collection across states as well as funding for research into causes and cures should remain a priority in the twenty-first century (Jogerst et al. 2003).

The Elderly as Perpetrators of Crime

Historically, we know that the elderly are the least likely to commit a crime. However, they are an increasing percentage of those housed in state and federal prisons in the United States. An explanation of these seemingly inconsistent trends is presented below.

Examining changing crime rates among the elderly between 1980 and 2004, Feldmeyer and Steffensmeier found that overall crime committed by the elderly has decreased. This decrease has been fueled by significantly lower arrest rates for alcohol-related crimes. Increased rates of arrests were noted for simple assaults, OBT (Offenses But Traffic), and drug law violations (Feldmeyer and Steffensmeier 2007). In terms of arrest rates for index crimes, larceny-theft continues to be the primary category among older Americans.

Addressing historical patterns of elder criminality, Flynn identified those categories with the most frequent arrest rates. Thus, in 1965, drunkenness, disorderly conduct, and other but traffic represented the three primary arrest categories. In 1984, the primary arrest categories were driving while intoxicated, drunkenness, and larceny-theft. By 1995, gambling, sex offenses, and driving while intoxicated represented the three primary reasons for arrests of elderly Americans (Flynn 2000).

In 1978, the arrest rate of males aged 65 and above was 1.1 per 1,000. Arrest rates among other age groups ranged from 3.5 for those 55–64 years of age to 32.3 for those 18–24 years old (U.S. Bureau of the Census 1978). Recent research indicates that the elderly represented 0.7% of the total number of arrests for 2008 (Federal Bureau of Investigation 2008). More specifically, Table 27.2 identifies arrest rates of older Americans by type of offense.

The data in Table 27.2 illustrate the changes in arrest rates among older Americans. Rates of violent and property crimes decrease significantly in almost all categories. Overall, violent crimes committed by older Americans declined by 20% between 1993 and 2001 and property crimes by 61%. Among violent crimes, older Americans were less likely to be arrested for murder, forcible rape, robbery, and aggravated assault. Among property crimes, there was less change over time, but continued downward shift in arrest rates in almost all categories. The only exceptions were embezzlement which remained static at 0.2 between 1993 and 2001 and drug abuse violations in which the arrest rate increased 34%. Nevertheless, older Americans remained the least likely to be arrested for violent or property crimes.

Reasons for the low arrest rates among the elderly are varied. According to Flynn, one reason is an "aging-out effect" in which biological, individual, and social factors frame the explanation (Flynn 2000). For example, as a person ages, his or her physical and mental conditions may make it more difficult to engage in those activities associated with criminal intent. Furthermore, the "aging-out effect" argues that as a person ages, his or her level of responsibility in adulthood increases, thereby

Table 27.2 Age-specific arrest rates, age 65 and above, United States

	1993	1994	1995	1996	1997	1998	1999	2000	2001
Violent crime	15.5	15.1	16.1	14.7	14.4	14.1	13.3	13.4	12.3
Murder	0.7	0.5	0.6	0.6	0.5	0.5	0.5	0.4	0.4
Forcible rape	1.0	1.0	0.9	0.7	0.7	0.8	0.7	0.7	0.6
Robbery	0.6	0.6	0.6	0.4	0.4	0.4	0.6	0.4	0.4
Aggravated assault	13.1	13.1	14.0	12.9	12.8	12.4	11.5	11.8	10.9
Property crime	51.7	46.0	40.7	36.9	32.9	28.9	27.6	23.9	20.0
Burglary	1.8	1.6	1.7	1.6	1.4	1.5	1.4	1.6	1.1
Larceny-theft	49.1	43.5	38.4	34.6	31.0	26.9	25.6	21.7	18.4
Motor vehicle theft	0.8	0.8	0.6	0.7	0.5	0.5	0.6	0.5	0.4
Arson	0.4	0.3	0.4	0.3	0.3	0.3	0.2	0.2	0.2
Forgery and counterfeiting	1.0	1.1	1.0	1.0	0.9	1.1	0.9	1.0	0.8
Fraud	7.2	7.9	8.2	8.5	8.5	7.8	8.2	8.0	6.7
Embezzlement	0.2	0.3	0.2	0.2	0.3	0.1	0.2	0.2	0.2
Stolen property	1.1	1.2	1.0	1.1	1.1	0.9	0.9	1.0	0.7
Weapons violations	5.8	4.9	4.8	4.5	4.6	3.8	3.6	3.1	3.0
Sex offenses	7.2	7.2	6.5	6.2	6.6	6.2	6.2	5.9	5.1
Gambling	2.7	2.3	2.0	2.2	2.1	2.0	2.1	2.0	1.7
Drug abuse violations	6.4	7.0	7.7	7.9	8.1	8.7	10.0	11.5	8.6

Age-specific arrest rates and race-specific arrest rates for selected offenses, 1993–2001. Uniform crime reports, November 2003. Federal Bureau of Investigation

reducing interest in criminal activity. While this argument provides reasons why the elderly as a group are less likely to commit a crime, it does not address why some elderly engage in criminal activity. Additional explanations for the low rates of criminal behavior among older Americans include a life course perspective in which Sampson and Laub argue that diminished engagement in criminal activity is tied to social connections in adulthood (Sampson and Laub 1990).

Incarceration

While arrest rates of older Americans have been stable or declining, the elderly are increasing in number and as a percentage of the overall prison population. Here, it is important to note that research on prison inmates utilizes a different designation of old. Most of the research on those incarcerated uses age 50 or 55 and above as elderly. The reason for a younger elderly age is that the health status of a 50-year-old prison inmate approximates that of a nonincarcerated elderly person some 10–15 years older (Reimer 2008).

In 1985, there were less than 10,000 prison inmates aged 55 and above in state prisons. By 2010, that number is expected to surpass 60,000. The growth in the number of federal prisoners aged 55 and above has also been increasing but at a much lower rate (Yates and Gillespie 2000). Overall, the elderly represent the fastest growing age group in American prisons (Rothman et al. 2000). This increase is the result of a number of factors including growth in long-term incarceration (5–10 years or more) and older Americans being sentenced for longer periods compared with other age categories (Aday 2003). In addition, prison recidivists, chronic offenders, and problems in retirement may lead to increased chances for arrest and incarceration (Reimer 2008). Among elderly prison inmates, the majority were convicted of nonviolent offenses, particularly those currently in federal prisons (National Center on Institutions and Alternatives 1997). Although in the minority, the number of elderly prison inmates under sentence of death continues to increase. In 1996, 1.8% of the prisoners under sentence of death were 60 years and older. By 2007, the elderly represented 5.8% of prisoners

under sentence of death (Pastore and Maguire N.d.). Demographically, elderly prison inmates are predominantly non-Hispanic whites (Dunlop et al. 2000) and as with the general prison population, are overwhelmingly male with generally low levels of education and job skills (Aday 2003). Table 27.3 illustrates the current breakdown of state and federal prisoners by age and sex. While the data demonstrate that relative to other age groups, older Americans are significantly less likely to be incarcerated in state or federal facilities, the number also reflects the level of difference between older male and female incarceration rates. Furthermore, the role of race and/or ethnicity reflects incarceration rates. Blacks, non-Hispanic men, and Hispanic women report the highest rates while white males and females the lowest. Among incarcerated elderly, however, is the increased potential

Table 27.3 Estimated number and rate (per 100,000 U.S. resident population in each group) of sentenced prisoners under jurisdiction of State and Federal correctional authorities

By sex, race, Hispanic origin, and age group, United States, 2007

	Male				Female			
Age group	Total	White, non-Hispanic	Black, non-Hispanic	Hispanic	Total[a]	White, non-Hispanic	Black non-Hispanic	Hispanic
Number, total	1,427,300	471,400	556,900	301,200	105,500	50,500	29,300	17,600
18–19 years	23,700	6,400	10,200	5,000	1,000	400	300	200
20–24 years	207,900	58,800	84,200	49,600	11,600	5,400	3,000	2,300
25–29 years	246,000	65,300	102,100	61,500	16,000	7,300	4,400	3,200
30–34 years	237,200	69,800	96,200	55,300	18,400	8,900	5,000	3,200
35–39 years	225,000	74,200	89,200	46,600	20,900	9,900	6,000	3,300
40–44 years	201,700	74,800	76,700	36,100	16,100	8,700	5,200	2,700
45–49 years	135,200	52,400	50,500	22,800	10,700	5,200	3,100	1,500
50–54 years	75,000	31,000	26,600	12,500	5,000	2,400	1,400	700
55–59 years	38,600	18,600	11,700	6,200	2,100	1,200	500	300
60–65 years	18,900	10,500	4,600	2,900	900	600	200	100
65 years and older	15,500	9,000	3,600	2,200	600	400	100	100
Rate, total[b]	955	481	3,138	1,259	69	50	150	79
18–19 years	539	238	1,561	656	24	16	47	28
2–24 years	1,915	887	5,580	2,507	114	86	203	134
25–29 years	2,256	1,025	7,256	2,624	154	117	303	172
30–34 years	2,385	1,214	8,166	2,500	191	157	386	175
35–39 years	2,113	1,124	7,215	2,344	199	151	434	191
40–44 years	1,859	1,044	6,106	2,111	166	121	364	176
45–49 years	1,196	658	4,013	1,619	93	65	214	113
50–54 years	719	404	2,422	1,164	46	31	108	66
55–59 years	432	274	1,337	787	22	17	47	36
60–64 years	266	188	771	526	12	10	26	16
65 years and older	95	68	294	200	3	2	5	7

Note: these data are compiled by a yearend census of prisoners in State and Federal correctional institutions. Data collection is sponsored by the U.S. Department of Justice, Bureau of Justice Statistics. Sentenced prisoners are defined as those serving sentences of more than 1 year under the jurisdiction of State and Federal correctional authorities. For information on methodology and definitions of terms, see appendix 15

[a]Includes American Indians, Alaska Natives, Asians, Native Hawaiians, other Pacific Islanders, and persons identifying with two or more races

[b]Based on estimates of the U.S. population on Jan. 1, 2008

Source: U.S. Department of Justice, Bureau of Justice Statistics, *Prisoners in 2007*. Bulletin NCJ 224280 (Washington, D.C.: U.S. Department of Justice, December 2008), p. 19, Appendix Tables 8 and 9

Source: Pastore and Maguire 2010

for death. According to Pastore and Maguire (N.d.), 168 elderly prisoners died in local jails in 2006 compared to 115 in 2000.

Once incarcerated, those over the age of 60 represent a greater expense than younger prisoners. One study estimates that prisoners over the age of 60 cost the state of California 2–3 times more than prisoners under the age of 60 (GW News Center 2003). Nationally, cost differences are estimated at $69,000 for inmates aged 50 and above and $22,000 for all other inmates (McMahon 2003). Reasons for the increased cost include the emergence of chronic health conditions that may have precipitated the commission of a crime or for long-term prison inmates, the development of poor health outcomes as a result of imprisonment. According to Kerbs, the need for alternative housing arrangements for elderly prisoners is a necessity in order to lower the overall cost of incarceration (Kerbs 2000). On the other hand, Kerbs and Jolley point out that as age increases, the rate of recidivism decreases (Kerbs and Jolley 2009).

Because of the increasing numbers of elderly prison inmates, some states are constructing prisons specifically for the elderly. The question of age segregation vs. age integration in the prison system is open for debate. Arguments in favor of age segregation include concern for frail elderly prisoners in a population of younger, stronger prisoners. Here, the issue is one of intimidation and control by younger-aged prisoners. In addition, age-segregated prisons could exclude older prisoners from vocational and other training programs. Conversely, proponents of age integration in prisons argue that older inmates can function as a role model for younger prisoners. Perhaps, most important is that older prison inmates are not a homogeneous group with similar needs, thus supporting the belief that elderly inmates represent a range of abilities and needs within the prison system (Yates and Gillespie 2000).

On a more controversial note is the effort to apply the Americans with Disabilities Act to the prison system. Although some prisons adhere to the requirements of the law, others claim that the ADA does not apply to the prison system. As Preston points out, “the disabled (including the elderly) face numerous challenges, in the prison system especially, that may defeat some of the manifest purposes of our justice system” (Preston 2003:324).

The past 30 years provides a rich history within which to assess the level of change in the relationship between aging, the law, and crime. The remaining sections address the broader implications associated with this relationship and offer possible future directions.

Intellectual Frontiers

The issue of crime and the law relative to older Americans requires forward thinking. Over the past 30 years, researchers have attempted to clarify the relationship between age and fear of crime and the social and environmental context in which it occurs. The future must move beyond crime alone and explore more deeply the relevance of other characteristics relative to this relationship. The fact that such a belief persists after 30 years indicates the need for new intellectual frontiers. Here, the emergence of the baby boom generation and their increasing predilection for urban living may offer new hope for rethinking the intersection of crime and aging. In addition, the work of Ferraro and LaGrange provides a beginning point for future gerontological examination of the role of the media relative to aging and the fear of crime. To what extent do the media reinforce negative stereotypes of older Americans as being frail and incapable of providing for their physical well-being, particularly within the urban settings? In addition, the role of new media and the construction of social networking within defined urban environments could facilitate the emergence of interaction and support systems among the elderly and nonprofit organizations. Such support systems could provide assistance to the elderly concerned with issues of crime and safety.

The intellectual frontier of exploding incarceration costs of elderly criminals lies again in technology. With low recidivism rates, it would be more appropriate to provide elderly criminals with

less expensive home environment settings rather than institutional arrangements. For those elderly inmates with medical problems, monitoring systems would allow medical personnel the ability to treat them in a home environment much as other elderly are encouraged to age in place with the assistance of routine medical and social visits.

More broad is the issue of age discrimination. Here, the need to rethink age-based laws and its consequences will offer fresh insight into questions of retirement and redefined roles within the world of work. The legal task is to restructure the social contract between society and the elderly. This effort should be based on the best interests of the elderly, not on expediency or economic limitations. The outcomes need to be intra- as well as inter-generational in nature.

Implications for Social Policy

Although older Americans continue to represent the age group least likely to engage in crime or to be a victim of a criminal act, their involvement in the criminal justice system is central to the restructuring of social policy. Sociologically, the role of the elderly within the criminal justice system creates a dynamic interplay between three interrelated foci: special vs. equal treatment under the law, age-based sentencing guidelines, and incarceration.

The following statement illustrates the inadequacies of current social policy toward the elderly, crime, and the law:

> (T)here has been little analysis of whether age-based distinctions intended to aid or assist older people have the unintended effect of further stigmatizing them. Laws that increase penalties for crimes committed against older people, for example, may reflect society's collective judgment that elders should be afforded a positive status and be protected by stiffer penalties for crimes against them. On the other hand, these laws may perpetuate the inaccurate perception that older people, by and large, are weak, helpless, and vulnerable to victimization. … Furthermore, to single out older people for differential or specialized treatment based simply on generalized or stereotypic ideas about their characteristics creates a risk of paternalism (Dunlop et al. 2000:353–4).

An example of a social policy directed toward reducing the cost of incarceration of older inmates is called the Project for Older Prisoners or POPS. Effectively, this program is designed to allow older prisoners to receive an early release from prison if they have "served the average sentence for their offense and are unlikely to repeat their crimes" (Yates and Gillespie 2000:172). Beyond release, the program offers job and housing assistance as well as support obtaining Social Security if available. The program is voluntary with support from law schools whose students screen possible candidates.

Rikard and Rosenberg offer a number of examples of how a gerontological perspective can assist in rethinking criminal justice policies. For example, rather than basing programs or resources on chronological age, institutions could utilize functional age as a determinant of a person's ability to perform a task. They also suggest explaining differences between age, period, and cohort effects as a tool for understanding what institutional changes are necessary and why. Utilizing indices such as Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), institutions could better assess the needs of older inmates. Finally, they suggest application of the Person-Environment Model for the purpose of "teaching new behaviors or problem-solving skills by modifying the residential prison environment to reduce its press on aging inmates" (Rikard and Rosenberg 2007:158).

As evidenced, the sociology of aging must explore current social policy to better meet the needs of older Americans when they come into contact with the criminal justice system. The discipline needs to engage in a multilayered analysis that goes beyond how older people should be treated when victimized to how and when to incarcerate, for how long, and guidelines outlining what constitutes special treatment under the law.

Barriers

The barriers to an improved sense of security among the elderly remain. Here, the need to create environments within which older Americans feel secure remains an unfunded barrier. Other barriers include an increasingly negative attitude toward an older age population. With diminishing economic opportunities for younger age citizens, intergenerational divides are likely to generate increased competition for limited public resources. Furthermore, as entitlement programs such as Medicare and Social Security continue to experience funding deficits, questions of their long-term viability will remain an issue. Among the younger age population, the viability of such programs may raise questions of fairness of cost and special treatment under the law. Among older Americans, these programs provide a much needed economic and medical support.

Conclusion

The past 30 years have witnessed significant changes within the elderly population. The demographic shift that continues to result in an increase in the number of elderly Americans, their relationship with the criminal and legal systems continues to evolve. We know that over the past 30 years, the elderly remain the least victimized and the least likely to commit crime. At the same time, their fear of victimization remains an issue. Although research has addressed this inconsistency and locates explanations for the fear in research methodologies, elderly concerns persist. We also know that the percentage of elderly prison inmates continues to increase because of the number of inmates serving longer prison sentences. The aging of prison inmates is beginning to strain state and federal budgets and creating the need for creative housing of elderly inmates.

The relationship between the elderly and the law is more difficult. Here, the evolving social contract has created social policies that vary between treating the elderly as equal with other age groups and as a special age category. As the elderly population increases as a percentage of the population, concerns have arisen over the potential economic consequences of special treatment. These concerns are framed as an intergenerational transfer that provides a disproportionate share of the resources to the elderly.

The future of aging relative to crime and the law is filled with considerable uncertainty and opportunity. The task will be to frame the relationship so as to ensure that the needs and well-being of aging Americans are adequately addressed within a social environment that does not limit the significance of aging.

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Chapter 28
Aging Veterans: Needs and Provisions

Janet M. Wilmoth and Andrew S. London

Current knowledge about aging is primarily based on cohorts that were born during the early part of the twentieth century. A substantial percentage of men in these cohorts, and subsequent cohorts who are currently middle aged, served in the military during war, peace, Cold War, or some combination thereof. Consequently, veterans are a sizeable demographic group in the United States. In 2000, over 26 million Americans were veterans, representing approximately 12.7% of those aged 18 years or older (U.S. Census Bureau 2003). Military service is particularly prevalent among older cohorts who served in World War II (WWII) and the Korean War (Hogan 1981); almost 9.2 million men age 65 years and older were veterans in 2000, which represents 64% of men in this age group (Interagency Forum on Aging-Related Statistics 2008). In addition, participation in the military has increased substantially among women; in 2000, nearly 1.6 million American women were veterans (U.S. Census Bureau 2003).

Military service and war are persistent features of Americans' lives. Because of the high prevalence of military service among men who were young adults during World War I (WWI), World War II (WWII), and the Korean War and the necessary concentration on these cohorts in earlier, large-scale data collection efforts that focus on aging Americans, Settersten and Patterson (2007:5) have argued that "…wartime experiences may be important but largely invisible factors underneath contemporary knowledge about aging." We contend that the role of military service in shaping age-related outcomes has more generally been under-acknowledged in gerontological research on men, as well as women who sometimes served in the military service roles that were made available to them historically, but more often lived their lives linked to men who served in the military. At the same time, the seminal work of Glen H. Elder, Jr. and his colleagues on the lives of the children of the Great Depression, who primarily served during WWII, has elucidated the impact of military service on men's lives, while also providing strong theoretical foundations for life-course scholars to use in studies of the effects of military service on the lives of men, women, and children.

In this chapter, we discuss the extant research that has used life-course perspectives to examine military service, paying particular attention to the theoretical contributions of this work to broader life-course studies. We argue that this area of research is unique in its careful articulation of within- and between-cohort variation, and then use that approach to discuss the characteristics of current and future aging veterans. We also consider the needs of and provisions to aging veterans by focusing on current patterns of benefit and service use, and linking this discussion to how needs for benefits and services may change as younger veterans with different historical experiences and demographic characteristics age. We are careful to distinguish between the needs and provisions

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that are rooted in general aging processes and those that are unique to the experiences of particular veteran cohorts. The chapter concludes with a discussion of the types of theoretical and empirical work that are necessary to understand the changing role of military service in the life course.

Life-Course Studies on Military Service

Over the past 30 years, a growing body of research has drawn on life-course perspectives to investigate the influence of military service on various life-course trajectories and outcomes. This research has demonstrated that the U.S. military is a critical social institution that can (re)shape educational, occupational, income, marital/family, health, and other life-course trajectories (London and Wilmoth 2006; MacLean and Elder 2007; Mettler 2005; Modell and Haggerty 1991; Settersten 2006). Life-course researchers who have addressed questions related to military service recognize that the military has the potential to transform the lives of those who serve in it for better or worse, but also that the transformative potential of the military varies across individual characteristics, the timing of military service in the life course, service experiences, and historical periods (Angrist 1990; Angrist and Krueger 1994; Gimbel and Booth 1994, 1996; Teachman and Call 1996; Teachman 2004, 2005; Teachman and Tedrow 2004). These insights serve as the foundation for much theorizing about how military service (re)shapes life course outcomes, as well as empirical life-course studies that have examined the role of military service in men's and, to a lesser extent, women's lives. This body of exemplary life-course research aims, in the words of Modell and Haggerty (1991) "to connect the micro- and macro-levels of analysis, thus connecting the soldier's story to that of his *[or her]* changing society" (p. 205).

Studying the role of military service in the life course provides researchers with an amazingly rich opportunity to investigate each of the five major principles of the life-course paradigm: human agency; location in time and place; timing; linked lives; and lifelong development (Elder and Johnson 2002; Giele and Elder 1998). Glen H. Elder, Jr. is responsible for the most-influential, early theorizing about the role of military service in the life course (Elder 1986, 1987) and, with a range of colleagues, for demonstrating the importance of military service for life-course studies (Clipp and Elder 1996; Dechter and Elder 2004; Elder and Bailey 1988; Elder and Clipp 1988, 1989; Elder et al. 1991; 1994, 1997; Pavalko and Elder 1990). This seminal body of research articulates each of the five principles of the life-course paradigm and, by focusing on the timing of military service in the life course, motivates and interrogates two corollary hypotheses that have wide-reaching implications for life-course scholarship: the military as turning point and the life-course disruption hypotheses.

The *military as turning point hypothesis* focuses on young age at entry into the military because it maximizes the chances for redirection of the life course and minimizes disruption to established life-course trajectories. Elder (1987) argues that early entry into the military represents a social and psychological moratorium, which both delays the transition to adulthood and allows for the maximal utilization of service benefits. Early entry may reflect selection of the most disadvantaged, who see military service as a route out of difficult life circumstances. While this would suggest that early entrants would have worse life-course trajectories and outcomes, it is theorized that they are precisely the persons who may benefit most from the range of benefits and services available to veterans. The *life-course disruption hypothesis* is a corollary hypothesis, which posits that relatively late entry into the military has the potential to disrupt established marital, parenting, and occupational trajectories, which may have consequences for the subsequent patterning of the life course and later-life outcomes. Later entrants often come from more advantaged backgrounds and may have already completed their educations. Because of the timing of military service in their lives, later entrants have less opportunity to take advantage of educational benefits for veterans. Consequently, the gains that accrue to more disadvantaged, earlier entrants through access to G.I. Bill educational benefits may not materialize to the same degree or with the same effects in their lives. The psychological

effects of military service, especially, but not exclusively, among veterans who have experienced combat, may intersect with disrupted occupational roles in ways that increase strains within families and influence the risk of marriage and family disruption.

Both of these hypotheses emphasize the potential of military service to produce discontinuity in the life course and remind life-course scholars of how participating in social institutions during young adulthood is influenced by and influences the process of cumulative inequality. In that regard, Elder's work laid a theoretical foundation for understanding the role of other institutions, including education, criminal justice, marriage, and family, in shaping life-course outcomes. His work has also spurred other scholars to elaborate the role of military service in the lives of cohorts who served during different historical time periods. This work is concerned with specifying between-cohort variation in employment, earnings, marital, and health outcomes and emphasizing within-cohort variation in experience based on gender and race/ethnicity, and to a lesser extent, sexual orientation.

Characteristics of Aging Veterans

Before turning to a discussion of the needs of aging veterans and the provisions available to them, we now provide a portrait of the current population of older veterans and how this population is projected to change between now and 2030. We believe that it is essential to ground a discussion of needs and provisions within a life-course perspective that takes historical context and individual characteristics into account.

2010

As shown in Fig. 28.1, in 2010, 4% of 25–44 year olds, 11% of 45–64 year olds, and 23% of adults aged 65 and older are veterans. The total number of veterans by age group and period of service is given in Table 28.1, which indicates that the current number of veterans increases from approximately 4.1 million for the 25–45 age group to over 9 million for both the 45–64 year old and 65 year or older age groups. The youngest group served primarily during the ongoing Gulf War: with the largest among them serving prior to 9/30/2001 (48%). The middle-aged group served primarily during the Vietnam Era (53%) or between the Vietnam Era and the Gulf War period (32%).

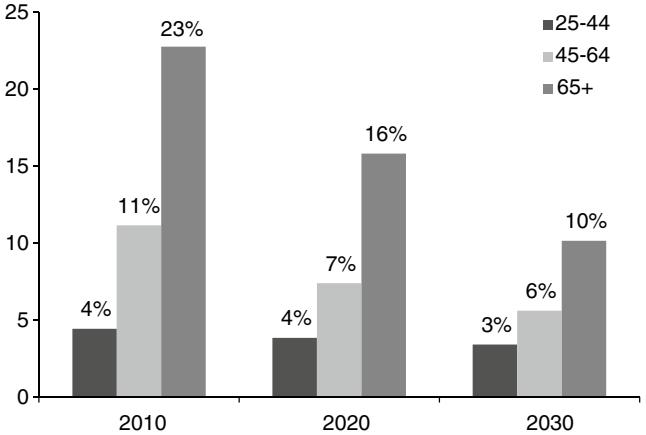

Fig. 28.1 Projected percent of veterans in the total U.S. population by age, 2010, 2020, 2030 (Authors' calculations based on VetPop2007 data (U.S. Department of Veteran Affairs 2008))

Table 28.1 Projected number and percent of veterans by age and period of service

	25–44 Years		45–64 Years		65+ Years	
	Number	%	Number	%	Number	%
2010						
World War II (WWII)	0		0		1,981,216	21.61
Pre-Korean War	0		0		115,440	1.26
Korean War	0		0		2,228,333	24.31
Between Korean War and Vietnam Era	0		17,593	0.19	2,247,980	24.52
Vietnam Era	0		4,756,230	52.59	2,515,536	27.44
Between Vietnam Era and Gulf War	455,173	11.00	2,889,455	31.95	66,683	0.73
Gulf War (Pre-9/30/2001)	1,990,312	48.09	962,681	10.64	9,884	0.11
Gulf War (Post-9/30/2001)	1,692,761	40.90	417,827	4.62	1,209	0.01
Post-Gulf War	761	0.02	0	0.00	0	0.00
Total	4,139,006	100	9,043,786	100	9,166,281	100
2020						
World War II (WWII)	0		0		269,721	3.11
Pre-Korean War	0		0		33,259	0.38
Korean War	0		0		804,947	9.28
Between Korean War and Vietnam Era	0		0		1,311,460	15.12
Vietnam Era	0		173,818	2.79	5,531,833	63.79
Between Vietnam Era and Gulf War	0		2,699,361	43.27	507,485	5.85
Gulf War (Pre-9/30/2001)	409,960	11.86	2,284,136	36.62	165,895	1.91
Gulf War (Post-9/30/2001)	2,080,399	60.18	1,079,714	17.31	47,441	0.55
Post-Gulf War	966,617	27.96	1,051	0	4	0.00
Total	3,456,976	100	6,238,080	100	8,672,045	100
2030						
World War II (WWII)	0		0		7,636	0.10
Pre-Korean War	0		0		3,087	0.04
Korean War	0		0		95,708	1.31
Between Korean War and Vietnam Era	0		0		388,026	5.31
Vietnam Era	0		0		3,341,176	45.70
Between Vietnam Era and Gulf War	0		417,839	8.86	2,313,522	31.64
Gulf War (Pre-9/30/2001)	0	0.00	1,865,246	39.53	756,667	10.35
Gulf War (Post-9/30/2001)	627,962	19.32	2,368,375	50.19	405,007	5.54
Post-Gulf War	2,622,466	80.68	67,065	1.42	169	0.00
Total	3,250,428	100	4,718,526	100	7,310,999	100

Source: Authors' calculations based on VetPop2007 data (U.S. Department of Veteran Affairs 2008). Percentages may not add to exactly 100% due to rounding error.

Notes: The VetPop2007 data draws information from the Census Bureau, the Defense Manpower Data Center, and the Department of Defense's Office of Actuary GORGO data.

Veterans are assigned to the period of war in which they first served. For example, a veteran who served in World War II (WWII) and the Korean War is assigned to World War II. (WWII) Similarly, a veteran from the Pre-9/30/2001 stage of the Gulf War may or may not have continued on to serve in the Post-9/30/2001 stage of the Gulf War.

The dates associated with the periods of service are as follows:

World War II (WWII)– September 1941 to July 1947;

Pre-Korean War – August 1947 to May 1950;

Korean War – June 1950 to January 1955;

Between Korean War and the Vietnam Era – February 1955 to July 1964;

Vietnam Era – August 1964 to April 1975;

Between Vietnam Era and Gulf War – May 1975 to July 1990;

Gulf War – August 1990 through a date to be prescribed by Presidential proclamation or law

Post-Gulf War – Hypothetical period of service after the Gulf War has ended, based on assumptions regarding continued stable enlistment rates.

The oldest group contains a mix of veterans who served in various mid-twentieth century wars prior to the establishment of the All-Volunteer Force (AVF) at the end of conscription in 1973. Among this group, the oldest-old, whose members are in their 80s, served in WWII (22%); the next oldest subgroup, whose member are at least 68 years old, served during Korea (24%) or between Korea and Vietnam (25%); and the youngest subgroup, whose member are mostly in their mid- to late-60s, served in Vietnam (28%).

Table 28.2, which presents the age, sex, and race/ethnicity distribution of veterans by time period, shows that the overwhelming majority of these older veterans are white men (86%). This reflects the gender and racial/ethnic composition of veterans who served during the pre-AVF era (see Lutz 2008 for a detailed review of historical changes in the racial/ethnic characteristics of those serving in the U.S. military). Despite their underrepresentation in terms of percentages, a substantial number of racial and ethnic minorities served in the military during the first half of the twentieth century. For example, it is estimated that over one million African Americans and one-half million Hispanics served in WWII (Lutz 2008; Allsup 1982). Research suggests that serving in the military during this time period profoundly affected the identities and lives of these veterans, and that their

Table 28.2 Projected number and percent of veterans by age, sex, and race/ethnicity

	25–44 Years		45–64 Years		65+ Years	
	Number	%	Number	%	Number	%
2010						
White Men	2,423,350	58.55	6,294,529	69.60	7,759,261	84.65
Black Men	508,852	12.29	1,106,493	12.23	574,052	6.26
Hispanic Men	349,703	8.45	508,853	5.63	314,039	3.43
Other Race Men	180,169	4.35	322,454	3.57	217,301	2.37
White Women	403,010	9.74	546,435	6.04	253,881	2.77
Black Women	161,999	3.91	171,601	1.90	24,816	0.27
Hispanic Women	69,677	1.68	51,281	0.57	11,839	0.13
Other Race Women	42,248	1.02	42,141	0.47	11,092	0.12
Total	4,139,006	100	9,043,786	100	9,166,281	100
2020						
White Men	2,002,274	57.92	3,786,323	60.70	6,865,405	79.17
Black Men	392,946	11.37	871,628	13.97	744,754	8.59
Hispanic Men	306,976	8.88	434,089	6.96	377,277	4.35
Other Race Men	160,652	4.65	246,575	3.95	259,140	2.99
White Women	353,103	10.21	565,166	9.06	316,765	3.65
Black Women	134,996	3.91	215,868	3.46	63,996	0.74
Hispanic Women	67,111	1.94	68,799	1.10	23,512	0.27
Other Race Women	38,918	1.13	49,632	0.80	21,195	0.24
Total	3,456,976	100	6,238,080	100	8,672,045	100
2030						
White Men	1,918,465	59.02	2,758,092	58.45	5,101,586	69.78
Black Men	364,037	11.20	583,849	12.37	851,643	11.65
Hispanic Men	273,266	8.41	386,591	8.19	394,535	5.40
Other Race Men	152,443	4.69	203,520	4.31	251,547	3.44
White Women	327,307	10.07	469,556	9.95	482,735	6.60
Black Women	119,693	3.68	189,939	4.03	147,817	2.02
Hispanic Women	59,425	1.83	78,434	1.66	44,579	0.61
Other Race Women	35,792	1.10	48,545	1.03	36,557	0.50
Total	3,250,428	100	4,718,526	100	7,310,999	100

Source: Authors' calculations based on VetPop2007 data (U.S. Department of Veteran Affairs 2008). Percentages may not add to exactly 100% due to rounding error.

honorable service helped pave the way for desegregation within the military and throughout the broader society (MacGregor 1981; Moskos and Butler 1996; Rivas-Rodriguez 2005).

Among the more than 70% of veterans aged 65 years and older who served prior to the current AVF era, the oldest served during WWII and are members of the birth cohorts that experienced higher rates of economic deprivation as children of the Great Depression, but went on to benefit from the post-WWII economic boom. The younger veterans in this group, who served between WWII and the Korean War or during the Korean War, were part of a relatively smaller set of birth cohorts that experienced WWII as children and came of age during the height of the Cold War. Military service provided men from these pre-Vietnam Era cohorts access to on-the-job training and higher education through generous G.I. Bill benefits. This had positive impacts on these veterans' subsequent life-course outcomes, including employment, earnings, occupational status, and marital stability, particularly among those from disadvantaged backgrounds, those who were officers, those who did not experience combat, and those who were white men (Bound and Turner 2002; Dechter and Elder 2004; Mettler 2005; Turner and Bound 2003). However, there is evidence that older pre-AVF veterans have higher mortality risk than nonveterans (London and Wilmoth 2006), which may be due in part to the pro-tobacco military policy (i.e., free and reduced price distribution of cigarettes) during WWII (Bedard and Deschênes 2006) and exposure to atomic radiation associated with the detonation of nuclear testing devices and the occupation of Hiroshima and Nagasaki, Japan (Bice-Stephans and Wynona 2000).

It is important to note that the G.I. Bill was not available to those who served from 1955 to 1965. Research indicates that during this time period men who were drafted were less likely to attend college than nonveterans and those who were not drafted, and that military service redirected academically ambitious men away from college attendance (MacLean 2005). This suggests that veterans who served during the period between the Korean War and the Vietnam Era might not have reaped the same benefits of service as those who served during WWII and the Korean War. In addition, the benefits of service were not as likely to be experienced by men who entered military service late. A series of studies indicate that late entry reduced the economic and job benefits associated with military service, increased the risk of life-course disruption, and resulted in poorer physical health trajectories over the life course (Elder et al. 1994, 1997; MacLean and Elder 2007).

2020

As shown in Table 28.1, it is projected that by 2020 there will be approximately 3.5 million veterans in the 25–45 year old age group, 6.2 million in the 45–64 year old age group, and 8.7 million in the 65 year and older age group. The youngest group of veterans will increasingly include individuals who served during the post-9/30/2001 period of the Gulf War (60%), which encompasses the Global War on Terror, including Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). Vietnam Era veterans will begin to move out of the middle age group and be replaced by the cohorts who served during the initial, peaceful years of the AVF era (43%) and the first 10 years of the Gulf War (37%). The oldest age group will overwhelmingly contain veterans from the Vietnam Era (64%), although the oldest and frailest among this group will be the nearly 1.1 million surviving veterans of WWII (3%) and the Korean War (9%). Although it is a small group, some existing research documents the specific needs of and provisions for current centenarian veterans (Selim et al. 2005). Table 28.2 demonstrates that the shift to veterans from the Vietnam Era is accompanied by increasing racial and ethnic diversity among veterans ages 65 years and older, as well as a notable increase in the proportion of older veterans who are women, from 3% in 2010 to 5% in 2020. By 2020, white men will represent 79% of all older veterans. The percentage of this older age group comprised of black men, Hispanic men, and men of other races/ethnicities will increase to almost 8, 4, and 3%, respectively.

The Vietnam Era veterans will have several unique characteristics compared to the cohorts that preceded them. These veterans are part of the large Baby Boom cohort that experienced increased competition for jobs during early adulthood, the economic downturn of the early 1970s, dropping rates of marriage and fertility, and rising divorce rates. In addition, there is evidence that the Vietnam War was more disruptive to the lives of veterans than previous wars (Frey-Wouters and Laufer 1986; Kulka et al. 1990) and that the economic outcomes of Vietnam veterans are lower than veteran cohorts who served earlier in the twentieth century (Angrist 1990; Cohen et al. 1986; Teachman and Call 1996). Due to advances in medical treatment, more wounded and injured soldiers survived, creating unique long-term health care needs due to war-related disability. Vietnam veterans also faced increased cancer risk due to exposure to Agent Orange (Pavuk et al. 2005). In addition, the nature of combat engagement, drug use during service, the relatively quick return to civilian life after assignments in combat zones, and antiwar sentiment in the United States contributed to the emergence of distinct mental health and substance abuse issues for Vietnam veterans.

2030

The projected profile of veterans in 2030 looks quite different than the one that exists today. As shown in Fig. 28.1, a smaller percentage of the total population will be a veteran in 2030: approximately 3, 6, and 10% of the 25–44 year old, 45–64 year old, and 65 year and older age groups, respectively. However, Table 28.1 indicates that the number of veterans will continue to be high: 3.2 million 25–44 year olds, 4.7 million 45–64 year olds, and 7.3 million 65 years and older. The majority of the youngest 25–44 year olds will be veterans the Post-Gulf War group (81%), which is a hypothetical cohort based on assumptions by the Department of Veterans Affairs regarding the end of the Gulf War and stable future enlistment rates. Nearly all of the middle-aged group will be veterans from the Gulf War: 40% will be from the Pre-9/30/2001 period and 50% will be from the Post-9/30/2001 period. The oldest veterans will represent three sets of veterans with distinct service histories. The oldest and largest group will be the surviving veterans of the Vietnam War (47%). There will also be a large number of veterans who served during the early years of the AVF Era that occurred after the end of the Vietnam Era (32%). The leading edge of the Pre-9/30/2001 Gulf War veterans will just be reaching retirement ages by 2030 (10%). The gender and racial/ethnic diversity of older veterans will become increasingly salient as the AVF-era veterans enter later life (see Table 28.2). White men will comprise 70% of veterans and the percentage of black and Hispanic men will increase to approximately 12 and 5%, respectively. The percentage of older veterans who are white and black women will increase to 6 and 2%, respectively.

In 2030, the characteristics of older Vietnam Era veterans are likely to dominate concerns about aging veterans. Not only will these veterans be among the oldest and frailest, but they are likely to have more needs relative to the slightly younger veterans who served during the early AVF era. These AVF-era veterans include the end of the Baby Boom and the beginning of the Baby Bust cohorts who came of age between the Vietnam Era and the start of the Gulf War. Young adults coming of aging during this period of relative peace experienced economic recession in the early 1980s, the rise of service sector employment, delayed ages of first marriage and childbearing, and continued high divorce rates. The experience of serving in the military also changed; as fewer young adults opted to enlist, military service became a less normative part of early adulthood, and more of those who enlisted chose military careers. Fewer veterans from this era took advantage of G.I. Bill benefits, in part because veterans became required to voluntarily contribute some of their own earnings in order to access the military's portion of the benefit. But, there is evidence that military service is associated with higher earnings for AVF-era veterans than nonveterans, particularly for

those from disadvantaged backgrounds (Teachman and Tedrow 2007; Angrist 1998; MacLean and Elder 2007). One recent study suggests that the downsizing of the military in the early 1990s had little effect on men's employment, but was associated with substantial increases in college attendance, especially among black men (Kleykamp 2009). In addition, the emerging literature on military service, race, and marriage (Lundquist 2004, 2006; Lundquist and Smith 2005; Teachman 2007; Usdansky et al. 2009), which posits a range of arguments to support the hypothesis that the American military became a relatively "pro-family," "pro-marriage" institution partly to recruit and retain personnel, suggests AVF-era veterans might not experience as much disruption in marital and family relationships as pre-AVF cohorts and that military service might be associated with increased marriage rates particularly among blacks.

Needs of and Provisions for Aging Veterans

The needs of aging veterans are shaped by their earlier premilitary, military, and postmilitary experiences, as well as the provisions they are able to make for themselves privately and obtain from family members, universal and means-tested social welfare programs, and benefits available through the Veterans Administration/Department of Veterans Affairs (VA). Veterans who experience significant life course disruption may find themselves aging without adequate economic and social resources to sustain themselves in the community. Those veterans who experience substantial physical and mental health problems as a result of combat experiences, being a prisoner of war, a sexual assault, or a service-related accident may need special health care services, as well as economic supports as they age.

A considerable literature documents the co-occurring struggles many veterans face with respect to mental health and substance abuse problems (Gatnache et al. 2000; Kang and Hyams 2005; Schinka et al. 1998; Sher 2009; Tessler et al. 2005), employment problems (Cohany 1990; Rosenheck and Mares 2007), incarceration, and homelessness (Kasprow et al. 2000; McGuire 2007; O'Connell et al. 2008; Tessler et al. 2003), as well as programs that aim to address these problems among veterans. As Vietnam Era veterans, whose military service is thought to have been particularly disruptive to their lives and who may have relatively high rates of midlife mental health, substance abuse, employment, and housing problems, become a larger proportion of the older veteran population in the next two decades, these earlier life-course experiences will have to be taken into account. For example, the lifetime prevalence of posttraumatic stress disorder (PTSD) (an anxiety disorder that was formally defined in 1980 in the American Psychological Association's third edition of the *Diagnostic and Statistical Manual of Mental Disorders*) is 30% among Vietnam veterans compared to 8% in the general U.S. population (Kulka et al. 1990; Kessler et al. 1995). In addition, among Vietnam Era veterans, those who served in Vietnam have poorer mental and self-rated health, higher cancer risk, and more treatment for specific health conditions than those who served elsewhere (Brooks et al. 2008a, b). This suggests that geriatric health care providers will need to become increasingly responsive to mental health conditions like PTSD and the unique health needs of veterans who served in different geographic venues as the veteran composition of the older adult population changes. Veterans whose transitions into and out of the military were less disruptive may have been able to capitalize on a range of educational and training benefits that led them to have better socioeconomic and more stable family outcomes. Such stability and status attainment may enhance their ability to care for themselves and obtain informal care from family members as they age.

The increasing gender and racial/ethnic diversity among older veterans may pose unique and complex challenges in terms of service provision. For example, there is some evidence that women and racial/ethnic minorities from disadvantaged socioeconomic backgrounds are more likely to join the military. Given this, some of that early life disadvantage might be carrying through the life

course and increasing the later-life needs of these veterans. However, among men, there is evidence that military service actually offsets early-life socioeconomic disadvantage, at least in terms of health outcomes (Parker, Wilmoth, and London 2009). Therefore, among older adults from disadvantaged backgrounds, those who are veterans may be doing better in later life than those who are not veterans. Still, female and racial/ethnic minority veterans face unique challenges as they age.

There is evidence that female veterans have comparable or worse health than male veterans, and more physical and mental health problems than female nonveterans (Frayne et al. 2006; Skinner et al. 1999; Skinner and Furey 1998). In addition, women who have served in the military often have experiences that are related to negative health outcomes, such as sexual assault during military service and weak social ties after military service (Frayne et al. 2006; Suris and Lind 2008; Turner et al. 2004). These negative outcomes appear to be more prevalent among younger female veterans who served during the Vietnam and AVF Eras (Cotton et al. 2000; Wolfe et al. 2000). However, female veterans are less likely than male veterans to have a service-connected disability, which may place them at a disadvantage in terms of accessing VA health care services because veterans with conditions related to or aggravated by military service receive priority for enrollment into the VA health care system. This potential disadvantage is offset to some extent by the expansion of VA services that aim to meet the specific needs of women veterans. Despite the existence of such services, older female veterans' knowledge about VA benefits and services is low, particularly their knowledge of VA aging-related services, such as long-term care (Silverstein and Moorhead 2001). This suggests that more needs to be done to inform older female veterans of the VA services available to them and to educate care providers in the community about these options for older female veterans. There is evidence that female veterans are more likely to use VA outpatient services than male veterans, particularly among those with medical and mental health conditions, which has implications for the necessity of providing integrated delivery of those VA services (Frayne et al. 2007). Integrated VA service delivery is also likely to be increasingly important as relatively advantaged older cohorts of female veterans are replaced by more disadvantaged younger cohorts of female veterans, who are more likely to be racial/ethnic minorities, have lower levels of education, and earn less income (Wolfe et al. 2000).

Thus, when considering the needs of and provisions for aging veterans, it is important to keep in mind that veterans and those to whom their lives are linked are a heterogeneous group. The composition of the veteran population is partly shaped by individual decisions about serving in the military, historical context, and military policies, including the size of, and restrictions on serving in, particular branches of the military. These restrictions on serving are particularly consequential for women, who have been barred from certain types of occupational specialties (Manning 2005; Segal and Segal 2004). These factors, in turn, influence combat exposure and service-related experiences among veterans with different sociodemographic characteristics, which shape the needs of and provisions to particular groups of veterans. Those needs for and provision of benefits to aging veterans are also shaped by the historical contexts in which veterans lived their lives outside of the military and the provisions made available to veterans from the time they re-enter civilian life through their later years. Such benefit and service provision will undoubtedly need to change as the size and composition of the older veteran population changes. Coordinating care for older veterans residing in rural areas will continue to be a specific challenge (Fortney et al. 2005; Ritchie et al. 2002), as will attending to the specific needs of persons with particular health conditions (Hwang et al. 2004; Trudel et al. 2007; U.S. Department of Veterans Affairs 2009c), women and racial/ethnic minority veterans (Frayne et al. 2006, 2007; Silverstein and Moorhead 2001; Skinner et al. 1999; Washington 2004), and LGBT-identified veterans. Coordinating care for veterans' family members will also pose significant challenges.

Provisions from the Department of Veterans Affairs most directly aim to address service-related needs. These provisions try to mitigate some of the disruption that military service can cause in

certain circumstances, such as during war-time mobilization, compensate and care for persons who have been harmed in the course of their service, as well as their dependents, and generally reward those who have taken risks and made personal sacrifices of various kinds in service to their country. The tradition of providing benefits to individuals who have served in the armed forces has roots in the founding of the United States (U.S. Department of Veteran Affairs 2009a). However, the social contract shaping benefits provision did not take its current form until after the establishment of the Veterans Administration in 1930 (which became known as the Department of Veterans Affairs when the agency was elevated to Cabinet-level status in 1989). Over time, provisions for veterans have expanded, but the basic types of provisions have remained the same since WWII.

VA benefits and services address the needs of aging veterans from two approaches. Some are designed to meet the general aging-related needs of veterans that are similar to the needs of any subgroup of the population that is aging. These benefits work in tandem with social insurance programs, such as Social Security and Medicare, which are available to all qualifying members of the U.S. population, and social assistance programs, such as Supplemental Security Income and Medicaid, which are used by a subset of the U.S. population with demonstrated need. Other aspects of these VA benefits and services are designed to accommodate the unique needs of specific subgroups of aging veterans, such as veterans with service-connected PTSD and disabilities, veterans from specific wars, and other veterans with unique service-related experiences. Currently, there are nine main categories of VA benefits and services: health care; service-connected disability compensation; pensions; education and training; home loan guaranty; life insurance; burial and memorial benefits; transition assistance, including vocational rehabilitation and employment; and dependent and survivors benefits (U.S. Department of Veterans Affairs 2009b). To qualify for VA benefits, the service member must have been other than dishonorably discharged from full-time active duty service, and in some cases must have served during wartime. Members of Reserve and National Guard qualify for these benefits under certain conditions. Special provisions are made for other historically relevant groups including WWII Merchant Marine Seamen, WWI and WWII Allied Veterans, and WWII Filipino Veterans, and 33 specific civilian groups who provided military-related services during WWI and WWII, such as Women Air Force Service Pilots (WASPs), and U.S civilians of the American Field Service, who served overseas under U.S. armies and U.S. Army groups in WWII (U.S. Department of Veterans Affairs 2009c).

Veterans with service-connected disabilities are given priority in access to benefits and premiums in resource allocations. For example, veterans with service-connected disabilities are given the highest priority for enrollment in the VA health care system (U.S. Department of Veterans Affairs 2009c). The VA's integrated health care system is the nation's largest with more than 1,400 sites of care, including hospitals, community clinics, community living centers, domiciliaries, readjustment counseling centers, and other types of facilities. Veterans are enrolled in priority groups that the VA uses to balance available resources with demand for enrollment; changes in available resources can lead to reductions in the number of priority groups that can be enrolled, with those in higher-rated priority groups retaining access. The top three of the eight priority groups that are currently defined are comprised of veterans with combat-related disabilities: Group 1 includes "veterans with service-connected disabilities rated 50 percent or more and/or veterans determined by VA to be unemployable due to service-connected conditions"; Group 2 includes "veterans with service-connected disabilities rated 30 or 40 percent"; and Group 3 includes "veterans with service-connected disabilities rated 10 and 20 percent, veterans who are former Prisoners of War (POW) or were awarded a Purple Heart medal, veterans awarded special eligibility for disabilities incurred in treatment or participation in a VA Vocational Rehabilitation program, and veterans whose discharge was for a disability incurred or aggravated in the line of duty" (U.S. Department of Veterans Affairs 2009c:2). Additionally, the compensation given to veterans with service-connected disabilities vary from $123/month in 2009 for veterans with a 10% VA disability rating to $376, $770, and $2,673 for veterans with 30, 50, and 100% VA disability ratings, respectively (U.S Department of Veterans

Affairs 2009c). Those with a VA disability rating of 30% or more are eligible for additional allowances for dependents, including spouses, minor children, children between the ages of 18 and 23 years who are attending school, children who are permanently incapable of self-support due to a disability arising before the age of 18 years, and dependent parents. Accounting for both the service member's disability and the access to additional benefits for dependents is important for life-course studies that focus on those whose lives are linked to veterans.

In addition to veterans with service-connected disabilities, other subpopulations of veterans are highlighted in policies governing benefits and services. For example, there are special programs that target homeless veterans, and those at risk of homelessness, including veterans who are re-entering public life after a spell of incarceration (U.S. Department of Veterans Affairs 2009c). Women veterans are eligible for the same VA benefits as men; however, comprehensive health services to address women's specific health care needs are available, including the management of acute and chronic illnesses, preventive care, mental health care, contraceptive services, Pap smears and mammography, gynecological and maternity care, and infertility evaluation at VA health care facilities; referral to community-based providers; and special initiatives. Certain groups of veterans participate in health registries in order to obtain free medical examinations and diagnostic tests. These include the Gulf War Registry, the Depleted Uranium Registries for veterans who served, respectively, in the Gulf War and OIF and those who served elsewhere, including Bosnia and Afghanistan; the Agent Orange Registry for veterans possibly exposed to dioxin or other toxic substances in herbicides used during the Vietnam War, while serving in Korea in 1968 or 1969, or as a result of testing, transporting, or spraying herbicides for military purposes; and the Ionizing Radiation Registry for veterans possibly exposed to atomic radiation across a broad range of historical circumstances (U.S. Department of Veterans Affairs 2009c).

Given that veterans have access to public social insurance and assistance programs, and that some VA programs are only available to veterans who meet certain criteria, not all veterans use VA benefits and services. Of the approximately 23 million currently living veterans, 36% (8,493,700) received at least one VA benefit or service in fiscal year 2008 (U.S. Department of Veteran Affairs 2009d). Among those who received a benefit or service, 68% (5.76 million) received only one, while 32% (2.74 million) used more than one. More veterans used VA health care than any other benefit or service: 61% of veterans who used benefits or services used VA health care; 33% (2.78 million) used VA health care only; and 28% (2.36 million) used VA health care and at least one other benefit or service. Forty percent of veterans receiving VA disability compensation did not use VA health care. Patterns of nonhealth single benefit or service use in declining order of prevalence are loan guaranty (11%), compensation (10%), insurance (9%), burial services (2%), education (2%), pension (1%), and vocational rehabilitation (0%). Patterns of multiple benefit use in declining order of prevalence are health and compensation (46%); health, compensation, and insurance (8%); health and pension (8%); health and insurance (6%); health, compensation, and loan guaranty (5%); compensation and insurance (5%); and compensation and loan guaranty (5%). Seventeen percent use some other combination of VA benefits and services.

The pattern of using VA benefit and services varies by gender and age. Overall, 87% of those who received a benefit or service were male and 81% were 45 years old or older, which indicates that the majority of benefits and services are currently used by older male veterans. Of the veterans who received at least one benefit or service, approximately 37% (3.14 million) were between the ages of 45 and 54 years and 44% (3.75 million) were aged 65 years or older. There is an interesting difference in the age patterns of single versus multiple benefit and service use, which suggests that benefit and service use changes dynamically over the life course. Focusing first on those who only used one benefit or service, 34% (1.93 million) were between the ages of 45 and 64 years, while 48% (2.75 million) were 65 years old or older. Among those using more than one service or benefit, 44% (1.21 million) were in the 45–64 year age category, while only 36% (1.00 million) were 65 years or older.

Although it is only part of the story that is relevant to tell in relation to the needs and provisions for aging veterans, careful consideration of the VA benefits and services available to and used by veterans in the past and present is essential. The snapshot of VA benefits and service use by veterans in one recent year that is provided above suggests considerable use by a sizeable portion of the veteran population, and that benefit and service use is concentrated among older veterans. As the population of aging veterans changes over the next two decades, adjustments to benefits and services will need to be made. Such adjustments should take into account VA benefit and service use histories of aging veterans across the life course, as well as the barriers to benefit and service use that older veterans with particular characteristics experience, such as veterans living in rural areas, homebound veterans, the oldest-old veterans, veterans with histories of homelessness, and veterans with psychiatric and/or substance abuse disorders. Efforts to determine unmet needs for benefits and services and underserved populations are also warranted. For example, even though most of the approximately 12,600 lesbian, gay, and bisexual service members dismissed from the military during the 15 years that Don't Ask, Don't Tell has been in effect were discharged honorably and maintain eligibility for VA benefits, it is unclear to what extent they know they are eligible for VA benefits and services, feel comfortable using them, and do use them. Even if they use benefits and services, they may withhold specific kinds of information about behaviors and social relationships from service providers and have unmet needs because of their sexual orientation. To address these issues and concerns, new data collection efforts will be necessary that allow us to more fully understand how institutionalized military practices, historical context, and human agency jointly affect needs for and use of benefits and services among groups of veterans with different social locations and experiences of cumulative inequality.

Future Directions for Research on Military Service and the Life Course

As we look toward the future of research in this area, we have to acknowledge the importance of the past in shaping what is known and what needs to be known. By necessity, the study of military service and the life course is grounded in historical periods of war and peace. Given this, the research in this area focuses on a classic concern of life-course scholarship: how lives unfold for individuals who experience certain historical times from the vantage point of particular social locations. The next generation of studies on military service and the life course must pay renewed attention to understanding the nexus of historical circumstance and individual biography. Of particular concern is how the structure of institutionalized practices related to military personnel and veterans influences individual choices and chances in ways that shape cumulative inequality. As noted by Ferraro et al. (2009:423), "life course trajectories are shaped by the accumulation of risk, available resources, and human agency." From this perspective, the individual decision to join the military is a critical turning point in early adulthood that creates life-course discontinuity by differentiating a subpopulation who experiences a powerful, potentially transformative, and resourceful social institution from a subpopulation who does not accrue a military service history or the possibility of enduring connections to the military through the use of the benefits and services offered by the VA to veterans and their dependents. This turning point has the potential to mitigate or accelerate unfavorable trajectories (and conversely accelerate or undermine favorable trajectories), depending on the timing, intensity, and duration of the resources provided to military personnel while they are serving and to veterans after being discharged from service. Thus, social structure–in this case represented by the policies and programs of the Department of Defense and Department of Veterans Affairs–acts in tandem with human agency–in this case embodied by individual decisions related to military service–to shape life-course trajectories.

Research on military service and the life course must continue to articulate the interplay between social structure and human agency in the lives of military personnel and veterans, as well as those

whose lives are linked to them. Pressing questions include: how historical conditions and personal circumstances influence individual decisions regarding the timing and duration of military service; how military policies shape the timing and sequence of other events during the demographically dense period of early adulthood; and how veterans mobilize the resources provided through VA programs and services over the life course. As the demographic profile of veterans becomes more diverse, it becomes increasingly important to recognize the ways in which intersectionality influences experiences during and after military service. It is also crucial that we develop a better understanding of the lives of those who are linked to veterans, including spouses/partners, children, and parents. All of this work must articulate clearly its contributions to understanding variation between cohorts whose members served during different historical time periods and/or variation within cohorts whose members served in a given period of war or peace.

The primary challenge to research on military service and the life course lies not in developing its theoretical underpinnings, but in collecting appropriate data. There are ample surveys of military personnel and veterans who use VA health care facilities. While these surveys are rich in the information they contain about military service experience, their exclusion of nonveterans precludes making comparisons on the basis of veteran status. Such comparisons, with controls for the selectivity of military service, are essential for understanding how the lives of those who participate in the military are different from the lives of those who do not serve in the military. There are also a number of under-researched nationally representative datasets that contain measures of veteran status. These datasets allow for direct comparisons between veterans and nonveterans, but, often, there are an insufficient number of female and racial/ethnic minority veterans to examine issues related to intersectionality. In addition, these nationally representative surveys typically have very limited information about military service experiences or the timing of military service in relation to other life-course trajectories, such as educational attainment or family formation. Often, all that is known is whether the respondent is a veteran and, if so, the time period of his or her service. Information regarding preservice circumstances, duration of service, branch of service, rank, exposure to combat, and service-related disability is infrequently gathered. The most promising avenues for advancing the scholarship in this area involve merging military and VA benefit usage records with prospective, longitudinal studies of samples that include both veterans and nonveterans.

Data collection efforts will also need to focus on gathering detailed information on veterans' use of VA and non-VA benefits and services across the life course in order to make it possible to determine how such resources shape the life course. It is clear from available data that patterns of VA benefit and service use are complex, vary with age and other characteristics, and are established shortly after deployment ends. But extant research tells us little about changes in use or cumulative use over the life course and how that varies between cohorts with different histories of service or among individuals within the same cohort who entered the military from and exited it to different social locations. This is an important gap in the extant literature and will affect what we know moving forward in the absence of efforts to collect better data. For example, descriptive data suggests that, compared to previous veteran cohorts, recent veterans may be using more benefits and services in early- and mid-adulthood. Specifically, a higher percentage of OEF/OIF veterans are using benefits and services relative to all veterans, and a higher percentage is using multiple benefits and services (U.S. Department of Veterans Affairs 2009d). This is noteworthy given the younger ages of OEF/OIF veterans relative to all veterans. This might reflect needs that are related to postservice adjustment. But, it could also be indicative of a higher pattern of service use that might persist as this cohort ages. These patterns of benefit and service use also reflect early- to mid-life course access to resources that have the potential to affect later life-course trajectories and outcomes as these veterans age. Given the relatively large percentage of OEF/OIF veterans who are women, analysis of how patterns of benefit and service use vary by sex, and sex differences in the effects of benefit and service use as veterans age, will be important topics for future data collection, research, and policy.

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Part VIII
Public Health and Aging

Chapter 29
Health and Aging: Early Origins, Persistent Inequalities?

Kenneth F. Ferraro

A sociological consideration of health and aging can be viewed primarily from one of two lenses. One focuses on the health of older people, emphasizing the centrality of health to the daily experiences and longevity of older people. For the most part, these studies examine older people only. Given that "older people" (65+) typically refers to a very wide cohort, the enormous health variability within this population spanning three or more decades merits systematic consideration.

A second lens focuses on the aging process and draws heavily from the life course perspective in order to understand how health variability plays out over time and culminates in the older adult population. It is also concerned with health variability among older adults, but emphasizes the life course processes leading to such variability. There is a clear need for both approaches; each is a valued intellectual endeavor with profound policy implications. Moreover, there is a need for integrative analyses that identify points of convergence and divergence.

Although both perspectives are needed and will continue to flourish, one of the great changes during the past three decades is a greater appreciation within sociology for the second approach emphasizing the aging process. This perspective is not new to the field of gerontology, but sociologists have played a critical role in promoting its utility. This has been seen most clearly in sociological theories of age, aging, and the life course (Elder 1974, 1998; Riley 1987; Settersten 2003). At the same time, the proliferation of longitudinal data, coupled with methodological innovations to analyze such data, has enabled a new and exciting genre of research on health and aging.

In this chapter, I recognize and draw from both lenses but emphasize the second – studying health processes over the life course. My aim is to highlight the scientific utility of this perspective to better understand health inequality in later life while reviewing some of the major findings during recent decades. Ultimately, I contend that greater appreciation for life course processes of health will aid our understanding of the health of older people, thereby enabling the design of more effective interventions.

Life Course Approach to Health and Aging

Sociologists, demographers, and psychologists have drawn important conceptual distinctions between individual, cohort, and population aging in order to better understand inequalities in physical and mental health (Alwin et al. 2006; Sliwinski and Mogle 2008). At the same time, a subfield of epidemiology known as "life course epidemiology" has emerged that shares many conceptual

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frameworks and methods of analysis with the life course sociological approach to health and aging (Kuh and Ben-Shlomo 1997; Lynch and Smith 2005; Wadsworth 1997).

In epidemiology's conceptualization of the interrelationships between host, agent, and environment, there is a premium placed on identifying exposure to potential risks. What is distinctive about life course epidemiology, however, is studying how these risks accumulate over time. When does exposure to a risk first occur? For how long is the host exposed to the risk? Once exposed to a risk, what mechanisms lead to compromised health? These and related questions have led to a pursuit of important periods of risk exposure that can be especially consequential to health. Although most sociologists are skeptical of complex stage theories of human development, they nevertheless recognize the importance of selected periods of the life course for shaping health outcomes (Ferraro and Shippee 2009). As Berkman (2009:30) described in a recent essay, "life course issues have recently come to permeate thinking about a broad number of exposures in public health. It is now commonplace to think of critical or sensitive periods in exposure to risk as well as to understand dynamics related to cumulative exposure."

If aging is a lifelong process from birth to death, then birth may play a pivotal role in life chances. This is seen in sociological analyses of the long-term effects of low birth weight on health and well-being, and this literature carries a heavy emphasis on socioeconomic differentials in birth weights and well-being (e.g., Conley and Bennett 2000). Stratification has a clear impact on the likelihood of a low birth weight, which, in turn, may shape socioeconomic status (SES) and life chances.

Birth weight is an outcome closely linked to maternal health, and British epidemiologists have pioneered a research program on the fetal origins of adult disease. Fetal origins of *childhood* disease is not a surprising link, but Barker's (1997, 2001) research has sought to identify how and why fetal development is related to *adult* health. In this sense, gestation may be a critical period for understanding health in later life. Such a notion was largely foreign to social gerontology three decades ago, but it is now considered quite plausible. Barker's findings that low birth weight is associated with elevated risk of obesity, diabetes mellitus, hypertension, and heart disease during adulthood have sparked other studies about whether diseases are programmed in utero. An alternative explanation to fetal programming is that the accelerated weight gain after a low birth weight is the mechanism for heightened risk of obesity and cardiovascular diseases (Singhal and Lucas 2004). In this sense, it may be the metabolic discontinuity (or whiplash) that links low birth weight babies with adult diseases. Whatever the case, diseases in adulthood and later life may have their origins in the womb. This realization is still permeating the gerontological community, but life course sociologists have widely acknowledged the importance of this critical period in shaping health outcomes.

Childhood is widely noted in psychology as a critical period for personality development, but its significance for physical health is equally important. During the past 30 years, we have witnessed a proliferation of studies on the long-term consequences of childhood conditions or experiences, including: adversity (e.g., Shaw and Krause 2002), health (e.g., Blackwell et al. 2001), or "disadvantage" (i.e., typically measured as parental social class, Smith et al. 2009; Willson et al. 2007; Yi et al. 2007). Many of these studies show that childhood conditions and experiences can have long-term negative consequences on health in later life, and this line of research has come from sociology (Blackwell et al. 2001; Preston et al. 1998), epidemiology (Singh-Manoux and Marmot 2005; Surtees and Wainwright 2007), economics (Case et al. 2002), and medicine (Dube et al. 2001; Felitti 2002).

At the same time, investigations of the link between childhood conditions and adult health also show the power of compensatory or neutralizing forces to reduce or eliminate the negative effects. Psychological, economic, and social resources in adulthood may reduce the noxious effects of early adversity (Irving and Ferraro 2006; Smith et al. 2009), and this line of research is very important for the development of effective interventions (Schafer et al. 2009).

Research on the link between health during childhood and adulthood is especially intriguing because of the mechanisms involved. Many studies reveal that poor health during childhood is

associated with poor health during adulthood (Case et al. 2002; Haas 2008), but Preston et al. (1998) identify an alternative outcome that drives different etiologic processes: acquired immunity. For instance, age differences in the recent prevalence of H1N1 infection reveal the highest rates among persons 5–24 years of age. Indeed, the Centers for Disease Control and Prevention (2009) suggest that "older people may have pre-existing immunity to the novel H1N1 virus." What this suggests is that the age differences in H1N1 are actually cohort differences due to historical differences in prior exposure. Aging does not reduce risk for H1N1; rather, life experiences of the earliest cohorts resulted in a protective effect via acquired immunity.

Another mechanism linking health in childhood with later life may be illustrated with a viral disease. Although a vaccine for chicken pox was approved for use in the United States in 1995, millions of adults contracted chicken pox during childhood. The uncomfortable sores associated with chicken pox typically disappeared within a week, but the virus that caused them – herpes zoster – remains in the person's body. Shingles in adulthood and later life is a rash that results from reactivation of the herpes zoster virus, and several studies reveal that stress can cause the reactivation of herpes zoster (Schmader et al. 1998). The stress process is usually identified as leading to the development of chronic disease, but it may also compromise immune responses, leading to heightened susceptibility to or reactivation of a virus. Thus, using a life course lens for studying health in later life may enable investigators to identify early and meaningful antecedents of both chronic and infectious diseases in later life.

Health Dynamics in Social Context: Selected Findings and Research Frontiers

Research on health and aging has proliferated over the past 30 years, and several findings have been transformative on the field. One of the major streams of research during the past three decades was sparked by Fries's (1980) discussion of the compression of morbidity. Fries envisioned a delay in the onset of chronic disease, enabling many people to live a larger proportion of their lives free from disease and disability. Sociological study of the compression of morbidity has given fairly limited attention to disease onset, but warmly embraced efforts to examine whether disability has been compressed. This emphasis is not surprising given that sociologists have long emphasized the functional consequences of disease in terms of social interaction and organization.

In the mid-1990s, two studies of disability were especially influential in shaping the field and discussions of the compression of morbidity. Verbrugge and Jette (1994) outlined the disablement process, by which disease led to functional disability. For older people, the expectation was that the disablement process had a strong gravitational pull – once begun, there seems little hope to escape from its forces, only ways to minimize or stall the decline in functional ability. The authors identified factors that might "speed or slow disablement," with little attention given to reversing the process (Verbrugge and Jette 1994:1). About this time, however, research by Manton et al. (1993:S194) reported that disability actually *declined* among "chronically disabled community-dwelling and institutionalized elderly populations." This sparked a number of studies by sociologists, demographers, and epidemiologists investigating whether this finding could be replicated. The scholarly paradigm at the time accepted slowing down the disablement process, but the notion that we might observe a decline in disability sparked scores of studies to determine whether this actually occurred (Crimmins et al. 2009; Freedman et al. 2004).

Three conclusions emerge from this literature. First, there is considerable evidence that disability among older adults, measured via activities of daily living (ADL), actually declined beginning in the mid-1990s (Freedman et al. 2004; Manton 2008). Second, the meaning of this finding is important: ADL disability taps whether or not a person is functionally capable of independent living.

This measurement of disability is focused on more advanced forms of disability, and some surveys actually limit their samples to persons who were screened to have some disability (e.g., components of the National Long Term Care Survey). In such surveys, the decline in disability, although important, needs to be interpreted as a decline among persons who previously reported some ADL disability. In short, the decline is a real but proverbial tip of the iceberg in the study of disability among adults (Verbrugge 1986). Third, in addition to the observed decline in ADL disability, alternative measures of health and functioning reveal notable improvements; and these improvements are due in part to cohort differences in disease prevalence and physical functioning (Manton et al. 2008; Martin et al. 2007, 2009).

Research on the compression of morbidity spawned a number of studies that elucidate health dynamics in later life. Many of these recent studies highlight the fact that health changes are often episodic and nonlinear. The bulk of our analytic methods, however, are premised on linear change. Disability, in particular, does not change in ways that are easily predicted with linear models. Rather, disability, and health status more generally, may increase, decrease, or plateau – and these transitions are frequently episodic. Cross-sectional point estimates of health status are helpful in some respects, but cutting-edge research on health has moved to dynamic models, especially growth curve models to capture oscillations in health over time.

Although there is excitement that we have recently witnessed notable health improvements for current cohorts of older adults, this satisfaction is tempered by a concern that the rising prevalence of obesity may undo these precious public health advances. Many scholars contend that the growing rate of obesity may well halt any further compression of morbidity (Manton 2008). The rising prevalence of obesity, and severe obesity, will likely yield an epidemic of diabetes mellitus (Ogden et al. 2006). Given that obesity is a potent risk factor for disability (Ferraro and Kelley-Moore 2003), an increase in the prevalence of obesity may compromise further improvements in population health.

We have also witnessed in the past 30 years a growing interest in ecological determinants of health. Although contextual analysis has been used for decades, both theories and methods for studying "clustered observations" have advanced considerably in recent years. Most theories in sociology have some component that addresses multiple levels of analysis such as macro-, meso-, and microstructures and processes. Thus, studying ecological antecedents of health dynamics in later life can be beneficial for both theoretical development and empirical generalization.

Sociologists are well aware of the power of social context in shaping health across the life course, but the past three decades have accentuated this tenet in new ways. Research has identified important influences on physical and mental health due to social capital (Snelgrove et al. 2009), neighborhood characteristics (Lee and Ferraro 2007), and even architectural features of one's residence that facilitate social interaction (Brown et al. 2009). These are especially important findings when considering the health of older people: Limited mobility means that the importance of local social ties is magnified. When social capital is low, older adults may be particularly vulnerable as illustrated by Klinenberg's (2002) finding that mortality was highest for older adults facing a Chicago heat wave. Also, older adults are less likely than younger adults to relocate to independent residences. As such, the irony is that their residential *stability* is often associated with neighborhood *change*. Thus, whether the person moves or the community changes, a frontier for this genre of research is to examine how both social context and social change influence health dynamics (Wheaton and Clarke 2003).

Health Inequality

One of the major conclusions from the study of health dynamics is that there is substantial variability in the pace of change experienced by persons. Some older people are experiencing health declines, while others are experiencing improvements or seasons of stability. As such, sociologists

systematically study *health inequality* by identifying the processes leading to advantaged or disadvantaged health status over the life course. What factors mitigate the anticipated health declines associated with aging? What social forces benefit or harm people's life chances? And are the effects of these forces more or less important with aging?

Among sociologists, the influence of SES has been singularly important for identifying health inequality. The influence of SES on health status is pervasive and substantial (Link and Phelan 1995). For instance, there is evidence that the compression of morbidity discussed earlier may be limited to persons of middle- or upper-class standing; it does not extend to lower-status persons (House et al. 2005). Coupled with the study of the early antecedents of health inequality, others have uncovered that there are long-term effects of SES, especially education, on health in later life (Elo 2009; Haas 2008; Ross and Wu 1996).

For decades, the focus of studies on the SES/health relationship was on the distinct disadvantage due to poverty, but there is more to the SES/health relationship than the profound disadvantage experienced by persons in poverty. Rather, what Marmot (2003) has referred to as the "social gradient" in health means that there are noticeable differences in health by SES among persons at each level of social class (Adler et al. 2008). Stated differently, if one were to exclude persons in poverty from the analysis, there is still a striking advantage for higher SES persons.

Beyond the influence of SES on an individual's health, there is also the question of the contribution of parental SES and intergenerational mobility on health. Studies of low birth weights revealed that parental SES is consequential (Conley and Bennett 2000), but, additionally, recent research reveals that intergenerational mobility is consequential to women's mortality (Tiikkaja et al. 2009). In many of these studies, the question is often asked which element of SES is most consequential. Although measurement of each element remains fairly crude, most scholars agree that education is generally the most important predictor of health and mortality. Interestingly, when Herd et al. (2007) differentiated between the onset and progression of disease and functional limitations, they found that education was better than income for predicting onset, but that the opposite occurred for predicting the progression of both outcomes.

Stratification involves overlapping systems of differentiation, and both race and ethnicity are closely related to social class in many modern societies. During the past three decades, numerous studies have documented the antecedents and extent of the health gap between racial and ethnic groups in America. Given that many Asian-American groups have better health and live longer than the White population, the focus of the research during the past three decades has been on Black and Hispanic Americans.

Acknowledging that the racial gap exists at birth (e.g., prevalence of low birth weight), scholars have sought to identify whether the Black/White disparity continues across adulthood and into later life. Studies of older adults only tend to show that the Black/White differences observed are relatively stable during later life – persistent inequality (Kelley-Moore and Ferraro 2004). And a few studies of older adults show that the racial gap decreases or even manifests a crossover after age 75 or 85 on selected outcomes (Johnson 2000). By contrast, more cohort-inclusive studies (i.e., adults of all ages) generally reveal a widening of the gap in health between White and Black Americans (Ferraro and Farmer 1996; Haas and Rohlfson 2010), accompanied by higher mortality for Black adults (Geronimus et al. 2006; Warner and Hayward 2006). Thus, findings on the reduction in the racial disparity in advanced ages must be couched in the context of lifelong disadvantage for the majority of the population. Given the higher mortality risk for Black Americans, the big-picture view is a major racial gap in health from birth into old age, resulting in an exceptionally selective group of Black adults at ages 75 and higher. Indeed, selective survival may give the appearance of decreasing inequality (Ferraro and Shippee 2009).

A major idea that has permeated much of the research on Hispanic Americans is the "Hispanic paradox" (Markides and Coreil 1986). It is deemed paradoxical because mortality risk is *lower* for Hispanic Americans than for many White and African-Americans of comparable

socioeconomic standing. Explanations for this paradox have centered on social and cultural practices that have salutary effects on health and the relationship between migration and health. It is possible that the healthy migrant tendency and return migration (i.e., "salmon bias") are two selection processes that may give the appearance of a paradox.

Others have questioned the concept of an epidemiologic paradox on both theoretical and empirical grounds. According to Palloni and Morenoff (2001), documenting a paradox is contingent on three items: a health outcome, a target population, and a contrast population. Thus, rather than an omnibus Hispanic paradox, there could be dozens of paradoxes – or none – and the authors claim that the empirical evidence to support a paradox is quite limited. If a Hispanic paradox exists, it is probably a fairly recent phenomenon and refers to Mexican Americans only, not all Hispanic Americans (Palloni and Arias 2004).

Regardless of the ethnic group considered, research on health and aging is evolving beyond simple contrasts between social categories to studying the underlying processes associated with health inequality (Whitfield and Morgan 2008). In reviewing the literature, I identify four major streams of research that are advancing the cutting edge of minority health research across the life course. First, research on the relationship between discrimination and health is a major innovation for the field. Perceived discrimination negatively affects the physical and mental health of African, Hispanic, and Asian Americans, but according to Williams et al. (2003:200), there is a need to study how "the association between discrimination and health unfolds over the life course" (see also Noh et al. 2007).

Second, for most ethnic groups, information on immigration and nativity is critical for understanding health disparities (Angel et al. 2001). For groups that have recently immigrated, it is essential to measure duration of residence and generational status because residential history and acculturation may shape health inequality.

Third, there is an emergent body of research on the effects of racial/ethnic segregation on health, but the findings are inconsistent. Although most studies of segregation and health reveal a detrimental effect (e.g., Acevedo-Garcia 2001; Jackson et al. 2000), some studies of Hispanic communities reveal a beneficial effect on selected outcomes – what some refer to as the *barrio* benefit (Eschbach et al. 2004; Lee and Ferraro 2007).

Fourth, more studies are integrating information on medical care use over the life course in studies of health. This type of research is clarifying the processes leading to and consequences of primary care (e.g., Decker et al. 2009) and hospitalization (e.g., Ferraro and Shippee 2008).

Health inequality is substantial in many modern societies. Although we can appreciate the progress made to understand the extent and sources of SES and ethnic health inequality, we need to turn to investigating the exposures and available resources over the life course in order to break the chains of risk that generate the inequalities.

Cumulative Inequality in Health

The inequalities discussed in this chapter have stimulated research on how to capture the many insults experienced by persons over the life course. In this regard, theories of cumulative disadvantage (Dannefer 2003; O'Rand 1996) have garnered considerable interest for understanding these life course processes. More recently, cumulative inequality theory has been advanced as a middle-range theory for the study of health and aging (Ferraro and Shippee 2009), integrating elements from cumulative disadvantage, life course (Elder 1998), and stress process theories (Pearlin 1989). Pertinent to this chapter, two elements of the cumulative inequality theory are especially relevant: (a) life course trajectories are shaped by the accumulation of risk, available resources, and human agency and (b) trajectories are affected by the onset, duration, and magnitude of exposures (Ferraro et al. 2009).

As has become clear in this chapter, the literature on health and aging is moving beyond point estimates of exposures to risks and resources to measuring the onset, duration, and magnitude of such exposures. Many scholars use the term "accumulation," but there is precious little specificity in the use of the term. In its simplest form, cumulative exposure often refers to a sum of exposures. Scholars routinely add together events or experiences, and this is a very meaningful first step. Nevertheless, there are alternative ways of conceptualizing and measuring accumulation.

To illustrate different forms of accumulation, consider previous research on the link between childhood adversity and health. If the aim is to study the health consequences of multiple adversities, there are many ways to specify the multiple adversities in analytic models. Figure 29.1 presents four heuristic models for the accumulation of such adversity.

First, some scholars examine the unique effects of given adversities on adult health, addressing questions such as whether material adversity (family poverty) is more or less consequential than insults related to family organization (Kuh et al. 2002). I refer to this as the *unique adversities* approach, depicted in Fig. 29.1 as Model 1. The letters A through K represent separate adverse events or experiences such as parent death or family poverty.

Other investigators conceptualize the effects of childhood adversity as a dose–response function, what I refer to as *additive adversity* (Model 2). They often do this by adding adversities into an overall measure of cumulative adversity, arguing that there is a need to study joint or *cumulative* effects of the adversity (Felitti 2002; Turner and Lloyd 1995). One might also test polynomial forms of this variable to capture nonlinearities in the relationship between childhood adversity and adult health.

Third, still other scholars conceive of clusters of adversity, whereby some adversities tend to co-occur with others (O'Rand & Hamil-Luker 2005). *Adversity clustering* is depicted in Model 3.

Finally, it is possible that some early adversities may be endogenous to other adversities, even during childhood. Such a conception of *pathway adversity* specifies that selected adversities heighten the risk of other adversities or experiences (Model 4 in Fig. 29.1). For an example of Model 4, early adversity may increase the risk of smoking initiation in adolescence (Anda et al. 1999), which may lead to other adversities.

The four models outlined in Fig. 29.1 are a sample of the ways in which previous investigators have used extant measures of adversity or disadvantaged status. One can readily specify additional models such as those that combine one or more elements of these four.

In thinking of how to better study accumulation processes, there are also some phenomena that have received little or no attention in prior studies of health. I contend that we need better measures of some of our familiar concepts as well as new measures to effectively analyze cumulative inequality in health. At a minimum, it may be useful to consider two dimensions of accumulation that merit greater attention: (1) temporal and (2) perceptual.

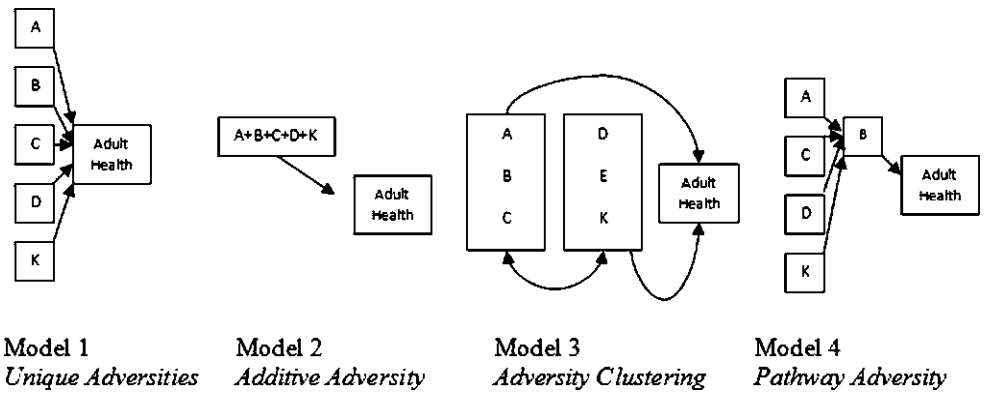

Fig. 29.1 Heuristic models for the accumulation of adversity

First, in studies of SES and health, we all too often resort to a single measure such as education at a given time. In studies of the link between religion and health, the predominant approach is measuring a religious phenomenon at a single point in time. In order to advance the science of the social antecedents of health, we will need more than a single slice in time to adequately capture exposure to risks or resources (Berkman 2009). Ideally, we want to know something about the onset of the exposure and its duration as well as interruptions. Did the accumulation begin during a critical period in the life course? The timing of accumulation matters, a fact easily illustrated with investment practices (i.e., contrast the consequences of investing the same amount of money but on two different time schedules). We are only beginning to see studies capture life course information on exposures and how they affect health outcomes (Schafer and Ferraro 2007; Willson et al. 2007), but they are needed to advance our understanding of health and aging.

Second, a good portion of the literature on cumulative inequality gives little attention to how the actor perceives his or her trajectory in a given life domain. Although the terms *adversity* and *disadvantage* are often used as synonyms, I draw a distinction between the two. Adversity refers to specific events that are perceived to be unfortunate or undesired, but disadvantage relates to a condition – a structural position – in some type of social hierarchy.

Cumulative advantage/disadvantage theory emphasizes the structural positions, but cumulative inequality theory emphasizes the dialectic between the structural positions and the actor's perception of experiences associated with these positions (Schafer et al. 2009). Not all positions, such as limited education, are regarded as a form of adversity. An actor may favorably judge what many consider to be an unfavorable position or vice versa.

Beyond a single judgment of a position, event, or experience, there also is the actor's evaluation of the accumulation of such experiences. Actors seek to make sense of their lived experiences. Thus, scientists may have a better understanding of why certain exposures do or do not have an anticipated effect by asking respondents about their experiences. As an exemplar for this type of research, Surtees and Wainwright (2007) asked respondents to assess the impact of various experiences on their lives. Life course epidemiology would benefit from tapping the actor's perceptions and definitions of life situations rather than presume what is in the actor's worldview. More generally, one could say that there is a subjective life course that needs to be considered in the study of aging and health.

In conclusion, the systematic study of accumulation is an important frontier in research on health and aging. If we can identify the accumulation processes related to health, we are better positioned to prevent disease, disability, and premature death. Moreover, as sociologists increasingly incorporate biomeasures into their analyses, earlier detection of health inequality should be beneficial to health for persons of all ages.

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Chapter 30
Mental Health and Aging: A Life-Course Perspective

David Mechanic and Donna D. McAlpine

Much written about aging focuses on the problems and challenges faced by elderly people. However, aging is a lifelong process in which physical, psychological, and social capacities and resources are acquired and modified. Understanding psychological function and mental health in later life requires a life-course perspective that takes account of biological predispositions, socioeconomic status (SES) and environmental exposures, changing social conditions, and interpersonal networks (George 1999).

Such a life-course perspective highlights that one's mental well-being at any particular part of life is shaped by earlier experiences, the historical period in which one lives, and the social context. One of the most remarkable changes in how we have come to think of aging and health over the past 30 years has been the distinction between aging as a biosocial process and disease occurrence. While it is obvious that ill health accumulates over the life course, and that the prevalence of chronic disease and serious comorbidities are found more commonly with advancing age, the link of later stages of the life course to disease and loss of function is hardly inevitable and many people live their lives free of serious morbidity well into old age. The relative role of predisposition and experience in establishing these patterns remains uncertain although we increasingly recognize that biological predisposition is itself shaped in interaction with the environment from fetal development and early life.

Research Perspective

In the field of mental health, much of the research on the determinants of health has been aimed at trying to identify the life experiences that account for later well-being. By mid-life, there is already extraordinary heterogeneity of capacity and function among persons in the same age cohort reflecting the cumulative influence of life experiences as they interact with biological endowments and as they come to vary among persons of different socioeconomic circumstances, race, ethnic and religious background, and the influence of the particular historical and contextual experiences of their age cohort. Even such factors as changing rates of marriage and fertility and the changing size of particular age cohorts set the stage for the types of opportunities and constraints people experience as they age. Thus, any serious examination of the sociology of aging must take account of the heterogeneity of experience and outcomes, a type of understanding very much enhanced by a life-course perspective. The appeal of life-course theory is tempered by the difficulty of fully applying

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it in empirical research. As Crosnoe and Elder (2002:309) have noted, "Studying the aging process as multifaceted and embedded in the life course is a demanding enterprise that requires long-term longitudinal data on multiple contexts. Except for some pioneering longitudinal studies, few data sets can meet such requirements."

Carrying out single studies of the life course is almost impossible although there have been some studies that cover much of the life span of selected cohorts with repeated measures over many years. While we have benefitted greatly from such studies, they are limited by the selectivity of the populations and the sample attrition that occurs over the years. Also, with new knowledge and theory, often the measures that we become interested in over time are quite different from those that were initially seen as most important, and the older measures themselves often are deficient from the perspective of current measurement standards. Thus, life-course studies, in reality, represent more a perspective and way of looking at human development than a particular type of study methodology. Using a life-course perspective makes possible synthetic approaches that combine data from varying ages, cohorts, and historical periods that illuminate our understanding of the variety of human experience.

Serious consideration of aging in a social context must substantially deal with issues of values and preferences and the cultural systems within which people function. Examples include attitudes toward household composition, work and retirement, personal independence, obligations to give and receive support and assistance among kin, and many related issues. These cultural attitudes are affected, as well, by such broader social patterns as geographic mobility within families, the role of gender in family caregiving, the increased employment of women, and changing educational preparation and economic capacities. For example, as persons enter older ages, becoming frailer and losing spouses and friends, they often have more need for assistance and social support than is available to them. Such persons might reasonably benefit from home sharing arrangements with relatives or other elderly persons in comparable situations. Yet increased economic independence allows many elders to retain single-person households which they prefer to protect their sense of independence or to avoid placing burdens on family members or friends. Thus, acting out one's values and preferences, and the opportunity to do so, may not provide the optimal social context for dealing with increased frailty.

One of the most challenging problems confronting life-course research is untangling the effects of age, cohort, and period when studying various health outcomes. Age refers to the period of time lived while cohort refers to the unique experiences of persons who share the same age at a particular point of time. Period refers to the historical period in which the person lives. Persons who make up a defined cohort, such as those born in a particular year, are exposed to the same historical events (period effects), but other age cohorts are, as well, and the influence of an environmental event will impact cohorts of various ages differently. Thus, period effects are aggregated among diverse cohorts that experience the event. Since the concepts of age, cohort, and period are interrelated, it is virtually impossible to assess the effects of each separately and independent of the others. This presents significant challenges to interpreting the prevalence of various mental disorders or the relative influence of risk factors over the life course.

Age and Risk of Mental Disorder

Definitions of mental disorder in the United States are based on the clinical criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association (current version DSM-IV-TR) (American Psychiatric Association 2000). The DSM categorizes disorders on a number of different axes, with Axis I describing common clinical disorders such as depression and anxiety, and Axis II describing personality disorders and mental retardation (although the next version of the DSM may drop this distinction). The DSM is

symptom based. For example, in DSM-IV, the diagnosis of major depression is based on patients having five symptoms that are present during the same 2-week period and reflect a change in prior function. At least, one of the symptoms must be either depressed mood or loss of interest or pleasure, but the remaining four may be any of seven others listed. Thus, the symptoms are largely treated as interchangeable although they vary from such symptoms as insomnia nearly every day, weight gain or loss not connected to a diet, fatigue or loss of energy every day as compared to a suicide attempt or a specific plan for committing suicide or psychomotor agitation or retardation nearly every day observable to others.

Early Onset Affecting the Life Course: Childhood and Adolescence

The DSM includes a specific category of disorders that typically have first onset in childhood and adolescence such as pervasive developmental disorders, which includes autism. The clinical definition of autism requires, for example, that onset is before the age of three. However, for the most part, the DSM is relatively indifferent to age. That is, the DSM is based on the assumption that the presentation of symptoms is similar across the life course, and that the essential features of the disorders are the same regardless of whether they are experienced in early or later life. This assumption has been largely untested in research and belies evidence that the presentation of symptoms of many disorders does vary over the life course and may be quite different for older compared to younger adults (Jeste et al. 2005).

The best estimates of the prevalence of various disorders across the life course come from community studies. Characteristics of treated samples may be systematically different in terms of demographics, health status, and help-seeking behavior than the majority of persons with a mental health problem who are not treated. While there are a number of nationally representative community mental health studies of the adult population in the United States, there are no comparable studies of childhood or adolescence.

Estimates of the prevalence of disorder in childhood and adolescence vary widely across samples and the measures employed. Autism is a good example of the difficulty in drawing any firm conclusions about the prevalence of mental illness and points to the importance of understanding the social construction of disorder. The Centers for Disease Control and Prevention (CDC) recently estimated that about one in 110 children has an autism spectrum disorder (ASD) (CDC 2009). These and similar high estimates of the prevalence of autism have supported the popular perceptions that rates have increased, and have generated considerable research and speculation in the popular media about the probable causes; the most controversial and highly unlikely causes involve the link with childhood vaccines. Despite the attention that the "autism epidemic" has received, there continues to be serious debate about whether the rates of autism have really increased. Indeed, there is some evidence that findings in support of increasing prevalence result from expanding the scope of behaviors that constitute autism, increased awareness of the disorder, or changes in diagnostic practices (Nassar et al. 2009; Rutter 2009). There is considerable evidence, for example, that cases previously diagnosed as mental retardation are now commonly diagnosed as ASD. There have been even more intense debates over estimates of the prevalence of attention deficit/hyperactivity disorder (Mayes et al. 2008).

Despite serious questions about the validity of DSM criteria for many mental disorders, a number of small community studies of children and adolescents have used these criteria to estimate the prevalence of disorder in children as young as preschool age. Estimates of disorder vary widely, but anxiety and conduct disorders appear to be the most common disorders among children age five through 17 years of age (Costello et al. 2005), with overall about 1 in 8 experiencing serious emotional disturbance. Egger and Angold (2006) argue that rate of serious emotional disorder among preschoolers (12.1%) is quite similar to that observed for adolescents.

Later Onsets

Risk for common disorders, such as depression and anxiety, and severe mental illnesses, such as schizophrenia, increase from childhood to adolescence into young adulthood, but patterns of risk over the course of adulthood are not well understood. Probably, the clearest evidence for an effect of aging on risk of mental disorders concerns cognitive impairment and other dementias, including Alzheimer's disease, where aging is associated with greater risk. The most recent national data on the prevalence of dementia in the United States suggest that dementia among persons over 70 is about 14%, while the prevalence of Alzheimer's disease is about 9.7% (Plassman et al. 2007). The rates increase with age; for example, almost 37% of the population over the age of 90 years meet the criteria for dementia (Plassman et al. 2007). Cognitive impairment without dementia is more prevalent, affecting about 22% of persons over the age of 70 and 39% of those over the age of 90 (Plassman et al. 2008). It is widely accepted that the aging process contributes to the increased prevalence of cognitive impairment and dementias.

The effect of aging on risk for other types of mental disorders is less clear. The most recent community data in the United States come from the National Comorbidity Survey Replication (NCS-R) and indicate that the 12-month prevalence of common mental disorders is about 32% for the total adult population, but only 16% for persons age 60 years and older (National Comorbidity Study Replication 2007).

The most commonly studied mental disorder in later life is depression because it is prevalent, disabling, often co-occurs with other important chronic diseases of the elderly, and because of the persistent belief among clinicians that depression is especially under-recognized and under-treated in elderly populations. Geriatricians and primary care physicians see many very elderly patients with complex comorbidities and it is hardly surprising that they see much depression as well. Community studies, however, do not bear out the perceptions of clinicians. Estimates from NCS-R, for example, suggest that 1-month, 12-month, and lifetime prevalence measured cross-sectional are lower among older persons compared to younger persons (Kessler et al. 2010).

Schizophrenia is also commonly studied; although the prevalence is much lower than more common disorders such as depression, the associated disability is substantial and commonly chronic. There are few national community studies that examine aging and schizophrenia, and there is much legitimate skepticism of estimates of schizophrenia using interview schedules in community studies. The Epidemiological Catchment Area (ECA) study estimated the overall prevalence rates of schizophrenia for 1 year and lifetime for the population as 1 and 1.5%. Comparable estimates for the population 65 and older were 0.2 and 0.3% (Keith et al. 1991).

Conceptual Issues in Interpreting Aging and Risk

The fact that lifetime prevalence of many common mental disorders appears to be lower for older adults compared to younger adults suggests that there may be important cohort differences. Some studies suggest that recent cohorts of younger persons have increased risk for disorder (Kessler et al. 2005). If correct, we would expect that in future decades the prevalence of mental disorder among older persons will be higher than it is today.

Conceptual and methodological issues make it difficult to draw firm conclusions about the association between aging and risk of disorder or to separate out age from cohort effects. First, it is not clear that the nosological categories and diagnostic criteria used in population surveys apply equally well to persons at older ages and particularly to the old-old. In addition, the low prevalence rates of mental illness at older ages may be a result of problems in memory and other distortions. Using ECA data, investigators examined the test–retest reliability of retrospective symptom reports

of depression. They found that approximately 40% of those who reported a lifetime history of depressed mood in 1981 did not report such a history when re-interviewed in 1994 (Thompson et al. 2004). There are various interpretations of such low concordance over time including the fact that respondents who are not depressed at time of interview are less likely to recall a previous episode. In any case, there is limited value in lifetime estimates using retrospective reports from persons in varying age groups.

There are a variety of other interpretations of the lower prevalence rates in the elderly. Persons with serious mental illness have significantly reduced longevity than others in the population and selective mortality obviously affects morbidity observed in the later years. Also, studies that focus on the mental health of the elderly tend to be small and nonrepresentative or have limited and/or inadequate measures. Further, population studies of mental illness typically exclude persons in residential facilities such as nursing homes who are disproportionately old, poor, and disabled. Such persons often have secondary diagnoses of depression although the validity of these diagnoses is not rigorously assessed (Mechanic and McAlpine 2000).

Many studies have focused on the prevalence of psychological distress or depressive symptoms in contrast to clinical depression. Mirowsky and Ross (1999) combined the data from three national surveys and one state survey in Illinois that asked respondents how many days per week they were depressed. The measure used represents general well-being or distress rather than clinical disorder. These data cover some 18,450 respondents and while each survey has somewhat different results they show a comparable pattern. They find an approximation of a U-shaped curve with a relatively high average of depressed days among the age group 18–22 that falls to its lowest levels in the middle years, around ages 40–60. At the end of the middle years, reports of depressed days begin rising and continues with increasing age reaching its highest levels in the age group 88–99.

The matter of the true association between aging and psychological distress or well-being is by no means settled. In an analysis of data from over 70 countries and multiple years which allows for looking at cohort and aging effects, Blanchflower and Oswald (2008) demonstrate an opposite U-shape pattern to that observed by Mirowsky and Ross. They report that happiness, life satisfaction, and psychological well-being are at minimum in middle age; they also find some evidence of a cohort difference in the U.S. data, with later cohorts reporting less happiness than earlier cohorts.

Risk of mental disorder across the life course is associated with social stratification – most importantly gender and social class. Women have a lower lifetime risk of impulse control and substance-related disorders and a higher risk for anxiety and depression (Kessler et al. 2005). It is unclear whether gender differences in the prevalence of specific types of disorders reflect differences in genetic vulnerability, exposure to risk factors, the availability of protective resources, or represent functionally equivalent ways of expressing psychological distress.

SES – commonly measured as education, occupational attainment, and income – is negatively associated with many measures of health, including psychological health, although the direction of the associations varies by type of disorder in the case of major mental illnesses (Muntaner et al. 2004). Low SES appears to have a causal role in depression. In contrast, schizophrenia results in downward social mobility or failure to keep up with peers (Dohrenwend et al. 1992). Understanding the casual mechanisms that link social position to health requires examining the timing of first onset and subsequent changes in SES position.

A Life-Course Perspective

Epidemiological research on the prevalence of various mental disorders for persons of different ages, and from different social statuses, is intriguing and important to our understanding of well-being over the life course. While a considerable amount of research has been devoted to trying to

explain the observed patterns, much of this work is cross-sectional and does not really take an explicit life-course approach. However, the principles of life-course theory offer a useful organizing framework for synthesizing this research. The core principles of life-course theory include the importance of (1) developmental transitions, (2) one's location in time and place, (3) human agency played out in the context of social structure, and (4) the concept of linked lives or the interdependence of individuals enmeshed in social networks (Elder 2000). These principles help us interpret observed epidemiological patterns of prevalence and risk.

Developmental Perspective

An essential feature of life-course theory is its emphasis on the timing of events or transitions in life for understanding later trajectories or outcomes. Simply put, "the developmental impact of a succession of life transitions or events is contingent on when they occur in a person's life" (Elder 1998:3). There are critical periods for certain developmental and social maturation phases but firm evidence is stronger in the biological than social areas. For some neurobiological functions there seem to be narrow early stimulative periods required for the system to function, such as the visual cortex (Cynader and Frost 1999). Similar arguments have been made for language acquisition and facility, attachment, and other psychosocial development processes but it is more contested as to whether critical periods exist in the same sense. Nevertheless, there is much evidence that early stimulation and experience help shape subsequent social and biodevelopmental outcomes. Increasingly, we learn that genes themselves are activated or modified by early environmental exposures.

Research indicates that the conditions of prenatal and early life, the nutritional history of the mother, and early growth and development are associated with chronic disease and mortality in middle and later life (Mechanic 2007). Although this work has focused for the most part on cardiovascular disease and diabetes, studies of early nutritional deprivation in famines have also found links with neurodevelopment and more specifically with schizophrenia (St. Clair et al. 2005; Susser et al. 1998). These pathways to causation are very complex and associated with SES. Low SES parents are more likely to have children of low birth weight and who have nutritional deficiencies, and these children have lower levels of educational and occupational attainment (Barker et al. 2001). There is also growing evidence that these influences are intergenerational in that the health status of grandmothers influences the subsequent health status of their children and grandchildren (Mechanic 2007). These outcomes are shaped by both family SES and nutritional deficiencies and their interactions. But they are then further moderated by the levels of education attained and associated factors. Thus, the story, like much else, involves complex and continuing interactions between biology and environment. Poverty itself is not a static state. Families and children move in and out of poverty over time as personal circumstance, economic conditions, and social policies change. Children exposed to more persistent lives of poverty do less well on cognitive and health indicators.

Timing is critical in many developmental and social processes. Three issues of timing are particularly important for understanding mental health across the life course: the timing of first onset of disorder, the timing of events that increase risk of disorder, and the timing of development of personal resources that affect adjustment to the disorder.

Timing of first onset of disorder: Most psychiatric disorders begin relatively early in the lifespan, typically around late adolescence and early adulthood but may not be recognized and treated without long delays. Even after initial recognition of symptoms, delays of 10 years or more are common before people receive any formal assistance for their mental health problems (Wang et al. 2005). However, many early symptoms of disorder are self-limited and resolve themselves without interventions. Much depends on the nature of the problem, the persistence of aggravating

circumstances, and the evolving life circumstances of the individual including neglect and abuse, poverty and deprivation, disruption of stable living conditions and social networks, and the like. Biological propensities interact with environmental exposures in ways that make individuals more or less susceptible to later risk of disorder or exacerbation of symptoms. Some disorders are substantially shaped by early biological incapacities that then carry through the entire lifespan such as mental retardation or autism. Others such as schizophrenia usually first become evident in late adolescence and early adulthood with the course of the disorder depending on intrinsic biological factors and environmental exposures, still poorly understood. Serious conduct disorder among children which disproportionately occurs in deprived SES contexts, while socially shaped to a considerable degree, tends to be associated with a negative trajectory involving cumulative failures and troubles that persist over the life course (Robins 1966, 1983).

Evidence of the importance of timing of first onset of mental illness on later outcomes comes from community studies that ask respondents to recall their first experience of serious symptoms of disorders such as depression. This research suggests that early onset of some disorders, particularly externalizing behaviors, is associated with many later life problems (Breslau et al. 2008).

Stronger evidence comes from cohort studies that follow persons over considerable lengths of time. There have been many studies of the outcomes of conduct disorder in children and adolescents beginning with the classic studies of Robins (1966). A more recent report based on the British 1946 birth cohort (children in the United Kingdom born during 1 week in March) and followed for 40 years is indicative of findings more generally (Colman et al. 2009). In this study, 3,652 children were assessed by their teachers for symptoms of externalizing disorders (disobedience, truancy, lying, etc.) at ages 13 and 15. Those characterized as having severe externalizing problems at baseline were significantly more likely to be male, to come from lower social class families, to have poorer cognitive abilities at age 8, and more depression and anxiety at ages 13 and 15. They were likely to become parents before age 20, had one or more divorces, were unhappy with their family lives, reported problems in relationship to others, lacked educational qualifications, had low status manual jobs, had financial difficulties, and high life adversity (Colman et al. 2009). They had more difficult lives as measured by outcomes at ages 36, 43, and 53. Those with severe externalizing problems as adolescents were also more likely to report symptoms of depression/anxiety or a history of nervous problems 40 years later.

Using the same survey, Colman et al. (2007) have also examined outcomes for children who showed evidence of internalizing disorders (fearful, timid, anxious, sad, etc.) at age 13 or 15. They found that while a single episode of problems (at age 13 or 15) in adolescence was not associated with poor mental health outcomes into adulthood and middle age, persistent problems during adolescence predicted more negative outcomes. However, other studies have found that internalizing symptoms early in life are much less damaging in adulthood than externalizing problems (Robins 1983).

We know too little about outcomes for persons with mental illness as they enter older age, although some studies of persons with severe mental illness such as schizophrenia paint a much more optimistic picture than one might suspect given the disability associated with disorders such as schizophrenia and clinical impressions. There are a number of long-term longitudinal studies of patients with schizophrenia that found that in later life the highly disturbing positive symptoms of schizophrenia (e.g., delusions and hallucinations) abate and that these patients are able to adapt to community life but at relatively modest levels of function and quality of life (Mechanic 2008:30–31). Cohen et al. (2009), for example, measured a wide variety of outcomes from recovery through community integration for persons over the age of 55 with schizophrenia. They report that about 17% of persons with schizophrenia had recovered and almost 50% had achieved symptom remission after the age of 55. However, outcomes related to community integration and successful aging (defined as absence of disease and disability, high cognitive and physical functioning, and engagement with family and friends and feeling useful to others) were less positive. Overall this literature contradicts the impression of schizophrenia following an inevitable downward course.

Timing of events and risk of mental disorder: A developmental perspective also calls attention to the importance of the timing of events in the life course that may increase risk of mental disorder. There is a substantial body of research that shows that stressful life events and chronic strains are associated with psychological health during all stages of life (Pearlin et al. 2005), with much of the research focusing on depression or psychological distress. Moreover, exposure to social stressors is not random; for example, women and persons from lower SES statuses are more likely to experience stressful events compared to men and individuals who are more advantaged (Turner et al. 1995). However, few researchers have taken a truly life-course perspective and tried to understand how the timing of events during the life cycle shapes later life transitions and trajectories and ultimately mental health outcomes (Pearlin et al. 2005).

The most intensive and sustained research program on the role of stress has been the work of George Brown, Tirril Harris, and their co-workers in the United Kingdom and collaborators in several other countries (Brown and Harris 1978, 1989; Harris et al. 1987). These investigators, in contrast to many epidemiological survey investigators, use a very intensive interview instrument to obtain rich data. Reported symptoms, life events, difficulties, and other measures are then derived using independent ratings that may be different from the subjective reports provided by the respondent. The purpose of these independent measures is to assess meaning of experiences without the biases characteristic of respondents' ratings of their experience. The model Brown and Harris present conceptualizes stressful life events as provoking agents, and one of their early findings that highlight the importance of life-course work was that early loss of a mother was associated with depression in adulthood. They found that such loss is associated with lack of adequate care, which contributed to a trajectory of premarital pregnancy, less effective coping, and often early and unsuitable marriages (Bifulco et al. 1987; Harris et al. 1987). Although these patterns occur more commonly in the lower classes, the investigators distinguish among the circumstances of lower class families that more or less contribute to depression. The larger theoretical frame characteristic of life-course analysis assumes that life experience at any point derives in important ways from earlier influences and choices that either open or constrain subsequent opportunities. Choices made about schooling, jobs, marriage, childbearing, divorce, retirement and much more, and their timing, establish the conditions for subsequent transitions (Brown 1986).

In addition to loss of a parent, other childhood adversities and traumas have also been shown to be associated with mental health much later in life. Horwitz et al. (2001) compare mental health outcomes in adulthood among persons who had been documented to have suffered sexual abuse, physical abuse, or neglect before the age of 11 with a matched sample who did not experience such abuse. Men and women who had been abused were more likely than the comparison group to have dysthymia and antisocial personality disorder 20 years later and women were also more likely to have alcohol use problems.

The effects of early life adversities extend into later life, but the pathways from childhood abuse to disorder much later in life are not clear. Horwitz et al. (2001) find that individuals who were abused or neglected as children also report more lifetime stressful events such as job loss, financial problems, and marital troubles and that accounting for these events reduces the association between childhood abuse and lifetime prevalence of mental disorder to nonsignificance. Similarly, Brown et al. (2008) argue that maltreatment in childhood is linked to depression in adulthood when it is associated with the greater exposure and vulnerability to severe life events more proximate to onset of depression.

Life-course theory also suggests that the timing of specific events is important for later development. For example, studies of men who joined the military service during World War II in their thirties had more negative outcomes into old age than men who joined the services earlier. Men who joined the service early in their life trajectories suffered less life disruption and related costs (MacLean and Elder 2007).

Timing of development of personal resources: Resources developed earlier in life also affect individuals' adjustment to patienthood and the subsequent course of disorder. When disruptions in educational acquisition, occupational advancement, family formation, childbearing, and many other important functions occur, they significantly shape subsequent outcomes and their impact. The occurrence of a serious mental illness well prior to full educational attainment vastly limits the life-course post illness as compared with its occurring after significant educational and occupational achievement. Although gaining employment is one of the largest problems faced by persons who have had serious mental illnesses, having higher educational attainment is one of the best predictors of workforce participation (Mechanic et al. 2002). It should be noted, however, that factors such as the manifestations and severity of the disorder may affect both educational attainment and subsequent occupational success and this is difficult to account for adequately in studies.

There are many contingencies that moderate outcomes. Whether a person with mental impairments can find work depends substantially on the labor market where toleration of impairment depends on the alternative workers available. Similarly, even late entrants who were generally disadvantaged by service in the armed services who had the prerequisite skills and who served as officers had opportunities for leadership and further skill acquisition that served them well when they returned to civilian life (Dechter and Elder 2004; MacLean and Elder 2007). Also, of course, the provisions that society makes for returning veterans such as the GI Bill significantly shapes future opportunities and trajectories.

The Importance of Historical Times

Life-course theory draws our attention to the fact that how we live out our lives is substantially affected by the time and place. For example, the life experience of persons currently over the age of 65 is quite different from their counterparts a decade or two ago. Demographic trends in marriage, education, mobility, fertility, labor markets, and the like shape individuals' experiences, life chances, and opportunities. Cultural changes in norms and attitudes, for example those related to the role of women or the meaning of race and ethnicity, affect the choices we can make about essential features of daily life. Other changes in health and disability policies and health technology mean that each cohort will confront different understandings of what constitutes illness and face different consequences of illness. It is not surprising, therefore, that the experience of mental health or illness may be quite different for older persons now than it was in the past, and we can expect it to be even more different for future cohorts of older persons.

One of the most dramatic changes observed in the past several decades in mental health policy was the rapid deinstitutionalization of the mentally ill whereby the number of persons in long-term public mental hospitals dropped from over 500,000 in the mid-1950s to less than 60,000 today (Grob 2008; Mechanic 2008). The promise of community care was never realized. As Grob (2008:98) explains, "The ideology of community mental health and the facile assumption that residence in the community would promote adjustment and integration was illusory and did not take into account the extent of social isolation, exposure to victimization, inducement to substance abuse, homelessness, and criminalization of persons with mental disorders." The failure of community care means that many persons with severe mental illnesses who once would have resided in mental institutions may now go through extended periods of time without treatment, have repeated admissions in short-stay hospitals and periods of homelessness, victimization, arrest, imprisonment, and social isolation – experiences that will shape the trajectories of their later lives. Others have benefitted from changes by avoiding the dysfunctions and disabilities associated with long-term institutional care (Mechanic 2008).

Changes in long-term care policies also shape the chances that individuals will stay in the community as they age or whether they live in nursing homes and other institutional settings. In the United States, most public care comes through the Medicaid program for persons who meet eligibility criteria based on disability and inadequate resources or who spend down their resources to attain eligibility. Medicaid has thus been the de facto American long-term care public system. There has been great reluctance on the part of the public sector to take on responsibilities commonly associated with informal care but rather to function more as backup when the informal sector can cope no longer. Although nursing homes remain the largest component of Medicaid long-term care, many states have made efforts to provide community-based long-term care services to persons who could meet the threshold for nursing home admission. In recent years, we have seen more assisted care communities, home care, and foster care arrangements for persons who previously had no alternative to nursing home admission.

Despite increases in the proportion of persons over the age of 65 and in life expectancy, the demand for nursing homes has declined (Manton 2003). The reduction in demand for residential care may be partially accounted for by the fact that successive cohorts attaining particular ages report less disability than previous cohorts at comparable ages. One view is that improved economic and social circumstances over the life course have allowed the delay of disability closer to the end of life (Manton 2003). More microanalysis suggests, however, that most of the gains in disability status have been in the realm of instrumental activities such as using the telephone, paying bills, shopping, and food preparation and less in activities of daily life such as bathing and physical mobility (Freedman et al. 2002). The ability to engage in instrumental activities of daily life has been much facilitated by new technologies and new products that make life easier for persons with increasing fragility. These include communication media such as the internet, technologies with voice commands, instruments offering enhanced visibility, delivery services for prepared meals, home banking, and much more. Mobility has also been enhanced by changing attitudes and laws and environmental modifications that make public places and public transportation more available for persons with impairments. Changes over time in the degree of disability associated with various conditions mean that each historical period brings differences in the chances of people being able to maintain their independence and continue to live in the community as they age.

Historical period also substantially shapes the chances that persons with mental illness in the community will receive care and the type of care received. Over the past few decades, the proportion of persons with a mental illness who receive some treatment has increased (Wang et al. 2005). But there have continued to be substantial barriers to care for older persons, including financial disincentives to seeking care. Medicare, the dominant insurance plan for persons over the age of 65 in the United States, has not covered psychiatric care to the same extent it covered general medical care. However, with the passage of The Medicare Improvements for Patients and Providers Act of 2008, over time coverage for outpatient care for psychiatric illness will achieve parity with care for physical problems. Thus, future cohorts of older persons with mental illness may face fewer barriers than the current cohort.

At the same time, historical period shapes the types of diagnoses received. For example, there has been a rapid increase in diagnosis of bipolar disorder for young children, with little evidence of an actual increase in prevalence and continued debate about whether bipolar disorder exists in children (Duffy 2007). Similarly, disorders once thought to be primary problems of childhood have expanded into adulthood as shown by the increasing numbers of adults receiving diagnoses of ADHD (Conrad and Potter 2000). Fundamental conceptualizations of mental health and illness are the product of time and place. With each revision of the DSM, the number of diagnoses has grown from 106 in DSM-I to 297 in DSM-IV (Mayes and Horwitz 2005).

In its efforts to gain greater precision and reliability, DSM moved to a diagnostic system substantially based on symptom checklists in which clinical diagnoses were determined when patients met specified symptomatic criteria. Using the case of depression, Horwitz and Wakefield (2007) note that throughout centuries depressive symptoms have typically been evaluated in relation to patients'

social contexts and life events. But the DSM, in seeking greater reliability, has neglected social context, resulting in defining many patients as having major depression when they are responding in normally expected ways to noxious life events. While the DSM makes exception for bereavement, Horwitz and Wakefield (2007) argue that other life circumstances are comparable and that distress reactions to such circumstances are "normal sadness." By "normal" they mean that persons' affective systems respond as programmed by evolution. They accept that such patients could benefit from help but argue that they are not clinically disordered. They estimate that about a quarter of such diagnoses represent over extensions of a true concept of major depressive disorder (Wakefield et al. 2007).

These debates have important relevance for depression in the elderly because such distress is often manifested in ways different than among younger persons and is commonly linked to physical comorbidities, greater use of medications, loss of physical function, loss of loved ones, and erosion of social networks. Moreover, depression in the elderly, more than among the young, is expressed in physical as compared with psychological complaints and the elderly have greater reluctance to seek and accept specialty mental health services. Definition of what is or is not "disorder" according to the DSM shape what patient and providers attend to, what is or is not covered by health plans, and access to disability programs.

Human Agency and Social Structure

Awful things happen to people not of their own doing; not infrequently they result from social and historical circumstances that expose persons to significant trauma. These include early loss of parents, physical abuse and victimization, rape and other sexual abuse, extended combat and other extreme exposures, life-threatening disease and handicap, famine and hunger, and extreme economic adversity. We know that such traumas increase risk of mental health problems even years after the occurrence of the trauma. But negative consequences are not inevitable. Depending on what people bring to these situations, some may gain personal strength and new capacities in coping with these adversities when they can be overcome.

People in difficult situations not infrequently have "second chances" – opportunities to reverse a negative trajectory. Second chances may occur in a variety of ways, such as developing an intimate relationship with a highly supportive other, having opportunities for educational advancement and for developing new skills, getting a new job that offers satisfactions and reinforcing experiences, or becoming part of a supportive friendship group. Studies of the military, for example, found that service in World War II was often a "second chance" for young men who had disadvantaged backgrounds or had problems with the law (MacLean and Elder 2007). Many social intervention programs have as their goal developing "second chances" for individuals who have had a difficult life trajectory, who lack confidence and self-esteem, and who aspire to a stronger sense of mastery over their life situations.

Individuals may overcome even the most severe events that happened in early life. Studies of survivors of the Holocaust, for example, show that while they continued to have elevated symptoms of psychological distress and posttraumatic distress decades later compared to their counterparts, the differences between groups were modest, and most appeared to show favorable adjustments as measured by marriage, children, and strong families in later life (Kahana et al. 2005).

Studies of Holocaust survivors, like all long-term studies of the effects of traumatic events, may exaggerate the resiliency of the people who experienced the events because the sickest or least resilient are likely to die earlier, leaving the most healthy to survive to old age. Despite this methodological problem, studies of long-term outcomes of traumatic events do show the remarkable resiliency of some people, even after experiencing extraordinary trauma. The challenge is to identify the characteristics of individuals and environments that lead to such resiliency.

Self-efficacy, or "people's assessments of their effectiveness, competence and causal agency" (Gecas 1989:292), is important to health across the life course. In the context of examining the effects of stressful life events on risk of mental disorder, a sense of control over one's life (mastery) may help individuals be active agents in confronting stressful life events to both cope with them and deliberately seek out solutions (Thoits 2006). Some studies suggest that a sense of mastery declines with age (Schieman and Turner 1998) and the experience of negative life events in late life appears to undermine levels of mastery (Pearlin et al. 2007). Moreover, past experiences also influence feelings of control during old age. Pearlin et al. (2007) hypothesize that exposure to stressors over the life course and status (both achieved such as education and ascribed such as gender and race) influences "life course mastery," or the degree that individuals feel that they had control over their life circumstances. Early hardships influence individuals' capacities to be active agents in shaping their own lives as they age.

Sociological work has long recognized that social agency is constrained by social structure, with most attention being devoted to the role of social class or its typical proxy socioeconomic status. While social class is not causative of disorder in any direct sense, it is commonly associated with many factors more proximate to the occurrence of disorder. Social class, or its SES proxies, is associated with almost every indicator of health including infant mortality, adult mortality, chronic disease prevalence, impairment and disability, and psychological distress. Families at the lowest rungs of the SES distribution, as compared with those higher in the SES hierarchy, are more likely to experience economic hardships, deprivations and household disruptions, intrafamily violence and abuse, child neglect, and disruptions in the normal course of development of their children. Children are more likely to do poorly in school, have difficulties with the law, engage in delinquency and substance abuse, leave school early, develop poorly considered and exploitative relationships, and bear children early. Children faced with these adversities have diminished life chances relative to peers from higher SES circumstances and are more likely to follow a life trajectory associated with many adversities. Of course, none of this is inevitable, and many low SES families provide their children the nurturance, encouragement, and coping skills that result in satisfying and productive lives and often high achievement. Moreover, the challenges of overcoming adversities associated with economic and social deprivations allow some to develop perspectives, motivations, and coping capacities that make for impressive success in later life.

Studies of the effect of SES on health over the life course have examined the impact of cumulative advantage or disadvantage. Early SES disadvantage in one's family of origin presages later disadvantages such as early school leaving and poor health which then are the precursors of later disadvantages. Miech and Shanahan (2000) argue that the negative relationship between lesser education and depressive symptoms is stronger in older age than before because older persons with less education have more physical health problems which contribute to depression. As people age and physical health problems become more common, the association between education and depression also strengthens, suggesting a cumulative disadvantage for those with less education over the life course.

Linked Lives

At the simplest level, the concept of "linked lives" in life-course theory recognizes that individuals are embedded in social relationships and social networks. The nature of these relationships affects many aspects of life, and not surprisingly health and well-being. Much of the research has focused on the social support function of our social ties and examined the positive effects of both emotional and instrumental aid. Feeling loved and valued and having people to count on for assistance may directly affect health, and also indirectly promote well-being by buffering the effects of negative life events (Cohen 2004).

Others have examined characteristics of social networks beyond the support they provide. Characteristics of networks can be defined by their size, density, proximity, and closeness (Berkman et al. 2000). In addition to be sources of support, social networks may affect health behaviors, coping, self-efficacy, and physiological functioning, all of which promote health. Social networks can also have negative effects through their norms and influences, the demands and obligations they promote, and the noxious behaviors they may encourage. The culture of one's networks is all important in understanding their effects.

The concept of linked lives highlights that what happens in the lives of others in an individual's social network matters for health and well-being. For example, among older persons, having a spouse hospitalized increases risk of mortality in the surviving spouse (Christakis and Allison 2006). Moreover, risk of mortality is highest for persons whose spouse was hospitalized for a psychiatric problem or dementia. Much of the work on the interdependence of social ties and health has focused on care giving. The chances of having to assume such responsibilities are greater among women than among men, and increases risk of depressive symptoms, especially for women, those caring for a spouse, and those caring for persons with dementia (Pinquart and Sörensen 2003).

Recent studies of social contagion offer further intriguing insights into the importance of social networks for health. Christakis and Fowler (2009) have shown how health behaviors and subjective aspects of well-being, such as happiness, also spread within social networks. For example, if you have a happy friend who lives nearby, it increases the likelihood that you will be happy. Similarly, they find that loneliness (conceptualized as perceived social isolation) is contagious. The mechanisms through which subjective states spread through social networks are not clear, nor is it clear whether network effects may differ with stage of the life course. However, together this work points to the importance of linked lives for understanding health outcomes.

While early accounts of aging portrayed it as a process of increasing isolation – we now know that this holds for only a minority of persons (Cornwell et al. 2008). In a large community sample of persons 57–85 years of age in the United States, Cornwell et al. (2008) find that while the size of social networks and the diversity of ties tend to decrease with age, the frequency of connections with social ties, religious involvement, and volunteer activity increase with age. The only measure of social integration that appears weaker with age is closeness to networks. The life-course transitions associated with aging, such as death of a spouse or retirement, may challenge social integration, but Cornwell et al. suggest that older persons may adjust to these transitions by becoming more involved in community activities.

The experience of mental illness over the life course is played on in the context of family. Familial expressed emotion, or overinvolvement and criticism, is linked to increased risk of relapse for people with depression and schizophrenia (Butzlaff and Hooley 1998). The relationships within families are reciprocal and one member's health can influence the health of others. For example, among older persons, having a spouse who is depressed increases one's chances of becoming depressed (Tower and Kasl 1996). The interdependence of family members also influences caregiving roles. The responsibility for caring for a family member with a severe mental illness brings different burdens and benefits depending on the stage of the life course the illness started, and the age of the care giver (Cook et al. 1997).

Conclusions

One of the challenges of life-course research is to capture life holistically but in a way that takes advantage of rigorous social science methodology. While life narratives offer the richest context for understanding how an individual life unfolds, researchers must seek generalizations across lives. For the study of mental illness, much of the research has focused on correlates of risk. As we noted,

however, most mental illnesses occur first relatively early in life. Thus, it is difficult to untangle the precursors of first onset of disorder from the correlates of re-occurrence in research lacking data from over the life course.

Insel (2009:130) sees cardiovascular epidemiology as a useful model for understanding future approaches to mental health intervention. For heart disease, like mental illness, some precursors are already evident in the womb and in early life, and other risk factors over the life span are readily identified, but cardiovascular disease itself may not become evident until late middle and early old age. While cardiovascular understanding is much advanced beyond psychiatry, some believe that it will soon be possible to reshape the course of conditions such as schizophrenia and related psychoses (McGorry et al. 2008). One approach of increasing interest is to identify prodromal attributes that predict subsequent development of the condition (Cannon et al. 2008). For example, unusual thought content, suspicion/paranoia, perceptual anomalies, grandiosity, and disorganized communication may not reach a diagnostic threshold but may be indicative of later disorder. Success in defining appropriate measures would allow early intervention but there are also obvious dangers of false positives in prediction and the possible harm of intervention and labeling.

Very little in life is so constrained as to make different life trajectories impossible. Certainly, there are congenital and genetic factors at their extreme that close out many options, but even here, under extremely favorable conditions, better outcomes than anyone can imagine occur. Preventing the negative sequelae that often follow early disadvantage and trauma and result in mental health problems is challenging but possible. At the individual level people draw on their own strengths and capacities and make choices that may turn a negative trajectory around and prevent mental health problems. They also can draw on social networks to find aid and support. But social policy also plays a large role in enhancing mental health throughout the life course and into old age. The role of policy in a wide variety of arenas from education to housing and disability to long-term care shapes the opportunities and constraints people face as they age.

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Chapter 31
Aging with HIV/AIDS

Allen J. LeBlanc

When the first small clusters of previously healthy, young gay men began to dramatically and mysteriously fall ill in the nation's urban centers toward the end of the 1970s, few might have guessed that the United States was facing an emerging epidemic that would shake our confidence in modern medicine and revive " … fears at least as old as the medieval plagues" (Institute of Medicine 1988:1; Shilts 1987). Tragically, over the past three plus decades such an epidemic has unfolded not only in this country, but worldwide. Indeed, human immunodeficiency virus (HIV) – the virus believed to cause acquired immunodeficiency syndrome (AIDS) – has become a global pandemic, one comprised of thousands of lesser epidemics with unique epidemiologic shapes and social contexts across the world (Mann et al. 1993).

Individuals can live – knowingly or unknowingly – with HIV for long periods of time without manifesting symptoms of AIDS. In 2007, there were approximately 33 million people living with HIV worldwide. While the global *percentage* of individuals with HIV has stabilized since 2000, the overall *number* of people who are seropositive has increased due to new infections and the beneficial impact of more widely available treatments that reduce morbidity and extend life. Sixty-seven percent of the world's HIV-positive population is concentrated in Sub-Saharan Africa, where heterosexual intercourse is the epidemic's driving force, women and children – especially girls – are more heavily affected. In virtually all other regions of the world, HIV disproportionately affects men who have sex with men, injection drug users (IDUs), and sex workers. Areas of specific concern due to increasing rates of HIV infection include Indonesia, the Russian Federation, and some high-income countries. There were an estimated two million people living with HIV in North America, Western and Central Europe – as a region – in 2007. Approximately 1.2 million of those individuals were living in the United States (UNAIDS 2008).

Gross aggregate statistics such as these readily demonstrate the magnitude and reach of HIV in the world today. They also clearly portray the reality that, more and more, people across the globe and from all walks of life are living – and in greater numbers than ever before, growing old – with HIV. Older HIV populations may be emerging more slowly in developing nations where treatments are less available (UNAIDS 2008), and relevant research lags behind. For example, data on the prevalence and incidence of HIV among older persons in developing countries are presently unavailable (Schmid et al. 2009). Therefore, existing data largely concern the experiences of people in developed areas of the world. Moreover, available reports generally rely on recent data, which require continuous monitoring to identify emerging and long-term trends.

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U.S. Population Estimates: Older People with HIV

The Centers for Disease Control (CDC) has produced statistics on the numbers of Americans aged 50 and over living with HIV/AIDS since 1981. In that time, the prevalence of cases in that age group – a symbolic indicator of "aging" in the HIV context – has increased steadily, in part due to the greater overall prevalence of HIV, which is largely accounted for by the fact that infected individuals are living longer. In short, better treatment and prevention of opportunistic infections associated with HIV – in particular the introduction of highly active antiretroviral therapy (HAART) in 1996 – are extending life, and improving its quality. In addition, the incidence of HIV in this age group has also continued to rise (Simone and Appelbaum 2008).

People aged 50 and older accounted for 15% of newly diagnosed HIV/AIDS cases and 25% of all cases in the United States in 2005, reflecting a rise from 17% in 2001 (Simone and Appelbaum 2008). In addition, persons aged 40–49 comprised the largest proportion of newly diagnosed HIV/AIDS cases among Americans in 2007, illustrating that a significant portion of the HIV-positive population will shortly age into the "older" category (Centers for Disease Control and Prevention [CDC] 2009). According to data compiled in high-prevalence cities, for example New York City, it is predicted that in the next decade the majority of people with HIV in that city will be over age 50 (Karpiak et al. 2006). Moreover, it may be that current statistics underestimate the true prevalence of HIV among older adults as many physicians do not perceive them to be at risk. Consequently, they are less likely to be tested and misdiagnosis is common (Casau 2005). Indeed, the CDC recommends testing people aged 65 and older for HIV only if they have known risk factors (Lee 2009).

Describing the Older HIV-Positive Population

Until recently, efforts to describe the older HIV-positive population in the United States and elsewhere have typically been based on samples recruited through clinics, hospitals, or other HIV-related service providers. These studies offer important descriptive data on local populations; and they also help to identify specific sub-population vulnerabilities and weaknesses in the local service systems. Studies conducted in the UK and Italy are recent examples of such work (Elford et al. 2008; Orchi et al. 2008; Sherr et al. 2009). Ongoing research based in New York City is another (Karpiak et al. 2006).

Nationally representative data for the United States are available. The HIV Cost and Services Utilization Study (HCSUS) – fielded in 1996 – has produced profiles of middle-aged and older (i.e., age 50 and older) Americans with HIV (Crystal et al. 2003; Joyce et al. 2005). According to HCSUS data, this population is perhaps best understood by comparing groups based on mode of HIV transmission: men who have sex with men, a group mainly composed of "gay men"; IDUs; and "other," including individuals whose mode of transmission was heterosexual contact, blood transfusion, and cases in which the source of exposure was unknown. It was estimated that these three groups account for cases of HIV among older persons as follows: gay men (40%); IDUs (23%); and "other" (37%) (Crystal et al. 2003).

With HCSUS data, it has been estimated that: The vast majority of older gay men with HIV are white (92%). Sizeable proportions of this group have a college education (49%), worked in the paid labor force full- or part-time (38%), earned more than $25,000 per year (48%), and had some form of health insurance (92%). In comparison, older IDUs with HIV – 17% of whom are women – are relatively more disadvantaged and vulnerable. Only small proportions have a college education (7%), are employed (11%), or earn more than $25,000 per year (10%). About one-fifth lack health insurance coverage of any kind. Over half (56%) of older IDUs with HIV are African-American. Finally, the "other" category,

which contains a greater proportion of women (30%), is also predominantly African-American (64%) and of exceptionally low socioeconomic status (e.g., 14.2% with a college education, 22.3% employed, 16.7% earning more than $25,000 annually, and 17.6% uninsured) (Crystal et al. 2003).

In sum, available data illustrate that the older HIV-positive population in the United States is sociodemographically diverse, which suggests a wide range of experiences and needs. Among older adults with HIV, gay men (a predominantly white group) have greater socioeconomic status – via their higher levels of education, employment, income, and access to insurance coverage – than persons who were infected through IDU, heterosexual sex, or other means (groups that include women and greater proportions of racial/ethnic minority persons).

As a whole, the older HIV-positive population is socially and economically disadvantaged in relation to the general population aged 50–61. For example, in analyses comparing HCSUS data with Health and Retirement Survey data – a longitudinal study representative of U.S. adults born between 1931 and 1941 – it was found that regardless of gender or race/ethnicity, older adults with HIV are much less likely to be employed, have employment-based health insurance, and have far less income and assets than their non-HIV-infected counterparts. Indeed, there are significant numbers of HIV-positive individuals over the age of 50 who are incarcerated or homeless, or moving between those states (Joyce et al. 2005). Even among older HIV-positive white men who are more likely to have a college degree than older men in the general population, total household income and assets are smaller in comparison (Kushel et al. 2005).

Although these studies are relatively recent, it is important to note that the HCSUS data were collected in 1996, which was a breakthrough year in terms of HIV treatments with the introduction of HAART. Consequently, it is essential that researchers continue ongoing examinations of the changing sociodemographic profiles of HIV-infected populations in a range of geographic locales – focusing on populations ranging from local to national. In addition, such work must begin in developing countries.

HIV-Related Risk Behavior Among Older People

A growing body of research suggests that older adults do not engage in sexual and drug-related behaviors that carry risk for HIV at the same rate as younger populations. However, general population studies demonstrate that among adults aged 50 and over who do have known risk factors, only small percentages adopt safer sexual practices or undergo HIV testing (Mack and Ory 2003; Stall and Catania 1994).

Research carried out with targeted samples is beginning to illustrate unique HIV-related risks for subpopulations of midlife and older persons. For instance, data collected from mid-life and older, urban men who have sex with men shows that they engage in risky sexual and drug-related behaviors through the sixth decade of life, at high levels (Dolcini et al. 2003; Stall and Purcell 2000; Koblin et al. 2006). Research on risky substance use among gay men includes some focus on the use of sildenafil, which is intended to treat erectile dysfunction typically associated with aging (Cooperman et al. 2007). In addition, studies of mid-life and older women suggests they face risk for HIV exposure by virtue of their relationship dynamics with male partners, sexual behaviors, and substance use, although these women are particularly unlikely to perceive of themselves as at-risk (Corneille et al. 2008; Neundorfer et al. 2005; Sormanti and Shibusawa 2007). Finally, available data regarding older IDUs suggest they are significantly less likely to share needles and are less active sexually than younger IDUs (Kwiatkowski and Booth 2003). These kinds of age-based differences in HIV-related risk warrant further investigation to articulate their social and cultural determinants (cf. Schensul et al. 2003), and future research must address additional populations.

Clinical Studies

Although the focus on this chapter is on the social and psychological aspects of aging with HIV, it is important to briefly recognize the implications of aging seropositive populations for clinical research and practice. At this point in time, clinical researchers are only just beginning to identify and understand age-based differences in the manifestations of HIV disease and responses to treatment. There has historically been a disproportionate focus on younger generations when it comes to HIV because they have been at greatest risk of infection, and this focus to some extent remains. For example, older patients (and those with comorbidities) are routinely excluded from clinical trials evaluating the efficacy of emerging HIV medications, which in itself is an important reminder of how little is known about the clinical issues faced by people aging with HIV (Gebo 2009; Martin et al. 2008).

In the United States and other developed nations, there is a small, but growing clinical research literature on the prevention, diagnosis, and management of HIV/AIDS among older adults (Martin et al. 2008; Simone and Appelbaum 2008; Stoff et al. 2004). It seems there are a number of interrelated challenges regarding HIV and aging that the clinical scientific community must address. For instance, researchers are attempting to more fully characterize the ways in which the natural history and symptom manifestations of HIV infection may differ between younger and older adults. Available data suggest that, relative to their younger counterparts, older adults living with HIV tend to be diagnosed later. In addition, they may experience a more severe HIV disease course, and scientists are striving to identify the underlying mechanisms that might explain such differences. Moreover, there is also considerable focus on potential interactions among concomitant and overlapping conditions in the older population, including HIV disease, comorbid conditions (HIV-related and non-HIV-related), normal aging, age-related medical challenges, and age-related diseases (e.g., Alzheimer's disease, osteoporosis, adult-onset diabetes, cancer, and hypertension) (Stoff et al. 2004). There is also now a growing literature on the relationship between HIV, reproductive aging, and health among mid-life and older women (Conde et al. 2009).

In short, the overall profile of HIV-associated health conditions and comorbidities is changing as the HIV-positive population ages. Consequently, the fundamental clinical and clinical research challenges will continue to revolve around developing better strategies for the long-term treatment and management of HIV as a chronic condition – often a comorbid one – that can be effectively controlled in most patients as they age into later life. Data from the CDC (2007) have been used to begin the estimation of survival after a diagnosis of AIDS. For example, over 80% of individuals receiving an AIDS diagnosis in 2002 have survived more than 36 months postdiagnosis. Survival appears to decrease as age at diagnosis increases, and is lowest among IDUs, a population with relatively few socioeconomic resources (Crystal et al. 2003).

Living, and Now Aging, with HIV

Receiving an HIV diagnosis – and/or an AIDS diagnosis – is a traumatic life event that alters one's life course. For many, in particular those who were diagnosed in the first waves of the pandemic, there was little time for reflection about the future, only the anticipation of rapidly approaching illness and death. Indeed, historically only limited aging with HIV has been possible. However, while the struggles of infected individuals worldwide continue – especially those without access to quality care and emerging treatments – the future outlook has changed dramatically for the better. Consequently, it is useful to examine key studies that attempted to understand the HIV experience through individual narratives. It is also helpful to distinguish between those conducted before and after the introduction of effective treatments.

Before Effective Treatments: Uncertainty and Adaptive Strategies

A powerful and recurring theme in research on the experience of life with HIV is that of uncertainty, in particular uncertainty about the future. Uncertainty is a central concern for all seriously ill persons, and it has been – and remains – a critical and multifaceted challenge for people living with HIV.

In one study conducted prior to the introduction of HAART, Weitz (1989) found that gay and bisexual men with AIDS struggled to cope with overwhelming uncertainty in their lives, which began with uncertainties about whether they were at risk of contracting HIV, and subsequently about emerging symptoms that may or may not be signs of AIDS. These uncertainties, sometimes coupled with a heightened sense of guilt about the behaviors that led to exposure, were found to drain their emotional and physical resources months and even years before they became ill. Once they had received a confirmed diagnosis of AIDS, many were then compelled to find answers to their questions about how they became infected – which were sometimes unanswerable – and faced further uncertainty regarding whether they would be able to function in the short term, whether their illness would take their lives, and whether they would be allowed to live – and if death was unavoidable to die – with dignity.

This study also illustrated some of the divergent strategies these men employed to manage uncertainty and assert control over their lives, including thoughts and actions reflecting both avoidance (e.g., avoiding knowledge about their serostatus) and vigilance (e.g., seeking knowledge and developing a realistic picture of what they could expect in the future) (Weitz 1989). For those infected early in the history of HIV, like Weitz's sample, learning to manage uncertainty and live with AIDS was all too often a tragically short process overwhelmed by the onset of serious illness and pending death.

In another pre-HAART study – but in recognition of the fact that the trajectory of life with HIV was steadily being prolonged by the first breakthroughs in antiretroviral treatment – Siegel and Krauss (1991) described a number of adapt strategies adopted by gay men to help them adapt to the challenges of living with HIV. Their sample was comprised of men who were HIV-positive, but did not have an AIDS diagnosis. This work identified three broad adaptive challenges, which cut across a number of adaptive tasks: (1) Dealing with the possibility of a curtailed life span, which included feeling a sense of urgency to attain life goals and deciding to what extent to invest in the future; (2) Dealing with reactions to a stigmatizing illness, which included making decisions about disclosing their illness to others and feelings of shame and contamination; and (3) Developing strategies for maintaining physical and emotional health, which included decisions about how to maintain a sense of control over – and an appropriate level of vigilance about – their health and treatment.

Like people facing other serious and chronic illnesses, some of these men worked to achieve purpose and control by reviewing and constructing their personal biographies. In other words, they engaged in biographical work, with many attempting to create a script for a more complete life. Career-related concerns became central to the script because issues relating to career success are key identity issues for people in their 20s, 30s, and 40s – like the men in their sample. Such an emphasis on personal accomplishment offered some not only a source of financial support and meaning, but also an opportunity to assert a normalized or relatively "disease-free" area of their existence (Siegel and Krauss 1991).

In addition, many of the men in Siegel and Krauss's sample described their attempts to avoid the pain of stigmatization, with some opting to primarily affiliate with people who were also seropositive, and not – or only selectively – disclosing their HIV status to others. Finally, the attentiveness – in many cases vigilance – that some exhibited in effort to maintain their emotional and physical health reflected efforts to distance themselves from further impact of HIV, and in cases where it was possible, to reinforce their experience of their selves as "not sick."

In sum, the adaptive strategies of these men reflected their underlying efforts to put their lives back together and resist being defined – by themselves or others – entirely through the lens of their HIV status (i.e., as a master status). Nonetheless, such strategies can become tenuous as physical symptoms emerge. For example, definitions of portions of one's life as "disease-free" or the self as

"at risk" (i.e., "not sick") may yield in the face of contradictory sensory evidence. Indeed, Siegel and Krauss (1991) found that the occurrence of symptoms marked a significant turning point for these men in terms of how they viewed themselves in relation to their disease. For those men who did experience significant symptoms, feelings of shame and contamination were common, potentially signaling their inability to insulate themselves from AIDS, the disease, or its social and psychological impacts.

After Effective Treatments: HIV as a Chronic Condition

Much has changed since the earliest and darkest days of the pandemic, especially in terms of advances in treatment, which have provided reason for great optimism and hope in the battle against HIV. With the introduction of HAART, many long-term AIDS patients realized dramatic improvements – sometimes called Lazarus Phenomena (Thompson 2003) – and many more recently infected individuals have been able to strengthen their bodies' capacities to keep opportunistic infections at bay indefinitely. People living with HIV today can enjoy virtually normal lives and pursue personal and work-related goals with a sense that "the future" – in many respects a full and bright one – awaits them. In short, in the past two decades HIV has been transformed from a "death sentence" to a chronic condition not unlike others – manageable with proper care and adherence to treatment.

However, current treatments can have side effects that affect both health and appearance, and studies of seropositive gay men have examined the effects of body image on a range of mental health outcomes – and on adherence with treatment regimens (cf. Sharma et al. 2007). Moreover, treatments do not take away the reality that HIV-positive individuals remain infectious, and they must therefore continue to negotiate their romantic desires and intimate relationships with care. For instance, they are faced with a range of difficult decisions concerning if and when to disclose HIV status, as well as the safety of various sexual practices. In particular, there is increasing focus on the role of serostatus – and the practice of serosorting – in sexual decision making, dating, and relationship formation (Frost et al. 2008; Xia et al. 2006). Moreover, if a woman with HIV is pregnant or if HIV-affected individuals or couples wish to have children, numerous additional issues are raised in that regard as well (Schönnesson 2002).

In addition, as emerging treatment breakthroughs have been heralded in the media, met with excitement, relief, and hope; they simultaneously place an expectation on patients that they should be able to rid themselves of earlier HIV-related traumas and readily adapt to living with what is now *merely* "a chronic illness" (Catalan et al. 2000). In reality, however, making such a transition can be very difficult, and moving through it successfully requires an exceptional capacity to tolerate ambiguity and manage new uncertainties. Moreover, for long-term patients it requires a reconstruction of the future, perhaps especially in relation to issues of work/disability and intimate relationships (Thompson 2003).

From a qualitative study with HIV-positive men and women, Merriam et al. (2001) described this reconstruction process using a developmental perspective of the life course and different dimensions of time. By interviewing seropositive individuals before and after the development of HAART – in late 1995 and early 1998 – they documented a relationship between advances in HIV treatment – which happen in "historical time" – and the efforts of people living with HIV to recapture their ability to see their lives in "social time." This return to social time, which is based in the developmental patterns and ordering of events typically associated with adult life, made possible a view of a future that did not exist just a few years before. This reorientation appears to carry some ambivalence about aging. Consider, for example, the words of one 29-year-old woman – who had lived for about 8 years before beginning effective treatment:

> You know, I don't know what it is like to be twenty-something and not acutely aware of my own mortality. [She goes on to say that she used to think of 30 as] kind of the edge of the world. Now, I'm approaching it and I'm finding out that the world isn't flat; that's an amazing, wonderful thing, but it's scary too. It's about redefining who I want to be and everything (Merriam et al. 2001:179).

In short, evolving treatments are offering people living with HIV the opportunity to envision a future that accompanies a full life. For those who have already experienced considerable illness, reconstructing their futures presents them with new uncertainties, and the need to manage them. Current cohorts of people aging with HIV are historically unique in that they will be the first to grow old. In some senses, they are living their lives "on the boundaries," for example: the boundaries between having a terminal and chronic disease, between illness and health, between despair and hope, and ultimately, between death and the existential concerns about their futures (Schönnesson 2002; Schönnesson and Ross 1999). Much can be learned from their examples.

Studies that have attempted to look "inside" life with HIV as it continually changes in relation to scientific discovery and clinical progress are useful for situating the experiences of aging with HIV within a broad social and psychological context that incorporates personal biography, challenging experiences (both eventful and chronic), and efforts to manage them. Undoubtedly, more work of this kind is needed. Existing studies have disproportionately focused on the experiences of gay or bisexual men in developed countries. Therefore, it is important that future research examines the experiences of diverse samples of men and women – in different social settings – as they grow old with HIV. In the context of aging, such studies must investigate how individuals think about "time" and navigate the events and transitions of later life (e.g., retirement, grandparenthood) that have been previously unforeseen by and for people with HIV. Lessons from life course scholarship will be useful in this regard (Settersten 1999).

Additional Lenses and Frames of Reference

Our evolving understanding of living and aging with HIV is not solely driven by medical advances that improve disease management. HIV and AIDS have been and remain, in significant degree, conditions whose meanings are socially constructed. For instance, as a mysterious new threat, it was initially termed Gay Related Immune Deficiency (GRID) in the United States (Shilts 1987), although worldwide HIV has always disproportionately affected heterosexuals. Institutional response to emerging HIV-related issues – and seropositive individuals who are public about their status – in the social worlds of religion, politics, law, education, entertainment, and sports will continue to influence public discourse surrounding, and personal experience of, HIV.

In turn, social and cultural events and shifts will continue to contribute in important ways to ongoing reconstructions of HIV as a chronic condition, one that individuals can manage into later life. Thus, future social scientific research must strive to better understand how these forces – in addition to future scientific breakthroughs concerning HIV exposure, infection, and disease progression – are shaping life with HIV. Lessons learned from this work have the potential to inform theories about successful aging, as well as policy and practice regarding the needs of aging populations.

Stigma and Discrimination: "Not Like a Lot of Other Diseases"

While HIV has clearly become part of the social fabric of modern life, people living today with HIV experience many of the same negative social reactions that they did early on in the epidemic. Research consistently documents alarming levels of stigma and discrimination, for example, in

studies concerning attitudes and beliefs about HIV and AIDS, HIV-positive individuals, and those thought to be at risk for HIV (e.g., Herek 1999; Herek et al. 2002).

To illustrate, although some overt expressions of HIV-related stigma have declined with time, nationally representative data suggest that inaccurate beliefs about risks from routine social interactions have increased (LeBlanc 1993; Herek et al. 2002), as has the belief that individuals with HIV deserve their illness. For instance, data collected in 1999 suggest that one in five Americans are "afraid" of individuals with HIV, and large proportions feel there is some risk of infection associated with being coughed or sneezed on by a person who is seropositive (50%) or simply using a public toilet (41%). In addition, one in four people in the general population endorses the sentiment that people infected with HIV through sex or drug use "have gotten what they deserve" (Herek et al. 2002). Finally, research has shown that negative attitudes toward people with HIV – and the groups most heavily affected by HIV – are associated with support for name-based HIV surveillance policies (Herek et al. 2003). Such findings underscore the reality that serostatus often plays a critical role in the formation and maintenance of social relationships of all kinds.

HIV-related stigma and discrimination also remain evident in high rates of violence and victimization associated with HIV-status, particularly for women (Zierler et al. 2000). Indeed, violations of human rights related to HIV are well documented, as are growing efforts to combat them (Gostin 1990; UNAIDS 2005), and HIV-based discrimination is observable in all areas of social life, including employment and health care settings (Schuster et al. 2005; Studdert 2002). Institutionalized policies may be especially slow to change. For example, it was only in October 2009 that plans were announced to lift the formal U.S. ban on HIV-positive immigrants and visitors, a policy established in 1987 (Preston 2009). Moreover, in many states, people with HIV may be subjected to criminal penalties for sexual activity; even when sexual activity is consensual, involves little or no risk of transmission, there is no intent to transmit, and the activity does not result in transmission (Lamda Legal 2007; Lange 2003; Patterson and London 2002).

The quote below, from a 39-year-old gay man who participated in a study published in 1991, illustrates the powerful social stigma that surrounds HIV as he experienced it:

> I do feel stigmatized. I feel as though somehow I have this dirty disease that everyone has learned to hate … I'm a carrier. At times I feel as though I bear all of the guilt and the responsibility for the negative comments we hear all the time. It's all on me, it's all in me. It's coursing through my veins. Sometimes I feel dirty because of it … And it is not in the same category as cancer. It is not in the same category as any so-called clean disease. The fact that I might be dying of HIV infection is not in the same category as anyone who innocently has a heart attack or any other long term chronic [disease like] diabetes (Siegel and Krauss 1991:24).

Many would argue that this quote applies as much today as it did nearly two decades ago.

Moreover, with the aging of the HIV population, there is increasing attention on the "double jeopardy" created by felt and enacted stigma and discrimination related to both HIV and aging. In a qualitative study of men and women over 50 and living with HIV or AIDS, Emlet (2006) identified stigma-related themes that reflected the experiences of HIV-associated stigma and ageism, as they occur independently and as they are interrelated. He has also developed a multi-dimensional HIV-stigma scale that has been examined in research with older adults (Emlet 2007).

For these older persons, HIV stigma included experiences related to: (1) fear of contagion; (2) homophobia; (3) violations of confidentiality; and (4) protective silence. Such themes are reminiscent of descriptions of stigma from earlier work based on younger samples. A substantial number of Emlet's respondents described others' irrational fears of contracting HIV from them, and several reported feeling stigmatized by the persistent homophobia that disproportionately links HIV with homosexuality. Violations of confidentiality, which is legally protected in medical settings and should never be compromised, were also present. One study participant described a particularly painful experience:

> So when I got there [to the medical clinic] they hand me my chart and I'd go see the blood pressure nurse, then I'd go see the nurse that draws blood, then I'd go see the doctor. I'd walk around with this big chart with

> this big sticker on it – HIV Positive. Everyplace I went I was carrying this. I felt, why don't they just tattoo my forehead (Emlet 2006:787).

Thus, it is not surprising that people with HIV of all ages practice "protective silence" – or non-disclosure of their serostatus to others – as a way to manage the fear of anticipated stigma. One woman who lived with her elderly parents chose not to tell them of her condition. One man expressed his fear that his church group of friends would cut both him and his wife off if they learned of his diagnosis. Several described their fears about telling potential sexual partners, with one stating: It is a very difficult disease to have when you still want to have a partner-companion. "It is a very difficult disease to have, not like a lot of other diseases" (Emlet 2006:787).

Experiences at the ageism–HIV stigma intersection are especially illuminating, and included the following themes: (1) rejection; (2) stereotyping; and (3) feeling "separate or alone." Rejection by others was a unifying experience, reported by the majority of study participants as experienced from multiple sources, such as service providers, friends, family, church members, and potential sexual partners. Rejection was not always solely based on HIV status, but often included an element of rejection based on age. This appears to be a typical experience of older, gay men living with HIV – particularly those who are not healthy – in part because of the gay community's heavy emphasis on youth, vitality, and masculinity (cf. Kimmel and Mahalik 2005; Scrimshaw and Siegel 2003). One seropositive gay man stated that ageism "… is a far mightier sword than HIV" (Emlet 2006:785), in keeping with what Green (2008) describes as a "sexual status order" – based in part on attractiveness – that privileges younger and healthier gay men. Such disparities create significant stressors for gay men, particularly if they are aging with HIV. Similar research on women and straight men aging with HIV is much needed.

Stereotypical attitudes about aging and sexuality, or assumptions about how one becomes infected, were also challenging for individuals aging with HIV. For instance, respondents described circumstances where it was clear that society expects older people to be more knowledgeable about the disease simply by virtue of their age. One woman expressed her belief that: "[I]n some cases … older people are held to a different standard … [because] … well, for crying out loud, [they] should know better" (Emlet 2006:786). One man shared: "There's a lot of people that go 'you're awfully old to have this disease'" (Emlet 2006:786). Another man, who is heterosexual, described how women around his age whom he would like to date assume that he must be gay or bisexual because of his HIV status (Emlet 2006).

Finally, older persons with HIV described an internalized stigma that Emlet termed "separate or alone," a fitting label for a variety of experiences that keep them segregated from the mainstream of social life. One single man described his feelings of extreme isolation: "I don't have a partner, you know. I could drop dead in my house and no one might know about it for three weeks" (Emlet 2006:786). Another shared that he felt "radioactive" (Emlet 2006:786), a powerful word that simultaneously portrayed his loneliness and his sense that he is perceived to be a threat to others.

In another study, Siegel et al. (1998) highlighted perceived disadvantages of age in the context of HIV, including: being more socially isolated; receiving less sympathy and being judged more harshly; and feeling that medical providers set higher goals when treating younger patients. Such findings highlight important avenues for additional, and more nuanced, study regarding social relationships for older people with HIV.

In sum, more than three decades into the pandemic, pervasive stigma and discrimination surrounding HIV remains, and we are beginning to understand the unique experiences of seropositive individuals who are now entering later life. Additional research based on individual narratives, of diverse samples across a range of social contexts, will build on this small but important literature.

In addition, future studies can further illuminate HIV-related stigma and discrimination as sources of social stress that can directly and indirectly affect the well-being of people aging with HIV. Existing theoretical frameworks found in the minority stress (Meyer 1995, 2003) and stress

process (Pearlin 1999; Pearlin et al. 1997) literatures could provide useful models for such work. Moreover, as important lessons are learned about HIV-related stigma and discrimination, stress, aging, and well-being; applied researchers can work toward the identification of more effective means of addressing stigma and discrimination (cf. Chesney and Smith 1999).

Finally, studies of HIV stigma and discrimination have typically focused on the perceptions and experiences of individuals, either as perpetrators or victims, reflecting the use of individualistic models in approaching this topic. However, social scientists should also attempt to examine HIV-related stigma and discrimination as social processes that are linked to the reproduction of inequality and exclusion – rooted in gender, race/ethnicity, and class as they interact with age. Such a focus may be particularly useful for work focused on the resistance of stigmatized individuals and community mobilization for creating rights-based approaches to transforming social climates in which stigmatization and discrimination are routinely tolerated (Parker and Aggleton 2003).

Social Networks and Social Support

As detailed above, nationally representative data from the United States portray significant social and economic vulnerabilities of the older HIV-positive population. Older individuals living with HIV are more likely than their younger counterparts to live alone, and they are also more likely to report conflict with family, friends, and others in their social networks. In addition, among older people with HIV, racial/ethnic minority persons and older individuals who were exposed to HIV through IDU experience relatively greater economic disadvantage, and consequently are more likely to lack access to supportive services (Crystal et al. 2003; Joyce et al. 2005). It has been suggested, for example, that IDUs are especially likely to exhaust their social resources as drug use lengthens and friends and family become disaffected with their problems (Levy 1998).

Smaller scale studies of the social networks and social support of older HIV-infected populations have also emphasized their high risk of social isolation, due to the lack of traditional supports and the effects of HIV-related stigma and ageism (Emlet 2006; Shippy and Karpiak 2005a). In a study of older people with HIV in New York City, it was estimated that only a third have a partner and nearly three-fourths (71%) live alone (Shippy and Karpiak 2005a).

Moreover, research has suggested that sources of social support vary by sexual orientation, with sexual minority persons reporting greater support from friends, which often comprise their "families of choice" (Weston 1991). Certainly, the large AIDS caregiving literature demonstrates the historically unprecedented rallying of support among persons unrelated by ties of blood or marriage (Turner et al. 1994). Moreover, resilient HIV-positive networks of friendship and support in some instances take the place of support lost to stigma and rejection. For some older people living with HIV, however, friendship networks have been diminished due to AIDS-related deaths and HIV-related morbidity (Scrimshaw and Siegel 2003; Shippy and Karpiak 2005a; Poindexter and Shippy 2008). Increasing bereavement is of course a natural part of the aging process, but unlike their contemporaries, long-term survivors of HIV have more often experienced losses of peers – often to HIV – who were only just entering young adulthood or middle age (cf. Martin and Dean 1993).

Further research into the ways in which older people with HIV seek and receive assistance – or not – from within their varying familial and social networks is needed. In particular, it is important to examine how social and cultural factors may affect support seeking, or lack thereof. For instance, Heckman et al. (2000) focused on differences in sources of social support between older African-American and white men, and found that African-American men received relatively more support from family members, and were simultaneously less likely to disclose their HIV status to close friends. It is also important to better understand the value of various types of social support – for

instance, emotional versus instrumental – to people aging with HIV, particularly with changes in their health over time. For example, existing research finds that those experiencing worse health were more likely to report having adequate emotional and instrumental support within their informal support networks, which conversely suggests that those in relatively good health are more apt to perceive inadequate support (Shippy and Karpiak 2005b).

In addition, in keeping with the longstanding literature demonstrating the health benefits of social integration and support (Thoits 1995; Turner and Turner 1999), more work is needed to understand the unique roles various types of social support – for instance, emotional and instrumental support from different sources – play as determinants of both physical and mental health among individuals aging with HIV. Indeed some research of this type has been conducted with HIV-positive populations, and a recent study of seropositive men suggests that the moderating effect of support on health may be especially important to older men (Chesney et al. 2003).

Lastly, this emerging literature suggests high levels of unmet need for informal social support among HIV-positive elders (Shippy and Karpiak 2005b), and we can therefore expect to witness expanding needs for ongoing assistance from the formal social and health care systems in the future as this population continues to grow. Unfortunately, we can also anticipate a high probability of witnessing more cases where individuals fall through the cracks of both the formal systems, and informal networks, of support, and are left to fend for themselves in later life.

HIV, Aging, and Well-Being

Clinical studies tend to neglect the aspects of quality of life (QOL) and health – well-being for short – as they are subjectively experienced. QOL measures typically encompass several dimensions, including patient-reported: physical function and symptoms, performance of social roles, emotional status, cognitive functioning, and feelings about his or her health. The first HIV-related QOL studies coincided with the advent of the first promising antiretroviral therapies in the late 1980s, and since that time QOL data have complemented findings from treatment trials, sometimes in support – and sometimes at odds with – clinical findings (Wu 2000).

QOL has been examined among people with HIV more frequently over time. Generic QOL measures have been adapted to address aspects of living with HIV that can differ from living with other chronic conditions, and new HIV-specific QOL measures have been developed as well (Avis and Smith 1998). The more prominent generic QOL instruments have been implemented with HIV populations to facilitate comparisons in QOL for people living with HIV and QOL for individuals living with other conditions, including breast cancer, clinical depression, and diabetes (Avis and Smith 1998; Hays et al. 2000). There have also been studies examining, within HIV populations, the influence of HIV-specific symptomatology on self-perceived QOL (Lorenz et al. 2001); in recognition of the fact that disease trajectories are diverse, and fluctuate over time.

Although researchers have also begun to examine how self-rated QOL varies by age, studies of aging and QOL in HIV populations are quite rare. Working with data collected between 1988 and 1990, Piette et al. (1995) concluded that older persons with HIV reported worse QOL on multiple dimensions than their younger counterparts. Studies of mental health outcomes among persons aged 50 and older with HIV illustrate the serious emotional difficulties faced by this population. One study estimated that one-fourth experiences "moderate" to "severe" depression, which was related to greater HIV-related stress, less support from friends, and reduced access to services due to HIV-related stigma (Heckman et al. 2002). Another found that just over one-fourth of a sample of middle-aged and older persons with HIV had considered taking their own life in the preceding week (Kalichman et al. 2000).

Findings based on self-report measures of general health and emotional well-being from the HCSUS study suggest that older gay men may enjoy some health-related advantages over their

younger counterparts (cf. Bybee et al. 2009), although older persons infected through IDU do not demonstrate such advantages, and the data regarding older people infected in other ways are mixed (Crystal et al. 2003). These better health perceptions reported by older gay men defy simple interpretation. For instance, it may be that they are, at least in part, merely comparing themselves with an older reference group with more health problems, or that with age comes some psychosocial advantages (e.g., wisdom, patience, and a relatively diminished sense of feeling "cheated" by their condition) (Siegel et al. 1998). Alternatively, this difference might also reflect the more consistent adherence to treatment regimens that has been observed in older HIV populations (Casau 2005; Crystal et al. 2003; Sherr et al. 2009).

In sum, additional studies of HIV, aging, and well-being – as assessed along a wide range of dimensions – are greatly needed. Studies that apply a life course framework (Settersten 1999) may be especially useful. For example, as the current research literature expands, it is important for investigators to take into account patient age at time of exposure (e.g., at birth through later life), in order to gain critical insights regarding the full diversity of HIV biographies and trajectories (cf. Avis and Smith 1998). Moreover, the available studies, however limited, serve as a reminder that the emerging data on disease manifestations and clinical markers – which garner disproportionate scientific and media attention – must be viewed alongside more subjective indicators of wellness, which stand to teach us important lessons regarding the subjective experiences of HIV as people age. Such work should focus not only on hardships associated with HIV and aging, but also positive changes that have liberating or transforming effects.

Finally, emerging research on mental health among older people living with HIV may offer especially useful insights for building stronger theoretical frameworks for studying HIV, aging and well-being. Stress process models, which consider how stress begets stress, appear especially relevant (Pearlin 1999) (Pearlin 1999). For instance, attention paid to the subjective experiences of social stress by individuals with HIV, as well as their efforts to access psychosocial resources (e.g., a sense of mastery, social support) to cope with challenges, highlights key psychological and social processes influencing well-being (cf. Goodkin et al. 2003). One developing body of research is focusing on the role of spirituality and religiosity in the lives of people aging with HIV (Vance et al. 2007; Vance 2006). The finding that suicide ideation among midlife and older persons with HIV is associated with greater levels of emotional distress, poor health-related QOL, and the use of escape and avoidance coping strategies (as opposed to positive-reappraisal coping) is one example of research reflecting the relevance stress process frameworks (Kalichman et al. 2000).

HIV-Affected Older Populations

The study of HIV and aging also inherently concerns the lives of older persons who are affected by, but not infected with, HIV. Certainly the longstanding AIDS caregiving literature has drawn attention to the experiences of aging care providers (cf. Wight et al. 1998; Wight 2000). For example, Wight et al. (2008) highlighted how uncertainty about the future is filled with shared experiences, in this case between people with HIV and their caregivers. Indeed, lives affected by HIV – like all others – are "linked lives" in multiple and complex ways, and should be examined as such by focusing on relationship dynamics for people aging with HIV. Moreover, a focus on HIV-affected – in addition to HIV-infected – older persons is perhaps especially relevant and useful in developing nations where at the current historical moment rates of HIV-related morbidity and mortality are relatively high (Williams, Knodel and Lam 2010; Knodel et al. 2010).

It is also essential that researchers simultaneously consider the extent to which older people with HIV are themselves sources of social support for one another (LeBlanc and Wight 2000), and for others in need of support. Indeed, many are primary caregivers to parents, spouses/partners, and

children, as well as for friends (cf. Wight 2000), and as they continue realizing improvements in their well-being, the obligations of such roles and obligations will only expand.

Discussion

More than three decades into the global HIV pandemic – and more than two decades after the social scientific community began writing about aging in the context of HIV (Riley et al. 1989) – it is clear that a diverse and growing HIV-positive population is aging into later life. Social science has a significant part to play in the production of knowledge that will facilitate better understandings of their experiences, as well as inform the design of better interventions and policy to support their unique needs.

Current research has accomplished a good deal toward developing sociodemographic profiles of aging seropositive populations. However, this work – like virtually all research on HIV and aging – pertains almost exclusively to populations in developed nations. It is clear that the significant diversity reflected in these initial studies will become even more apparent as similar data are collected across more locales and updated over time. Indeed, much more of this basic descriptive study is required – in developed and developing countries and local settings – because it provides the foundation for both basic research that attempts to examine HIV and aging in greater depth and applied research that strives to address related social problems.

Past studies have produced useful qualitative understandings of what it is like for people to live and age with HIV, in terms of their existential concerns as well as in regard to their social interactions. Because AIDS has taken the lives of so many young adults, existing research has privileged the impact of "disease" over "age" in thinking about the experiences of people aging with HIV. However, with the diverse and rapidly expanding population of people growing old with HIV, it is time for more thoughtful examinations of the unique effects of HIV-status and aging – and their combined effects – on well-being. It is also apparent that this work must be conducted across a wide range of settings with people from all backgrounds. To date, research on the day-to-day experiences of women and racial/ethnic minority persons with HIV – of all ages – is especially lacking (Brown and Sankar 1998; Zablotsky 1998). Life course perspectives – drawn from multiple disciplines – may particularly facilitate this work by situating it within the broader social and cultural contexts of time and place (Settersten 1999).

Many of the relevant studies to date have been necessarily concerned with how the introduction of effective treatment has dramatically altered the experience of living and aging with HIV, at least in populations with access to care. In short, new treatments have made aging a possibility for many. However, it is time for the field to move beyond period effects associated with scientific advances in the war against HIV, paying attention also to the social and cultural changes that also determine the contextual landscape and personal experience of HIV. Moreover, life course researchers must also focus on the effects of cohort. For instance, as the first generation to do so, older people with HIV are now entering later life without role models. Their younger counterparts will benefit from their examples, but they will also navigate a larger proportion of the life course with HIV, managing more of life's important events and transitions along the way. For instance, in the existing literature, there appear to be significant cohort differences in the well-being of gay men with HIV, with the older generation reporting some health-related advantages over their younger counterparts (Crystal et al. 2003); despite facing what the clinical literature is also beginning to suggest, a more severe disease course. Deeper qualitative understandings of such differences stand to teach us important lessons about successful aging with chronic conditions.

There are a range of social and psychological factors that must be considered in relation to this growing understanding of HIV as a chronic illness that can be experienced over the course of a long life. Issues relating to the still pervasive HIV-related stigma and discrimination are of paramount con-

cern. Existing studies poignantly illustrate their demeaning, demoralizing, and isolating powers. Research also suggests that HIV-related stigma overlaps in some respects with ageism, which points to the potential use of further conceptual research regarding the intersection of HIV-related stigma and other forms of marginalization and oppression. Moreover, the recognition that stressful experiences and conditions emanate from HIV- and age-related stigma and discrimination draws our attention to current models of minority stress (Meyer 1995, 2003) and stress process (Pearlin 1999), both of which provide useful approaches for understanding the relationship between social stress and health. Indeed, new frameworks that integrate the two may be particularly promising in the study of HIV and aging.

The emerging literature on the present – and likely growing – unmet need for social support among people aging with HIV also addresses critical issues of interest. Available studies portray differences in the ways in which older people with HIV define their familial and social networks, as well as in whether and how they seek and receive social support. There is also diversity in the networks and supports available to them. As a whole, this population experiences relative socioeconomic disadvantage, with many enduring severe hardship. Available studies document the unique vulnerabilities of sexual minority and IDU support networks as well. Future study must continue to explore for these kinds of differences in order to facilitate a more refined understanding of the potential role of social support in the lives – and well-being – of the aging HIV-positive population.

The recognition of the unmet needs for social support among individuals aging with HIV – viewed against the backdrop of persistent stigma and discrimination – offers a useful vantage point for considering future applied research that informs policy. Certainly, the aging HIV-positive population will continue to expand, and we are only beginning to understand age-based differences in the experience of HIV, not only in terms of symptomatology but also with regard to the social interactions involved in seeking informal and formal supports, as well as in accessing medical care. Thus, it is time for more in-depth research on the support and care needs of diverse, aging seropositive populations. As more about such differences becomes known, appropriate social and medical services can be developed and made available (cf. Emlet et al. 2009; Poindexter and Shippy 2008). This work will also inform the creation of better policy for people entering late life with HIV, as they face personal, social, and economic challenges – similar and unique from those facing the general aging population – associated with medical care, disability, retirement, independent living, and long-term care. In the United States, for example, we might anticipate interesting policy research questions concerning the ways in which steadily growing numbers of HIV-positive individuals aging into Medicare eligibility could create age-based disparities in access to treatment.

Ultimately, success in the battle against HIV is understood by the well-being – along a range of social and health-related dimensions – of people who live with the virus. Amidst so much change in the evolution of our understandings of HIV as a medical condition, research on the subjective well-being of infected individuals has lagged behind. Studies of well-being among older HIV populations are exceptionally rare. As discussed above, research to date points to the need to locate future research within the theoretical frames of the life course and stress research in order to better explain social determinants of well-being among individuals aging with HIV (Pearlin et al. 2005). We stand to learn a great deal from people who are now aging in later life with HIV. They are the first cohort in the history of the pandemic to grow old.

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Chapter 32
Obesity: A Sociological Examination

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Over the past several decades, the prevalence of obesity has increased across all ages and socio-economic groups in the United States. Obesity has been described as one of the most significant public health issues of the new century (National Institutes of Health 2004). The associated health problems have raised concerns about the costs of lost productivity, increased medical care needs, and the possible effects on longevity (Cutler et al. 2003; Finkelstein et al. 2005; Olshansky et al. 2005). Because of these concerns, researchers are interested in understanding the factors behind the increase and the potential for changing the trend. In this chapter, we will examine the patterns, explanations, and consequences of the increased prevalence of obesity for the older population. We will end with a discussion of the social implications of increasing obesity and social policy options for addressing the issue.

Patterns

Obesity

At the most basic level, obesity is the result of an energy imbalance, individuals taking in more calories than they expend. The equation for energy balance has not changed over time, so the increased prevalence of obesity in the population must be the result of changes in caloric intake, energy expenditure, or both. These changes do not have to be large; researchers have concluded that the observed increase in mean BMI in the United States could be accounted for by an excess of 100–150 calories per day (Hill et al. 2003).

There is evidence that energy intake has gone up over the last 30 years, more calories are consumed per capita. Working at the macrolevel, economists comparing national measures of food consumption concluded that the trend in per capita daily total energy supply is responsible for the trend for increased obese and overweight individuals (Silventoinen et al. 2004). The Centers for Disease Control and Prevention (CDC) agree with this analysis (CDC 2004a). They found that between 1971 and 2000 the mean energy intake in the United States increased from 2,450 to 2,618 kcal for men and from 1,542 to 1,877 kcal for women. The CDC goes on to show that fat and protein intake decreased in the same time period while carbohydrate consumption increased. The CDC suggested that this increase in caloric intake was due to foods consumed away from the home:

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salty snacks, soft drinks, pizza, and increased portion sizes. As we will discuss later, the types of food consumed, irrespective of caloric count, may also contribute to obesity.

Food consumption has increased, but what has happened to the other side of the energy balance equation, energy use? The measurement of energy expenditure starts with the basil metabolic rate (BMR). Since the BMR must be measured under strict conditions (before a person gets out of bed and after a 12 h break from all physical activity, consuming any food or beverage, or inhaling any nicotine), it is rarely used (Mahan and Escott-Stump 2000). Instead, an alternative measure, resting energy expenditure (REE), is more common. REE can be calculated by direct calorimetry, in which heat output is measured by, for instance, submerging a person in water and measuring the change in the temperature of the water. Alternatively, indirect calorimetry measures oxygen consumption. For indirect calorimetry, a person is asked to breath into a tube that measures the levels of oxygen and carbohydrates in the air before the person inhales them and after he or she exhales, several times. REE accounts for 65–70% of daily energy expenditures and is thought to have remained relatively constant over time (Mifflin et al. 1990).

Another factor of energy expenditure that has not changed in the last 30 years is the thermic effect of food (TEF), the energy used to digest food. TEF varies by the types of food that an individual consumes and usually is approximately 10% of total energy expenditure (TEE) (Mifflin et al. 1990). The shift in energy consumption noted by the CDC, above, might suggest that an increase in carbohydrate intake with a decrease in fat and protein intake would result in lower TEF, since sugars dissolve in water. It is however important to remember that fruits and vegetables are forms of high caloric foods that often require more energy to digest.

The final piece of the energy expenditure equation is the energy used in activity. Physical activity expenditures account for the remaining 20–30% of daily energy expenditure (Mifflin et al. 1990). This is the element of the equation which has very likely changed during the last 30 years. Activity factors were developed to estimate the energy used in physical activity. A sedentary person is assigned an activity factor between 1.0 and 1.4. Someone who participates in low levels of activity has an activity factor between 1.4 and 1.6. An active person burns 1.6–1.9 times his or her resting metabolic rate, and a very active person can spend up to two and a half times his or her REE. Current guidelines call for a minimum of 150 min of moderate-intensity physical activity a week, like brisk walking, water aerobics, slow bicycling, playing doubles tennis, ballroom dancing, and general gardening (USDHHS 2008). Approximately, 25% of adults receive no leisure time physical activity, and this percentage has been decreasing approximately 1% each year (CDC 2004b). Nearly one-half of those over the age of 65 receive no leisure time physical activity, and 80% participate in no vigorous leisure time activity (NCHS 2009).

The relative contribution of the increased intake of calories and decreased physical activity to the increased prevalence of obesity is unclear. The relationship between energy intake and expenditure is complex with many compensatory loops. Recent research has shown, for instance, that weight loss rarely occurs due to exercise alone (Church et al. 2009). Bleich et al. (2008) conclude that the primary cause of the observed weight gain in the population is overconsumption. Some researchers argue that food intake is more important for changing weight while activity is more important for maintaining weight (USDHHS 2008). Before exploring some of the reasons that both energy intake and expenditure may have changed over the past 30 years, we will look at the overall patterns of obesity in the population.

Measurement

Ideally, the percentage of body fat is determined at the individual level by directly measuring lean and fat body masses. Methods such as dual energy X-ray absorptiometry (DEXA scans)

allow the precise measurement of lean soft tissue and total body fat. This, and similar methods, are very accurate; however, they require specialized equipment and trained administrators. Bioelectrical impedance is another alternative for measuring body composition and is based on the differing electrical impedance of water and fat tissues in the body. It is not considered a gold standard method for measuring body composition, but is widely available and relatively simple to use.

Most population surveys rely on the body mass index (BMI) for measuring obesity. Calculation of BMI requires only current height and weight. In most surveys this information is self-reported, but some national health surveys, most notably the National Health and Nutrition Examination Survey (NHANES), clinically measure both height and weight. Individuals with a BMI of 30.0 or higher are considered obese, and those between 25.0 and 29.9 are considered overweight. Within the category of obesity further distinctions are made, having those with a BMI between 30 and 35 are considered Class 1 obese, those with BMIs between 35 and 40 are considered Class 2 obese, and those with BMI of 40.0 or higher are considered Class 3, or morbidly, obese. These levels were selected to parallel the types of health problems associated with different levels of BMI (NIH 1998).

BMI as a measure of adiposity suffers from several flaws. It is imperfectly correlated to body fat, since individuals with muscular bodies can have identical weights to those with more fatty tissue at the same height (Prentice and Jebb 2001). This problem becomes increasingly important with age, as older adults tend to have less fat than younger individuals of the same weight (Gallagher et al. 1996). The distribution of body fat changes with age and BMI becomes increasingly inaccurate as a measure of adiposity (Kuk et al. 2009). At very old ages, underweight and weight loss, rather than obesity, are significant health problems and are often associated with increased frailty (Wallace et al. 1995). The self-reported nature of height and weight is also problematic. Individuals tend to underreport weight and overreport height (Burkhauser and Cawley 2008).

Some sociologists and policy analysts argue that the over reliance on BMI as a definition of obesity reflects current social trends and attitudes, rather than true health problems, and is associated with a moral, rather than medical, stance (Kwan 2009; Oliver 2005). As noted above, BMI is only a proxy measure for body composition and the definition of obesity; a BMI of 30.0 or higher is an arbitrary point selected to reflect the level at which health problems are believed to begin (NIH 1998). Using BMI as the sole measure of body composition will undoubtedly lead to misclassification of some individuals, particularly those with large muscle mass or the elderly (Prentice and Jebb 2001).

Alternatives to BMI include waist circumference (WC), waist to hip ratio (WHR), waist to stature ratio (WSR), and skin fold thickness. In an analysis of the relationship of BMI, WC, and WSR to body fat, Flegal et al. (2009) found that those three indicators were more closely related to each other than to body fat. For any individual, these measures may be inaccurate indicators of body fat, but they correspond fairly well to categories of body fat (such as overweight and obese). There is evidence that abdominal fat is more closely related to cardiovascular disease than BMI. Measurement incorporating WC may identify persons who are at increased risk for obesity-related cardiometabolic disease, above and beyond the measurement of BMI (Klein et al. 2007).

Trends

The proportion of the American population that is overweight and obese has risen dramatically for all ages although there is evidence that this trend may be slowing. Between 1960 and 2004, the proportion of overweight adult men rose from 50 to 71%, while the proportion of women who were overweight rose from 40 to over 62%. The percentage of men who were obese rose from 10 to 31%, and the proportion of women who were obese rose from 15 to about 33% in the same 44-year period (Ogden et al. 2006). However, between 2004 and 2006 there was no significant change in obesity prevalence for either men or women in the United States (Ogden et al. 2007).

The increase of obesity hides an important trend in the overall distribution of BMI. While the overall distribution of body sizes shifted to the right, the shift was greatest among those in the upper percentiles of BMI (Ogden et al. 2007). This shift indicates that while the entire population is heavier, those who are the heaviest have become much heavier over time. Analysis of data from the Behavioral Risk Factor Surveillance System (BRFSS) shows that between 2000 and 2005 the prevalence of a BMI over 40 increased twice as fast as the prevalence of a BMI over 30 (Sturm 2007). The rapid increase of those in the morbidly obese category, for whom the health consequences are most severe, contradicts the past understanding that individuals in this group suffered from a rare pathological condition.

Obesity rates vary across racial, ethnic, and socioeconomic groups. Although the prevalence of obesity is greatest among those at the lowest levels of educational attainment, the prevalence of obesity has increased for all educational groups (Himes and Reynolds 2005; Truong and Sturm 2005). A similar pattern is found by relative income: Those in the highest income group have lower prevalence of obesity, but the increase – particularly in the last 20 years – is similar to the increase in prevalence seen in the lowest income group (Truong and Sturm 2005). Among men, there are no significant racial or ethnic differences in obesity prevalence. This is not the case for women. Non-Hispanic black women and Mexican American women are significantly more likely to be obese compared to non-Hispanic white women (Ogden et al. 2006).

Obesity and the Life Course

Understanding the changing prevalence of obesity across age and time provides insights into the possible explanations for the increase and its effects. The transition from normal weight to overweight to obese tends to occur gradually over the life course, sometimes starting in childhood, but often beginning in middle age. Because obesity is difficult to reverse, understanding the timing of the transition and the lifetime consequences of obesity is vital. A life course perspective underscores particular concern over the increasing rate of obesity among children and adolescents (U.S. Surgeon General 2001). The health problems associated with obesity affect children, as well, and are difficult to reverse. For example, there is a strong relationship between childhood obesity and the development of diabetes in adulthood (Bloomgarden 2004). There is evidence that individuals who are obese as children are more likely to be obese as adults; about one third of obese preschoolers and half of obese school age children are obese as adults (Serdula et al. 1993). Ferraro et al. (2003) find that overweight children are at significantly greater risk of becoming severely obese ($BMI \geq 35$) compared to normal weight children. In some cases, obesity in childhood is related to parental obesity. The familial transmission of obesity is poorly understood and could be the result of genetics, learned behaviors of eating and exercising, or other socio-economic factors.

The standards for measuring obesity are slightly different for children and are age and sex dependent (Barlow 2007). About 10% of children aged 2–5 are at or above the 95th percentile BMI for age. This nearly doubles to 19.6% of children age 6–11. This represents an almost tripling in prevalence rates since 1976. Among adolescents age 12–19, the proportion considered obese is 18.1% (Ogden et al. 2010). Below age 6, girls are slightly more likely to be obese, but from age 6 onward, boys have higher levels of obesity, measured by BMI. The racial and ethnic patterns of children mimic those of adults; obesity is more common among non-Hispanic blacks and Mexican Americans, compared to non-Hispanic whites, with differences significantly larger for girls (Ogden et al. 2008).

Weight gain is steady through early adulthood (Baum and Ruhm 2009). After adjusting for the secular trend in obesity, average BMI rose from 24.3 to 27.3 between the ages of 18 and 40 in the National Longitudinal Survey of Youth (NLSY) cohort. Similarly, the prevalence of obesity generally increases with age through adulthood (Cook and Daponte 2008). People between the ages of

18 and 32 have the lowest average BMI (Cook and Daponte 2008) and BMI increases steadily until about age 75, when there is a small drop (Flegal et al. 1998). In cross-sectional studies, peak values of BMI are observed in the age range 50–59 in both men and women, with gradual declines in BMI after age 60 (Flegal et al. 1998; Hedley et al. 2004; Ogden et al. 2006).

However, premature mortality of the obese may influence these cross-sectional relationships. In a 10-year follow-up study, individuals under age 55 exhibited a greater tendency to gain weight, with the magnitude of increase decreasing with age (Williamson 1993). Rates of overweight and obesity in longitudinal studies generally increase with age until age 75, when there is a small drop (Ferraro et al. 2003; Flegal et al. 1998; Must and Strauss 1999). Adults who are obese are more likely to remain obese until death than to leave the classification of obese (Ferraro et al. 2003). The loss of weight in late adulthood is often considered a sign of underlying chronic health problems or increased frailty (Kuk et al. 2009). This loss of weight, however, may mask an increase in adiposity since the amount of fat an individual has for a given weight may change as lean muscle mass is lost (Carmelli et al. 1991).

The observed increase in obesity over time appears to have affected all ages and cohorts. Three studies (Cook and Daponte 2008; Reither et al. 2009; Reynolds and Himes 2007) use age-period-cohort analyses to examine the reasons for the observed increase. Age-period-cohort analyses are useful for determining if an observed trend in the population is the result of a particular cohort's experience, of changes in one age group, or if the observed trend is seen across ages and cohorts at a particular time. The overwhelming conclusion is that the observed increase in obesity prevalence occurred at all ages and for all cohorts, and that period effects are principally responsible for the increased obesity prevalence. Cook and Daponte (2008) note that the increases in obesity prevalence are fastest at youngest adult ages; indicating that more adolescents are reaching adulthood already obese. Within the middle and late adulthood years, however, the rate of increase in obesity has been similar. Older adults were not immune to the obesity "epidemic."

Explanations

A wide variety of explanations have been put forth to explain the increased prevalence of obesity in the population. Some focus on individual psychosocial factors, such as self-control. Other explanations look at genetic influences. Still another set of explanations focuses on cultural, environmental, and economic factors.

Psychosocial Factors

Obesity is often considered a measure of personal failing, an indication of an inability to exercise self-control. This explanation for obesity puts the responsibility on the individual. Research suggests that it is easier for individuals to gain weight than to lose it (Berthoud and Morrison 2008). This would imply that the control of appetite and eating is not symmetrical (Blundell 2002). Although eating is controlled according to biological need, eating is also subject to environmental constraints. Since eating can be consciously controlled, as in hunger strikes or dieting, the assumption is that limiting food intake can be controlled in order to control weight or limit weight gain. Individuals are bombarded with seductive messages designed to increase the consumption of less healthy, high calorie foods. The expectation that individuals can counteract these messages may be unrealistic.

Another psychosocial explanation advanced to explain individual obesity is stress. Stress is thought to influence eating behavior. Individuals experiencing stress may over- or under-eat

(Oliver and Wardle 1999; Popper et al. 1989). Although the evidence is mixed, acute stressors tend to result in a lower food intake while those experiencing chronic stress show a preference for foods high in sugar and fat and a greater food intake (Torres and Nowson 2007). These effects are thought to operate because stress alters the control of cortisol and insulin leading to a disregulation of appetite and fat distribution (Adam and Eppel 2007). The effects can be long term, as at least one study shows a relationship between stress in childhood (measured by exposure to family violence) and obesity in adulthood (Greenfield and Marks 2009).

Genetic Factors

Genetic influences cannot explain the increased obesity of the past 3 decades. However, genetic influences set the stage for the current rapid increase in body weight. Evolutionary influences created a human body with a powerful defense against under-nutrition, the capacity to store excess energy as fat. However, this advantage in times of scarcity is not well adapted to an environment in which food is plentiful. The theory of the "thrifty gene" emerged in the 1960s advanced by James Neel to explain the prevalence of Type II diabetes and obesity in the population (Neel 1962). In its most general form, the theory posits that genotypes enabling the deposition of fat during times of abundance would be an evolutionary advantage. Over time, however, this genotype advantage would be lost as food sources became more abundant. As a result, individuals are predisposed to deposit fat, regardless of the need to store such reserves for times of famine. This hypothesis, although later rejected by Neel himself (Neel 1989), gained popularity as an explanation for high rates of obesity among particular groups exposed to Western diets.

The thrifty gene hypothesis cannot explain all of the increase in obesity prevalence or the variation within population groups. It is more likely that a wide range of genetic influences affect weight gain. Research has shown that there are individual differences, based on biology, in the predisposition to gain weight (Bouchard 2007; Farooqi and O'Rahilly 2007). Genes have been identified associated with poor regulation of satiety and appetite, diminished ability to use dietary fats as fuel, and easily stimulated ability to store body fat (de Krom et al. 2009). The value of pursuing a biological – or genetic predispositional – approach to obesity lies in its ability to contribute to pharmaceutical development and behavioral or dietary strategies for weight loss (Farooqi and O'Rahilly 2007). The interaction of genetic predisposition with shifting environments is likely to be the explanation of increased obesity.

Cultural Factors

Genetic explanations, while useful for understanding the long-term trends in body size, and for understanding the biological framework upon which the current obesity levels can be viewed, cannot explain the very recent changes observed. Similarly, individual level psychosocial factors cannot explain the long-term trend. For this, we must look more closely at social and cultural factors, which have changed in the past 40–50 years and may have contributed to the increased body size seen in most developed nations.

One cultural change often associated with the rise of obesity is the increased participation of women in the labor force. The argument is that as more women have begun working full time, families have tended to eat out more and to prepare more convenience foods at home – foods that, in general, have higher fat contents than foods prepared from fresh ingredients. Anderson et al. (2003) advanced this argument as a partial explanation for the rising obesity among children. Chou et al. (2004)

show that as the value of women's time has increased with labor force participation, the amount of time spent in the home is reduced, increasing the reliance on convenience foods. However, in their analysis Cutler et al. (2003) conclude that there is no relationship between female labor force participation and obesity trends.

Another area of cultural change has been the decline in smoking. In general, smoking is associated with lower body weight. This effect might be particularly strong in determining the initiation of smoking behavior. Young women who are overweight or trying to lose weight are more likely to begin smoking (Cawley et al. 2004). Chou et al. (2004) argue that as the cost of smoking has increased, smoking rates have declined, and there has been a concomitant increase in weight. In their research, Cawley et al. (2004) found that this price effect was strong for young men, but not for young women.

The use of leisure time has changed as well. Over the last few decades more recreational time, especially among children, is spent on television watching, computer use, and video games. Based on data from the National Time Use Survey, Americans spent about 3 h a day watching television, compared to less than 1 h/day in leisure time physical activities, like sports or exercising (American Time Use Survey 2008). Although national estimates of the time spent on the computer are not available, in the latest data available, 2005, over 60% of households had access to the Internet at home (U.S. Bureau of the Census 2007).

Data from the National Health Interview Survey indicate that 32% of American adults engage in some regular leisure time physical activity, defined as light-moderate activity at least 5 times a week for 30 min or vigorous activity at least 3 times a week for 20 min (NCHS 2009). This prevalence declines steadily with age, to about 26% of Americans age 65–74 and 18% of Americans age 75 and older. At all ages, the rates are higher for men than for women. There has been little change in the population level of physical activity since 1997, with the annual age adjusted percentages ranging from 29.6 to 32.8 with little consistent trend evident.

Environmental Factors

A variety of environmental factors may also play a role in the rise of obesity prevalence. Environmental changes have affected both diet and levels of physical activity. One dietary change suspected of contributing to weight gain is the increased use of high fructose corn syrup (HFCS). An extensive review of epidemiologic and clinical evidence finds that this hypothesis can be neither supported nor refuted (Forshee et al. 2007). HFCS is used more extensively in the United States than in other countries where sucrose continues to be the primary caloric sweetener. The link between HFCS and weight gain is indirect. Some research has shown that HFCS is sweeter than sucrose and leads to greater consumption of calories. There is also evidence that increased levels of HFCS have adverse metabolic consequences due to changes in the fructose:glucose (F:G) ratio. HFCS may decrease production of the satiety hormone leptin and increase levels of ghrelin, associated with appetite stimulation. In addition, the use of HFCS may be related to an increased consumption of liquid calories, primarily in the form of carbonated soda drinks. Liquid calories tend to be less satiating than calories obtained through solid food consumption.

Environmental changes may have contributed to a decrease in physical activity, and, consequently to an increase in weight. One such factor is the fear of crime. In areas where crime rates are high, children and adults may not feel safe walking in their neighborhoods or using playgrounds. This effect might be particularly strong for girls (Gomez et al. 2004). In addition, in many urban areas, sidewalks and public parks have not been maintained, making them both unsafe and unattractive for use. In other areas, sidewalks may not exist at all. Schools devote less time to physical activity, either through free play time, like recess or structured physical education courses (Story et al. 2006).

Another environmental change is the changing nature of work and work-related tasks. As labor has become less physically demanding, the amount of energy expended in paid employment has declined (Philipson and Posner 2003). However, evidence from time diary studies indicates that the majority of the declines in energy expenditure occurred between 1965 and 1975 (Cutler et al. 2003). In addition, the shift to cars rather than walking to work may have contributed to a decline in physical activity. However, both of these changes occurred before the obesity increase, making them less likely as explanations.

Economic Factors

One economic explanation for the obesity increase focuses on the relative prices of food items. Lakdawalla and Philipson (2009) argue that technological advances in agriculture have caused food prices to fall. This decline in real prices of groceries caused a surge in caloric intake. Cawley (1999) finds that BMI is negatively related to prices. In addition, if the prices of calorie-dense foods (e.g., foods sold by fast food restaurants) fall faster than those for less calorie-dense foods (e.g., vegetables), consumers will tend to shift consumption to the cheaper alternatives (Finkelstein et al. 2005).

It is unlikely that any one explanation can account for the recent dramatic increases in BMI. The evolutionary predisposition toward storing energy in the form of fat and increasing appetite in times of plenty has created a situation in which imbalances in caloric intake and energy expenditure will lead to excessive fat. In addition, cultural and environmental changes have made such an imbalance more likely to occur. The increased availability and reliance on energy dense foods at the same time as physical activity declined have made the energy balance more precarious. Given the increased levels of overweight and obesity, attention has focused on the potential negative consequences of this trend.

Consequences and Harm

Physical Health

It is well established that overweight and obesity are significant risk factors for developing several chronic health conditions in later life, including diabetes, high blood pressure, high cholesterol, coronary heart disease, arthritis, and certain types of cancer (Mokdad et al. 2003; Paul and Townsend 1995; Wolf and Colditz 1998; Villareal et al. 2005). These effects are found across the life course, beginning in childhood and persisting into later life (Ferraro et al. 2003; Gregg et al. 2005; Koplan et al. 2005; Whitmer et al. 2005). Most generally, obesity has been shown to be related to an overall decline in health-related quality of life (Ford et al. 2001). Most of the increased risk for chronic diseases is a direct physical result of overweight and obesity, but several authors suggest that the stigma of being overweight is so pronounced in the medical field that many avoid going to the doctor, complicating the diagnosis of medical conditions and their care (Puhl and Brownell 2001, 2003; Schwartz et al. 2003).

The diseases most closely associated with obesity are Type II diabetes and coronary heart disease. Since the likelihood of developing diabetes increases significantly as body fatness increases, many have attributed the increased prevalence of Type 2 diabetes to the increased obesity of the world's population. According to the *World Health Report 2002*, approximately 58% of diabetes globally is attributable to excess weight (WHO 2002), while in the United States the prevalence of diabetes

rose 132% between 1980 and 2006 (CDC 2008). Diabetes in midlife is associated with a variety of complications later in life. Those with diabetes are more likely to develop heart problems or suffer from strokes (see http://diabetes.niddk.nih.gov/dm/pubs/stroke/index.htm).

The effects of obesity on mortality are less definitive. Although researchers agree that there is some effect, the overall magnitude and age gradient is less clear (Flegal et al. 2005; Fontaine et al. 2003; Olshansky et al. 2005). The risk is highest for those who have been overweight for longer periods of time and decreases if one does not become overweight or obese until after age 50 (Flegal et al. 2005). Adults under the age of 50 show the clearest association between obesity and increased mortality (Stevens et al. 1998; Thorpe and Ferraro 2004). In longitudinal analyses, obesity in middle adulthood (ages 30–49) has been shown to be associated with an approximately 6 year lesser life expectancy when compared to normal weight individuals (Peeters et al. 2003). At very old ages, higher BMIs may be associated with lower mortality risks and the BMI associated with the lowest mortality appears to increase compared to younger age groups (Heiat et al. 2001). The lack of a clear relationship between obesity and mortality at older ages has been labeled by some as the "obesity paradox" (Beddhu 2004; Uretsky et al. 2007).

The reasons for the observation that obese subjects tend to fare better than, or at least as well as, their normal weight peers may be related to an unobserved underlying factor, nutritional reserves, or medical therapy (Osher and Stern 2009). Variations in weight, including weight loss, gain, and weight cycling, among the elderly may signal underlying health problems associated with higher mortality (Arnold et al. 2010). The effect of obesity on mortality may be changing over time as well. The introduction of better drugs for treating high cholesterol and hypertension appears to be reducing the disease risks of the obese, at least with respect to cardiovascular disease (Gregg et al. 2005). Although opinions differ, the long-term impact of these interventions on mortality rates and life expectancy may counteract the increased risks associated with obesity, at least at BMI levels below 35.0 (Olshansky et al. 2005; Preston 2005; Reuser et al. 2008).

Perhaps because of the association between obesity and disease, obese individuals tend to have an increased prevalence of functional limitations (Ferraro et al. 2002; Himes 2000; Jenkins 2004). Ferraro and Booth (1999) summarize three pathways through which obesity may impact physical functioning. First, excess weight adds stress to the skeleton and weight-bearing joints, increasing the likelihood of arthritis and joint problems. In addition, excessive weight contributes to insulin resistance, which may damage connective tissues. Finally, they argue, weight may lead to a pattern of blood lipids that leads to atherogenesis and decreased functioning.

Obesity may also limit physical activity, depriving individuals of the benefits of exercise resulting in decreased cardiovascular fitness and muscle strength. This would be particularly relevant for the development of mobility limitations. Obese individuals have more trouble walking, climbing stairs, and getting in and out of bed compared to those who are not obese (Himes 2000; LaCroix et al. 1993; Launer et al. 1994). Jenkins (2004) examines individuals 70 and older over a 3-year time period and finds that obese are more likely to suffer the onset of functional limitations (loss of lower body mobility, strength, or ADL limitations) than those who are not obese. Ferraro et al. (2002) find similar longitudinal results across a wider age range, and also note that obesity is associated with a more rapid increase in disability over time. This limitation in mobility may be particularly problematic for older individuals who may need assistance to carry out daily tasks.

Numerous cross-sectional studies have examined the relationship between body weight and a variety of measures of functioning and disability. In general, greater levels of impairment are found at the extremes of the body size distribution (Galanos et al. 1994; Okoro et al. 2004).

Cross-sectional studies also have shown that excess weight has a negative effect on lower body functioning when using both direct measures of functioning (Apovian et al. 2002) and self-reports of limitations (Himes 2000). Data from the NHANES III survey show that for women aged 70 and older there is a strong relationship between obesity and mobility-related functional limitations. Obese women were two times as likely to report a functional limitation as normal weight women.

This relationship is weaker for men, but obese men were still 1.5 times as likely to report a limitation as their normal weight counterparts (Davison et al. 2002).

There is a documented negative effect of both obesity and overweight on ADL and IADL functioning. Sturm et al. (2004) find that for older women the probability of ADL limitations doubles for those with moderate obesity and quadruples for those with severe obesity. Using data from the Medicare Current Beneficiary Survey, Lakdawalla et al. (2005) estimate that obese 70-year-olds can expect to spend 40% more time in disability than their normal weight counterparts. In addition, the obese spend more time in the most disabled groups (at least three ADL limitations or institutionalized) than those of normal weight. At the same time, they find few differences in life expectancy or disability free life expectancy when comparing the overweight and normal weight groups.

In terms of cognitive functioning, BMI may operate differently at different stages of the life course. Higher BMI at midlife is associated with higher risk of dementia at older ages (Whitmer et al. 2005). One reason for this relationship may be the increased prevalence of diabetes among the obese in midlife. Diabetes at midlife has been linked to dementia more than 3 decades later (Beeri et al. 2004). At the same time, independent of disease status, there is a link between weight loss and Alzheimer's disease in later life (Atti et al. 2008; Buchman et al. 2005). Unexplained weight loss among the elderly may be an indicator of incipient cognitive decline in late life (Atti et al. 2008).

Combining the effects of mortality and morbidity, researchers have compared estimates of active life expectancy between obese and nonobese adults (Lakdawalla et al. 2005; Peeters et al. 2004; Reynolds et al. 2005). All find that because of the increased risks of disability and mortality, obese populations have significantly lower life expectancy free of disability than the normal weight population. The explanation for this difference may be due to a similar number of years of disability lived between normal weight and obese populations, but shorter life expectancies (Peeters et al. 2004) or due to similar overall life expectancy, but differences in the number of years spent disabled (Lakdawalla et al. 2005; Reynolds et al. 2005).

Mental Health

Obesity is considered one of the strongest stigmas in American society. Obesity is still viewed by many as a personal failing, a sign of character weakness. Common stereotypes of the overweight include laziness, self-indulgence, impulsivity, and incompetence (Paul and Townsend 1995; Roehling 1999; Rothblum 1992). People hold those who are overweight responsible for their own condition and often think that if they simply had more willpower, they would reduce their food intake and, thus, lose weight (Puhl and Brownell 2003; Rothblum 1992). These stereotypes persist despite evidence that overweight people generally do not have higher caloric intakes than those of average weight (Rothblum 1992). Even overweight and obese people themselves have been found to subscribe to these stereotypical anti-fat attitudes, suggesting that they have internalized the social stigma of being overweight (Wang et al. 2004). The stigma of obesity is so strong, that one survey found that 24% of women and 17% of men would choose to live three or more years less if they could be their desired weight (Puhl and Brownell 2003). Being overweight at older ages appears to have somewhat fewer social consequences than does at younger ages. There is significantly more pressure on younger adults to be thin and fit. Moreover, older people are significantly less likely to be in either the marriage or job markets, thus they are less likely to be subjected to sanctions on the basis of body size. Thus being overweight may not be as stigmatizing for the elderly as for those at younger ages.

The relationship between weight and psychiatric disorders is complex. There is little evidence that obesity is associated with anxiety disorders (Bjerkeset et al. 2007; Williams et al. 2009). However, obesity may be a clinical condition that predisposes an individual to depressive disorders

(Williams et al. 2009). Weight stigmatization may be one factor increasing the vulnerability to depression among obese individuals. Recent analyses of a community-based sample in Norway found higher body mass to be associated with increased risk of depression for both men and women (Bjerkeset et al. 2008). Studies of obese patients find a relationship between childhood teasing based on appearances and adult depression (Jackson et al. 2000). This supports the finding that it is not obese itself which contributes to depression, but the interpersonal mistreatment due to weight (Carr et al. 2007).

Individual-Level Economic Consequences

As a result of both the physical consequences and stigmatization, obesity has been shown to be related to generally negative economic outcomes at the individual level. For example, in the United States white females have both lower rates of obesity and higher average income than African-American or Hispanic women. Chang and Lauderdale (2005) find strong negative correlations between income and BMI for white and African-American women, with a weaker correlation for Mexican-American women. Among men, they find a weak negative correlation between income and BMI for white men, but for Mexican-American and African-American men they find a positive correlation between income and BMI. Hedley and Ogden (2006) find that within each race-gender group, the prevalence of obesity rose across all income categories in recent decades, and that the differences in the prevalence of obesity by income (within race-gender group) have decreased over time.

The lower earnings of obese individuals have been attributed to several factors. Obese adolescents, especially women, are less likely to graduate from high school and less likely to attend college than their average weight peers (Crosnoe 2007). This effect is stronger if obesity is normative in the school (Crosnoe and Muller 2004). Obese employees also suffer from discriminatory practices (Puhl and Brownell 2001). In addition, obese workers are more likely to have moderate to high levels of absenteeism from work than their nonobese counterparts (Wolf and Colditz 1998). In addition, Cawley (2004) finds that heavier women are significantly more likely than women at the recommended weight to report employment disability. The effects of lower earnings may persist into later life. Many retirement benefits, including Social Security, are determined at least in part by lifetime earnings. Lower earnings can translate into lower incomes and increased economic insecurity in later life. In fact, older women who are obese have lower net worth than their normal weight peers (Fonda et al. 2004). This relationship appears not to hold true for men, however, indicating a difference in the effects of body size on earnings and asset accumulation.

Societal Economic Impact

The impacts of obesity on individual health, well-being, and economic situation are not the only considerations. The high prevalence of obesity in the adult population also has broader economic implications. Given the public financing of many health care services, especially Medicaid and Medicare, the medical costs of obesity are important to consider. Estimates are that from 5 to 7% of all annual health care expenditures are attributable to obesity (Finkelstein et al. 2005). As noted above, the effects of obesity are much stronger for morbidity than mortality, particularly at old ages. The use of simulation models of the health care costs associated with obesity. Lakdawalla et al. (2005) estimate that from age 70 onward Medicare spends 35% more on an obese person than one of normal weight. Underweight individuals also have high Medicare costs relative to normal weight, but these costs are incurred for fewer years. In similar analyses, Daviglus et al. (2004) have shown that obesity is linked to higher lifetime health care costs.

Health care costs are not the only economic considerations. Most studies show that overweight, and particularly obese, individuals miss more days of work. Obese employees are more likely to have moderate to high levels of absenteeism from work than their nonobese counterparts. Wolf and Colditz (1998) estimate that in 1988 alone, over 52 million work days were lost to obesity, while in 1994 another 58 million work days were lost, at annual price tags in excess of $5 billion. Burton et al. (1998, 1999) found that as BMI increases, so do the number of sick days and absenteeism from work. Tucker and Freidman (1998) studied over 10,000 employees and found that obese workers were 2 times as likely to have high-level absenteeism, defined as seven or more absences in the past 6 months, and 1.5 times as likely to have moderate absenteeism, defined as 3–6 absences in the past 6 months, than lean employees. The higher rates of absenteeism and missed work days contribute to lower overall productivity and reduced public revenue.

The individual and societal costs of obesity are numerous. Individuals who are obese have poorer physical health, lower educational attainment, and lower earnings. As a country, an increasing proportion of health care dollars is spent treating and managing the effects of obesity. Despite these costs, the proportion of the population considered obese has increased. If efforts to date have done little to stop or reverse the trend, what new approaches to the problem can be considered?

New Frontiers

The majority of American adults are now overweight and over a third are obese. Within specific subpopulations, the prevalence is even higher. Current approaches to curbing obesity focus on individual change. However, as the preceding discussion makes clear, the obesity problem has sources outside of the control of individuals. Even individual behaviors like diet and exercise patterns are embedded in social relationships and culture. The recent emphasis on social network analysis to examine the spread of obesity through social relations highlights the complex social nature of the factors leading to weight gain (Christakis and Fowler 2007). To expect that individuals can, on a widespread scale, overcome those cultural strictures is unrealistic. The focus on individual self-control for weight control cannot be effective. Like other public health problems throughout history, obesity needs to be addressed on a societal level. The complex causes and consequences of obesity point to a multidisciplinary and multilevel research approach. If obesity is considered as a social problem, with multiple causes outside of the control of individuals, new considerations can be given to a wide range of approaches (Nestle and Jacobson 2000).

Although obesity is linked to a variety of health problems, the advantages of weight loss at older ages are unclear. Among those with diabetes, a modest weight loss of 5–10 lb has been shown to significantly improve control of glucose levels and a reduction in cardio-vascular risk factors (Espelande et al. 2007). Weight loss is recommended for obese patients suffering from high blood pressure, heart disease, and arthritis (Osher and Stern 2009). The value of weight loss among the elderly population without chronic conditions, however, is unclear. The BMI associated with lower mortality is higher for those over age 65 compared to those under 65 (Janssen and Mark 2007). In fact, weight loss is associated with excess mortality among normal, overweight, and mildly obese among those aged 50–70 (Myrskala and Chang 2009). This suggests that the benefits of lower BMI may not hold true late in life. Still, there is considerable evidence that entering later life obese increases the chances that an individual will have chronic health problems and an increased chance of experiencing limitations in activity (Osher and Stern 2009). Focusing on addressing obesity at younger ages is likely to result in a healthier older population (Ferraro et al. 2003; Olshansky et al. 2005).

An individual focus often leads to medical solutions. For instance, the rates of bariatric surgery have increased dramatically in recent years (Santry et al. 2005). Such surgery can be effective for

some individuals; however, long-term results are difficult to maintain (Shah et al. 2006). Other medical interventions are based on pharmacological treatments options. There is great interest in studying the hormonal and neural mechanisms involved in the control of appetite in hopes of identifying methods of controlling eating. But current drug treatments for obesity are limited and the associated weight loss is small, usually not more than 10% (Berthoud and Morrison 2008).

What types of societal interventions are possible? Fiscal and regulatory policies can be implemented at the federal, state, or local level. Two widely discussed options are tax policies that would influence food prices and food labeling policies in restaurants that would provide consumers with nutritional information. Other, broader, options focus on making changes in the built environment which would encourage physical activity and influence children's behavior through school-based programs.

Over the past several years, there have been many attempts to regulate food prices through differential tax policies. These efforts are modeled after the established "sin taxes" in place of tobacco and alcohol products. Proponents argue that taxes on certain foods would limit their consumption and result in desirable health effects. The item most often targeted is sugared beverages. As noted above in the discussion of HFCS, but even more generally of all sugared beverages, their consumption is linked to increased body weight, poor nutrition, and increased risk for diabetes (Nielsen and Popkin 2004). Limiting their consumption, through increased prices, could be one factor in obesity prevention. One study has suggested that for every 10% increase in price of sugared beverages, consumption decreases by 7.8% (Brownell and Frieden 2009). Objections to this type of tax focus on the unfairness of targeting one type of food; that such a limited approach would not solve the obesity problem. However, if obesity is seen as a multileveled problem, requiring multiple approaches, tax policy could be one part of such an approach.

Food labeling policies may influence food choices through better information on the nutritional value of specific foods. One study of the effects including calorie information on menus showed that consumers altered their behavior only when additional information on the daily recommended allowance of calories was included (Roberto et al. 2010). New York City recently implemented a menu labeling policy requiring fast food restaurants to post calorie labels on their menu boards and sit down restaurants to include calorie information on the printed menu. Analysis of the implementation of this policy found limited effects at the population level on the total number of calories purchased (Elbel et al. 2009). One conclusion is that labeling must be accompanied by widespread educational campaigns to be successful in altering behavior (Nestle 2002). As with tax policies, one single intervention is unlikely to have a large impact on behavior, and a multifaceted approach has greater chances of success.

Environmental changes that would increase physical activity are another approach to creating more balance in the energy equation. Federal funding has focused on the development of interstate highways and the facilitation of motorized transportation. Prompted by both health and environmental concerns, emphasis is shifting to the construction of pedestrian and bicycle pathways as alternatives (Handy et al. 2009). This focus on "active travel" can influence behavior. An overview of the evidence demonstrates that changes in the built environment can increase physical activity levels (Transportation Research Board and Institute of Medicine 2005). One study of residents in neighborhoods with high walkability (well-connected streets, sidewalks, and nonresidential destinations) got 40–50 min more exercise per week than their counterparts in low-walkability areas of the same cities (Sallis et al. 2009).

The best programs may involve multiple levels of involvement. An example of a successful partnership between school and community is the Shape Up Somerville program in Somerville, Massachusetts (Economos et al. 2007). Started in 2002 the program involved children attending grades one through three in public elementary schools in three participating communities. The intervention involved increased physical activity and increased availability of healthful foods. Most notably, the efforts extended beyond the school to include changes in home and community environments.

The success of the program, measured by lower BMI increases in children at high risk for obesity, demonstrates the potential value of a multi-pronged approach.

All of these options – tax policy, food labeling, changes in the built environment, and education – can address one piece of the energy imbalance. Just as the increased prevalence of obesity has no one identifiable cause, it has no one identifiable solution. Efforts to limit the increasing body size of the population cannot focus solely on individual and medical intervention. Bariatric surgery can be beneficial for individuals facing severe health consequences, but reliance on surgical and pharmaceutical solutions ignores the societal structure in which individuals will continue to live. With obesity, social scientists have the opportunity to apply their understanding of the social world to address a pressing social problem.

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Chapter 33
Religious Involvement, Health Status, and Mortality Risk

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Religious involvement – indicated by observable feelings, beliefs, activities, and experiences in relation to spiritual, divine, or supernatural entities – is a prevalent and powerful force in the lives of older adults. Despite evidence of secularization and the declining significance of religious institutions (Chaves 1994), elderly Americans continue to exhibit high rates of religious involvement. According to national estimates from the 2008 General Social Survey, a large percentage of adults aged 65 and older affiliate with religious groups (93%), characterize their affiliations as strong (56%), attend religious services weekly or more (42%), pray at least once per day (68%), and believe that the Bible is the actual word of God and is to be taken literally (37%). These figures are remarkable in their own right. They also inspire countless questions concerning the consequences of religious involvement in late life.

This chapter provides an overview and critical examination of published research on the health consequences of religious involvement in the elderly population. After describing general religious variations in health and mortality risk, we present major theoretical and empirical explanations for these patterns. We conclude with a detailed discussion of the limitations of previous work and note viable avenues for future research. In the sections that follow, we emphasize seminal research articles, recent studies, and notable reviews of empirical evidence. Although we intend for this research collection to be representative of the field, we do not consider it to be exhaustive.

Health and Mortality Patterns

In this section, we briefly summarize known religious variations in health and mortality risk. We first highlight patterns across several indicators of mental and physical health. We then consider the evidence from studies of all-cause and cause-specific mortality.

Mental Health

Numerous studies show that religious involvement is associated with favorable mental health outcomes in the elderly population. This general pattern is remarkably consistent across indicators of mental health, including anger (Carr 2003), depression (Braam et al. 2004; Idler 1987; Idler and

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Kasl 1997a; Idler et al. 2009; Jang et al. 2005; Law and Sbarra 2009; Norton et al. 2008; Strawbridge et al. 1998), anxiety (Cicirelli 2002; Krause 2005), nonspecific psychological well-being (Fry 2001; Idler and Kasl 1997a), life satisfaction (Levin et al. 1996; Krause 2003a, 2005), and cognitive functioning (Hill et al. 2006; Reyes-Ortiz et al. 2008; Van Ness and Kasl 2003). Although the majority of studies are cross-sectional, longitudinal evidence also suggests that religious involvement is associated with favorable mental health trajectories in late life (Braam et al. 2004; Hill et al. 2006; Law and Sbarra 2009; Norton et al. 2008; Reyes-Ortiz et al. 2008; Van Ness and Kasl 2003).

Physical Health

Surprisingly few studies have considered the association between religious involvement and physical health in the elderly population. Nevertheless, studies indicate that religious involvement is associated with favorable physical health outcomes. This pattern is consistent across a limited range of physical health indicators, including self-rated health (Idler et al. 2009; Krause 1998, 2006a; Musick 1996), functional status (Benjamins 2004; Idler 1987; Idler and Kasl 1997b; Park et al. 2008), and stroke (Wolinsky et al. 2009). Once again, available longitudinal evidence demonstrates that religious involvement is associated with favorable physical health trajectories in late life (Benjamins 2004; Idler and Kasl 1997b; Krause 1998; Park et al. 2008; Wolinsky et al. 2009).

Mortality Risk

If religious involvement favors mental and physical health in the elderly population, evidence of a survival advantage should come as no surprise. Indeed, several longitudinal studies indicate that religious involvement (typically indicated by attendance at religious services) is associated with lower risk of all-cause mortality (Dupre et al. 2006; Ellison et al. 2000; Gillum et al. 2008; Helm et al. 2000; Hill et al. 2005; Hummer et al. 1999; Koenig et al. 1999; Krause 2006b; la Cour et al. 2006; Lutgendorf et al. 2004; Musick et al. 2004; Oman and Reed 1998; Oman et al. 2002; Strawbridge et al. 1997). There is also some evidence to suggest that religious involvement is associated with lower risk of mortality from specific causes, including circulatory diseases, respiratory diseases, and other causes (Hummer et al. 1999; Oman et al. 2002).

Major Theoretical and Empirical Explanations

In this section, we consider major theoretical and empirical explanations for why religious involvement might favor health and longevity. Several significant articles and books have addressed this issue (e.g., George et al. 2002; Idler 2004; Koenig et al. 2001; Seeman et al. 2003). Drawing on this body of work and relevant empirical evidence, we discuss several potential social, psychological, behavioral, and biological mechanisms.

Social Resources

Social isolation and its health consequences are major concerns in the elderly population (Gray 2009; Kobayashi et al. 2009). As adults transition to old age, they retire from socially engaging work roles, their children grow up and move away, and health conditions increasingly limit social activities, create significant caregiving responsibilities, and enhance the probability of spousal loss.

Religious involvement may help to counteract the risk of social isolation and promote health and longevity by enhancing a range of social resources.

Studies show that religious involvement (especially religious attendance) is associated with larger and more diverse social networks, more contact with network members, more stable marriages and extensive family ties, more types of social support received and perceived (both instrumental and emotional), and greater civic participation, including memberships to religious and secular organizations and groups (Ellison and George 1994; Gray 2009; Idler and Kasl 1997a; Krause 2008; McIntosh et al. 2002; Strawbridge et al. 1997). Recent work by Kobayashi et al. (2009) demonstrates that regular religious attendance (at least monthly) reduces the odds of social isolation among older adults by 128%, even with adjustments for health status, chronic conditions, and activity limitations.

Public involvement in religious communities clearly influences the size and nature of social networks in late life. Strong religious beliefs concerning the sanctification of the family could encourage older adults to maintain strong family ties, although some research suggests that religious beliefs can also contribute to conflict between older parents and adult children (Clarke et al. 1999). Divine relations may also play a significant role in promoting health and well-being when older adults believe that they are constantly supported and loved by a supernatural entity (Harvey and Silverman 2007; Van Ness et al. 2008).

Several studies have formally tested whether social resources help to explain why religious involvement might favor health and longevity in old age; however, many of these tests are difficult to interpret because multiple mediators are entered simultaneously. Research suggests that leisure social activities and, to a lesser extent, number of close kin help to explain favorable disability trajectories (Idler and Kasl 1997b). Other studies show no support for social interaction and interaction satisfaction as links to self-rated health (Musick 1996) or marital status, number of children, and financial support as mechanisms to functional health (Benjamins 2004). With respect to mortality outcomes, some research confirms the mediating influences of marital status, social connections, social activity, and the receipt and provision of social support (Ellison et al. 2000; la Cour et al. 2006; Strawbridge et al. 1997), while others show no evidence of mediation for number of confidants, frequency of social contact, and perceived social support (Hill et al. 2005; Koenig et al. 1999; Musick et al. 2004).

Psychological Resources

Old age is also characterized by the loss of important psychological resources, including self-esteem, the sense of control, optimism, and meaning and purpose (Koenig et al. 1988). In addition to deficiencies in health, valued social roles, and sources of love and support, many elderly persons are especially vulnerable to financial hardship and numerous stressors in the environment (e.g., poor neighborhood conditions). As older adults struggle with multiple adverse conditions, they are forced to question themselves in very fundamental ways: Who controls my life? Am I valuable? Is my life meaningful? Am I loved or even worthy of love? Am I safe? Religious involvement may favor health and longevity by helping to answer some of these questions by reinforcing important psychological resources.

Studies show that religious involvement is positively associated with key psychological resources, including self-esteem (Krause 1992, 2003a, 2005), self-control (McCullough and Willoughby 2009), personal control or mastery (Dillon and Wink 2007; Jang et al. 2003; Schieman et al. 2005), optimism (Ai et al. 2002; Krause 2003a, 2005), and meaning and purpose (Ardelt and Koenig 2006; Krause 2003a). Religious involvement may enhance psychological resources and positive coping by promoting social connections, social activities, and specific religious beliefs.

Religious attendance provides people with the opportunity to interact with those who hold similar values and beliefs, and these interactions can be important for self-esteem because they reinforce positive role identities and role expectations. Ellison (1993) notes that active religious participants

are often valued for skills and abilities that are uniquely connected with church-related activities (e.g., singing in choir, participation in religious discussion groups, and praying for others), respected for service to others in the community (e.g., volunteering and specific leadership roles), and admired for personal spiritual qualities (e.g., wisdom and morality). Positive self-perceptions gained through religious involvement may be especially valuable for the elderly who lack important socially valued roles.

Religious involvement is characterized by social control and self-regulation. Within the context of religious communities, there are social (and perceived divine) sanctions associated with conformity to and deviance from established religious standards (e.g., behavioral and ritual standards and expectations). Religious involvement contributes to self-control by building generic self-regulatory strength over the life course (McCullough and Willoughby 2009). Because religion is, in many respects, a routine practice of constraint and restraint, older religious adults are more likely to believe that they can control their emotions and behavior. A strong sense of divine control may also help to promote a sense of personal control or mastery over various aspects of life when older adults trust that anything is possible through faith and a strong partnership with God (Harvey and Silverman 2007; Schieman et al. 2005).

Religious involvement may contribute to hope and optimism by fostering positive self-conceptions and control beliefs. When older adults are faced with adversity, confidence derived from self-esteem and a sense of control can be instrumental in solving problems. It can be useful to think of life as unfolding according to some divine plan. Beliefs such as these promote a sense of meaning and purpose, which helps to buffer appraisals of difficult life conditions (Harvey and Silverman 2007; Pargament 1997).

Although psychological resources are theoretically viable explanations for why religious involvement might favor health and longevity in old age, very few studies have formally examined this class of mechanisms. Nevertheless, research suggests that self-esteem (Krause 1992) and a sense of meaning and purpose (Ardelt and Koenig 2006; Krause 2003a) help to explain the association between religious involvement and mental health.

Healthy Behaviors

When older adults experience the loss of health and valuable social and psychological resources, they often struggle to maintain certain healthy behaviors. Healthy behaviors like exercise require a certain degree of health. Proper adherence to complex medical regimens also calls for a strong sense control. Religious involvement could contribute to health and longevity in old age by promoting healthy behaviors.

Studies show that religious involvement is associated with a wide range of healthy behaviors in the elderly population, including lower levels of smoking (Idler and Kasl 1997a; Klemmack et al. 2007; Koenig et al. 1998a) and drinking (Idler and Kasl 1997a; Krause 2003b), higher levels of exercise (Idler and Kasl 1997a; Oman and Reed 1998; Strawbridge et al. 1997), greater use of preventive health care services (Benjamins 2005, Benjamins and Brown 2004), and more rigid adherence to medication regimens (Koenig et al. 1998b). There is even some evidence to suggest that older religious adults exhibit a stronger preference for and willingness to undergo life-sustaining treatments (Cohen-Mansfield et al. 1992; Van Ness et al. 2008). Body mass is one possible exception to the healthy lifestyle profile of religious adults. Studies clearly demonstrate that older religious adults tend to weigh more, not less, than their less religious counterparts (Idler and Kasl 1997a; Oman and Reed 1998; Strawbridge et al. 1997). However, research also suggests that religious adults are less likely to be underweight (Musick et al. 2004), which is especially relevant in old age.

There are several compelling explanations for why religious involvement is associated with so many healthy behaviors in old age. First and foremost, religious involvement exposes individuals to moral directives that are supported by the authority of longstanding religious traditions and sacred texts. With prolonged exposure (through religious involvement), individuals may internalize religious messages that discourage specific health-relevant behaviors (e.g., biblical proscriptions against intoxication). Specific religious proscriptions may help to explain why religious individuals might avoid particular behaviors (e.g., heavy drinking), but they cannot account for the effects of religious involvement on health-relevant behaviors that are unspecified in religious scripture (e.g., smoking and use of preventive health care services).

Interestingly, many religious groups adhere to general religious principles that sanctify the body and promote the instrumental importance of physical health as a means to greater spiritual commitment and involvement (e.g., 1 Corinthians 3:16–17; 1 Corinthians 6:19–20). Mahoney et al. (2005) refer to sanctification as a process through which objects are infused with divine or spiritual significance. 1 Corinthians (6:19–20) provides an especially direct example of the sanctification of the body: "…your body is the temple of the Holy Spirit who is in you…therefore glorify God in your body, and in your spirit, which are God's." Many religious groups use this passage to promote the body as a sacred object and to discourage a wide range of health-relevant behaviors, including, for example, alcohol consumption, tobacco smoking, illicit drug use, risky sexual behaviors, and even body piercing and tattooing.

Religious involvement could also contribute to healthy behaviors by encouraging deference to authority and conformity to rules and laws (Welch et al. 2006). Numerous biblical passages counsel adherents to submit to various "authorities" and "ordinances" (e.g., Hebrews 13:17; Peter 2:13–14; Romans 13:1–7). For instance, Romans (13:1–2) advises: "Let every soul be subject to the governing authorities. For there is no authority except from God, and the authorities that exist are appointed by God. Therefore whoever resists the authority resists the ordinance of God, and those who resist will bring judgment on themselves." Welch et al. (2006) explain that religious involvement may favor conformity through fear of divine retribution, internalized moral codes, guilt avoidance, and the social context of similarly obedient peer networks. If religious individuals are more sensitive to authority, which is often sanctified, they may be more likely to trust physicians, adhere to recommended medical regimens, and avoid risky health-related activities. Indeed, many religious older adults view physicians and institutions of medicine as instruments through which God heals (King et al. 2005).

Healthy behaviors are the most intuitive explanations for the effects of religious involvement on health and longevity, and several studies have formally examined these links. With respect to disability status, studies support the mediating influences of smoking (Benjamins 2004) and exercise (Benjamins 2004; Idler and Kasl 1997b); however, Idler and Kasl (1997b) also show no evidence of mediation for alcohol consumption, smoking, and body mass. Musick (1996) tested smoking and alcohol consumption as links to self-rated health, but found no support for these mechanisms. Some mortality studies indicate that smoking (Dupre et al. 2006; Ellison et al. 2000; Hummer et al. 1999; Strawbridge et al. 1997), body mass – especially underweight (Dupre et al. 2006; Hummer et al. 1999; Musick et al. 2004; Strawbridge et al. 1997), exercise (Musick et al. 2004; Strawbridge et al. 1997), and alcohol consumption (Strawbridge et al. 1997) are important explanatory factors, while others show little to no mediating influence for smoking (Helm et al. 2000; Koenig et al. 1999; la Cour et al. 2006), body mass (Helm et al. 2000; Koenig et al. 1999; la Cour et al. 2006), and alcohol consumption (Dupre et al. 2006; Ellison et al. 2000; Hill et al. 2005; Hummer et al. 1999).

Biological Markers

Biological markers or biomarkers are objective indicators (derived from independent assessments like blood and saliva, not self-reports) of physiological functioning (e.g., cardiovascular and

immune functioning) that are known to predict health and mortality risk. Like most health outcomes, biomarkers are not randomly distributed in society. They are shaped by repeated and patterned social, psychological, and behavioral processes. Does religious involvement favor healthier biomarker profiles in the elderly population? If so, do biomarkers help to explain any health and mortality advantages associated with religious commitment?

To this point, very few studies have considered biomarkers as outcomes of religious involvement. Nevertheless, research shows that various indicators of religious involvement are associated with biomarkers across sympathetic nervous, hypothalamic–pituitary–adrenal, cardiovascular, immune, and metabolic systems (Seeman et al. 2003; Seybold 2007). When we limit the evidence to older adults, we find that religious involvement is associated with lower levels of blood pressure (Koenig et al. 1998b; Krause et al. 2002), c-reactive protein (Gillum et al. 2008; King et al. 2001, 2002), interleukin-6 (Koenig et al. 1997; Lutgendorf et al. 2004), white blood cells (King et al. 2001), and cortisol (Ironson et al. 2002).

How might religious involvement get "under the skin" to contribute to favorable biomarker profiles? Religious involvement (e.g., religious meaning systems) may help to buffer appraisals of stressful life conditions and, by extension, their physiological consequences (Seybold 2007). Religious involvement might also support healthy biological functioning indirectly by promoting important social, psychological, and behavioral resources. For example, instrumental support, the sense of control, and moderate drinking practices could help older adults to avoid stressful life conditions (events and appraisals) and chronic activation of the physiological stress response (i.e., allostatic load). In the event of stressful life conditions (and the activation of sympathetic systems), religious beliefs and practices, supportive relationships, strong self-concepts, and healthy lifestyles may also favor healthy coping strategies (and efficient activation of parasympathetic systems and various growth responses).

Given the limited amount of research in this area, it should come as no surprise that very few studies have formally tested whether biomarkers help to mediate or explain the effects of religious involvement on health and longevity. Lutgendorf et al. (2004) demonstrate that the inverse association between religious attendance and all-cause mortality risk in older adults is fully mediated by lower levels of interleukin-6, a biomarker implicated in the development of heart disease, cancer, osteoporosis, frailty, and functional limitations. Although Gillum et al. (2008) report a similar pattern for c-reactive protein, these results are unclear because several potential mediators were entered simultaneously.

Research Limitations and Future Directions

The research reviewed in this chapter is characterized by several limitations. In this section, we review these shortcomings and highlight important directions for future research and policy initiatives.

Measurement Issues

Religious involvement is a multidimensional phenomenon (Idler et al. 2003; Krause 1993); however, most studies employ only one or two single-item indicators of religious involvement (typically religious attendance or some measure of religious salience). Single items prevent a comprehensive understanding of religious involvement as a multidimensional phenomenon and are less reliable

than would be ideal. Several multi-item indices have been developed to assess multiple dimensions of religious involvement (e.g., Frey et al. 2005; Idler et al. 2003; Krause 1993). To this point, however, limited and discipline-specific applications of these instruments undermine the potential for comparisons across studies (and disciplines).

Health Outcomes

Although previous studies have considered a wide range of health and mortality outcomes, this body of literature is heavily focused on mental health. Because most studies of mental health emphasize depression, it is important for future research to examine outcomes like anger and anxiety in the elderly population. Studies of physical health and mortality are usually limited to self-rated health and all-cause mortality, respectively. Additional research is needed to establish the effects of religious involvement on specific physical health conditions (e.g., heart disease, diabetes, cancer, and sensory impairments), biomarker profiles, and cause-specific mortality outcomes.

Indirect Effects

Previous research is also limited by theoretical models that overemphasize the main or direct effects of religious involvement on health and longevity. Although studies often speculate as to why religious involvement might favor health and longevity, empirical support for these explanations is sorely lacking. We have noted limited empirical support for several classes of mediators. It is important for future research to confirm these patterns and to examine understudied mechanisms for mental health (e.g., social resources, lifestyle factors, and physical health), physical health (e.g., psychological resources, biomarker profiles, and mental health), and mortality risk (e.g., psychological resources, mental health, and physical health). While it is important to establish individual mechanisms, it is time to focus more on developing and testing elaborate theoretical models with multiple mediators and complex causal chains.

Healthy Lifestyles

The idea that religious involvement might contribute to health and longevity by promoting healthy behaviors is perhaps the most intuitive and most widely accepted explanation in the religion-health literature (and the popular mind). Religious involvement is clearly associated with a wide range of healthy practices, and these healthy practices are strong predictors of health and longevity. This process should work theoretically, but, as discussed above, empirical support is limited and mixed. Given that religious involvement is associated with so many healthy behaviors, it makes sense to think less in terms of individual health behaviors and more in terms of healthy lifestyles (Hill et al. 2007). Are older religious adults healthier simply because they avoid smoking and heavy drinking or because they are also more likely to exercise, use preventive health care services, and follow medication regimens simultaneously? Adjusting for an index of healthy behaviors would directly test the mediating influence of the clustering of healthy behaviors within individuals and groups. This re-conceptualization could be the key to finding consistent empirical support for this traditional explanation.

Subgroup Variations

It is also often unclear whether the effect of religious involvement varies according to theoretically relevant subgroups. In other words, under which social, psychological, and physiological conditions is religious involvement more or less protective? Some studies show that religious involvement is more beneficial to the mental health of older blacks (Krause 2003a, 2005) and older women (Idler 1987; Jang et al. 2005). Research also suggests that the positive association between religious involvement and self-rated health is more pronounced among individuals with functional limitations (Idler et al. 2009; Musick 1996). There is even some indication that the association between religious involvement and longevity is stronger for older women (Koenig et al. 1999; la Cour et al. 2006; Strawbridge et al. 1997) and weaker among elderly individuals in the oldest ages (Dupre et al. 2006; Ellison et al. 2000; Musick et al. 2004), with functional limitations (Helm et al. 2000), and low levels of social support (Oman and Reed 1998). Additional research is needed to confirm these patterns and to consider new and understudied subgroup variations. We also need better theoretical explanations for these variations *a priori*.

Stress Moderation

While numerous studies emphasize how religious involvement might influence health and mortality risk directly or, to a lesser extent, indirectly, less attention has been devoted to religious involvement as a moderator or buffer of stressful life conditions. Studies show that religious involvement is protective against the mental health consequences of spousal loss (Carr 2003; Coleman et al. 2007; Fry 2001), financial hardship (Strawbridge et al. 1998), neighborhood disorder (Strawbridge et al. 1998), hospitalization (Koenig et al. 2004), disability (Braam et al. 2004; Strawbridge et al. 1998), other physical health conditions (Braam et al. 2004; Strawbridge et al. 1998; Wink et al. 2005), and terminal illness (Ardelt and Koenig 2006). Research also indicates that religious involvement is protective against the physical health consequences of poor neighborhood conditions (Krause 1998, 2006a). Our review of the religion-mortality literature revealed only one test of stress-moderation. In a national study of older adults, Krause (2006b) reports that the positive association between financial hardship and mortality risk is attenuated by the provision and receipt of church-based social support. More work is needed to establish these patterns and to comprehensively examine the extent to which religious involvement protects older adults against the health consequences of stressful life conditions.

The "Dark-Side" of Religious Involvement

Although the evidence reviewed thus far clearly demonstrates a salubrious role of religious involvement in the elderly population, this research does not exclude the possibility that religious involvement might also undercut health and longevity. Studies show that religious involvement can undermine psychological well-being when older adults have religious doubts (Krause et al. 1999), feel abandoned by God (Allen et al. 2008), exhibit high levels of extrinsic religiosity (Ardelt and Koenig 2006), and combine strong religious beliefs with low religious attendance (Dillon and Wink 2007). Strawbridge et al. (1998) report that religious involvement can exacerbate the mental health consequences of intimate partner violence, marital problems, caregiving, and problematic parent–child relations. Research also indicates that religion can contribute to poor physical health outcomes

when older adults suppress religious doubts (Krause and Ellison 2009). One study of elderly hospital patients demonstrates that various indicators of religious struggle – wondering whether God has abandoned you, questioning God's love, and attributing poor health conditions to the devil – can actually elevate the risk of mortality (Pargament et al. 2001). Although studies confirm that there is a distinct "dark side" of religious involvement, explanations for these processes are not as thoroughly developed as explanations for the healthful consequences of religious involvement. More research is needed to explore and explain these processes.

Alternative Explanations

There are three main alternative explanations for why religious involvement might favor health and longevity: health selection, personality selection, and social desirability. Although longitudinal evidence is growing, most mental and physical health studies are limited to cross-sectional data. Because cross-sectional studies are unable to establish the causal order of any observed associations, it is often unclear why religious people appear healthier. We assume that religious involvement predicts health status, but health status might also predict religious involvement. For example, studies show that physical health problems, including broken hips, disability, cancer, and stroke, can undermine or limit public religious activities in old age (Benjamins et al. 2003; Kelley-Moore and Ferraro 2001). In the absence of longitudinal designs and adequate controls for baseline health status, certain indicators of religious involvement (especially indicators of public religious activities) "select" healthier older adults into religious activities. This pattern can be seen in various mortality studies when associations with religious attendance are noticeably attenuated or even eliminated with comprehensive adjustments for baseline physical health and functioning (e.g., Ellison et al. 2000; Hill et al. 2005; Hummer et al. 1999; Musick et al. 2004).

Research clearly demonstrates that a significant portion of the association between religion and health is produced by health selection processes in old age. Researchers also argue that individuals with certain personality traits are selected into religious involvement. Some even view religious involvement as a strong indicator of personality. Personalities are patterned ways of thinking, feeling, and behaving. Studies show that religious involvement is reliably associated with several personality characteristics, including lower levels of psychoticism (risk-taking and lack of responsibility) and higher levels of agreeableness (friendly and helpful to others), conscientiousness (dependability and self-discipline), and cooperativeness (Koenig forthcoming). Because studies of religion and health rarely (if ever) adjust for personality, there is little to no evidence for personality selection. Psychoticism could reasonably select individuals into risky lifestyle patterns and, as a consequence, out of religious institutions. Agreeableness could even draw individuals into religious communities through various social aspects of public religious activities. Although there appears to be considerable continuity between religious involvement (rituals and expectations) and conscientiousness (especially the component of self-discipline), it is important to acknowledge that religious involvement can also foster self-regulatory strength over the life course. If any of these processes are at work, personality selection could account for at least some of the effect of religious involvement through social and behavioral mechanisms.

Finally, there is the potential for bias due to social desirability. The idea is that some older religious adults might falsely respond to health-related questions (e.g., risky health behaviors and depressive symptoms) in order to protect their religious beliefs, values, and identities. Since studies generally fail to control for social desirability, reports may, to some extent, exaggerate associations between religious involvement and self-reported health outcomes. To this point, however, there is little to no empirical support for social desirability as an alternative explanation for religious influence.

Policy Implications

This chapter clearly demonstrates that religious involvement favors health and longevity in the elderly population, but what are the policy implications of this research? Neither scholars nor practitioners can ethically or practically prescribe religious practice, much less belief. Are there other possibilities? Physicians routinely take note of employment status and marital status because these social characteristics provide health-relevant information. If religious involvement is associated with health outcomes and health-relevant decisions and practices, it may be important for physicians and other health professionals to take such socio-cultural information into account. As discussed above, religious involvement may influence how well older adults follow medical regimens. Religious beliefs and practices may also disagree with specific treatments. For example, religious beliefs surrounding substance use and mental illness could affect the use of medications like pain relievers and antidepressants, respectively. Religious norms concerning dietary restrictions and fasting may also play various roles. When older adults experience health problems and marital loss, social isolation becomes a major cause for concern. Under these conditions, older religious adults may become disconnected from their religious communities. Programs or interventions designed to help the elderly to maintain their religious involvement (e.g., ride programs) may uniquely contribute to the health and well-being of older religious adults.

Given that a substantial portion of older adults are involved in religious institutions, the congregation is an ideal setting for addressing health maintenance and disease prevention, as well as mobilizing support for those elderly with health problems in need of care (Koenig and Brooks 2002). Parish nursing is one example of programs linking religious institutions with health care systems. A parish nurse is a registered nurse who is a member of the congregation and often provides medical services on a voluntary basis. A parish nurse usually does not provide much of the hands-on care needed by sick members of the congregation, but instead acts as a health educator (teaching classes on diet and exercise, medication usage, and disease management), medical interpreter, and trainer of volunteers that may help with these activities (Koenig and Brooks 2002). Similarly, the Faith-Based and Community Initiative launched by President George W. Bush developed a number of programs linking religion with health care. Faith-based programs provide a range of services aimed at the elderly, ranging from disease prevention and treatment to outreach programs for those with dementia. Such programs may be particularly relevant for delivering services too hard to reach elderly populations (e.g., racial/ethnic minorities and rural residents) (Brooks and Koenig 2002).

Conclusion

Our overview and critical examination of published research suggests that older religious adults are happier and healthier and tend to live longer than their less religious counterparts. These general patterns are remarkably consistent across studies of various health and mortality outcomes. Even more impressive is the consistency of findings across disciplines, including sociology, religious studies, gerontology, psychology, public health, medicine, and geriatrics. Having said this, additional research is needed to establish: (1) valid and reliable measures of religious involvement, (2) understudied health outcomes, especially in the areas of physical health and cause-specific mortality, (3) social, psychological, behavioral (lifestyle), and biological explanations, (4) subgroup variations, (5) and patterns of life stress moderation. It is also important for future studies to: (6) thoroughly explore the "dark side" of religion, (7) formally test alternative explanations like health and personality selection and social desirability, and (8) consider the policy ramifications of the religion–health connection. Research along these lines will no doubt contribute to a better and more practical understanding of how and why religious involvement might favor health and longevity in the elderly population.

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Part IX
Care Arrangements and Aging

Chapter 34
Civil Society and Eldercare in Posttraditional Society

Ronald J. Angel

My maternal grandmother died when I was very young so I never knew her well. What I remember most clearly about her, though, is that whenever I saw her she was living in one of my aunts' homes. For a while she lived with us. My grandfather built the house in which my grandmother gave birth to thirteen children, many of whom died in infancy, and in which she raised the survivors once she became a young widow. Without a husband she raised her children by herself with whatever income she could earn, primarily as a janitor at the local school. When the children had grown and left home and when grandmother became too frail to take care of herself, my parents, my sister and I moved into the old house with her. Four of my aunts lived nearby. Even though they grew up in poverty my mother and three of her sisters managed to attend university and become teachers. They were ahead of their time in terms of modern gender roles since they worked full-time while raising children and taking care of their own homes, but they were traditional in that they combined efforts to care for their mother, even as they continued to work and raise their own families. After several years of living with one or another of her daughters, my grandmother died in her own bed at the age of 87 in the house in which she had raised her children.

Unlike my grandmother, when my mother died at the age 96 it was in a long-term care facility far from the city in which she was born. Since her only daughter had died at 50, she had only one surviving son. Although she was far more financially secure than her own mother, she had no large group of family caregivers who could combine eldercare with work and other family responsibilities. Formal long-term care was the only realistic option. In only one generation, then, my family had changed dramatically in terms of its eldercare capacity. But my family's story is not unique. Changes in family size, the migration of children away from their place of birth, longer lives, and much more have changed the caregiving capacities of families generally. Today, with clear exceptions, the family is less able to provide all of the care that frail elderly parents need. Other alternatives must be explored. In this chapter I investigate the possibilities for civil society to provide at least some of the day-to-day care that the family can no longer provide. By civil society I refer to the wide range of nongovernmental organizations (NGOs), from faith-based organizations and community groups to formal charitable organizations like Meals on Wheels. In the modern world such organizations are becoming an increasingly important part of the social world and in the future they may assume a greater role in eldercare.

For individuals born at the end of the nineteenth or early in the twentieth centuries the family was the major source of care and support when they became old and frail. With the passage of the Social Security Act in 1936 and the introduction of Medicare in 1965 the State has assumed a large part of the financial and long-term care responsibility for elderly citizens. Income supports and

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medical care consume a large fraction of the budgets of most developed nations. Yet the State faces limits in what it can provide in terms of instrumental care. Many of the needs of frail elders are routine and personal and require close and frequent contact. This sort of care is most easily and efficiently provided by family members. The state might pay for such services, but there are practical limits as to what the State can afford. In this new context organized voluntary action represents at least a partial solution. The challenge for public policy is to determine how best to combine the efforts of nongovernmental actors and organizations with those of formal governmental programs.

The New Demographic and Social Reality

Today longer life spans, migration, lower fertility, increased female labor force participation and more have contributed to a rapidly changing long-term care reality for the elderly (Haber 2006; Quadagno 1982; Thane 2005). During the nineteenth century fertility declined significantly in the United States, but families remained large by today's standards even at the turn of the twentieth century when the average female had nearly four children (Coale and Zelnik 1963; Himes 1989; Tolnay et al. 1982). Family members for the most part stayed close to home and older parents could call upon at least some of their children who lived nearby to provide basic care when they became frail. Nobody, or almost nobody, entered a long-term care facility other than perhaps a poorhouse or an insane asylum (Grob 1983; Wagner 2005). That remains true today in most parts of the world, although the situation is changing even in countries like India where the number of long-term care facilities is increasing (Liebig 2003).

The reality of the situation, then, is that given the demographic and social changes that have occurred over the last two generations traditional family caregivers find it increasingly difficult to combine eldercare with the demands of work, child rearing, and other duties. Today in Western Europe fertility rates have reached historic lows (Sobotka 2006). In Italy, Spain, and other European countries where almost everyone married and had large families just a generation ago, fertility rates among the native populations are below replacement. The fertility rate in Italy and Spain is barely 1.3, far below the 2.1 that is necessary to assure a stable population (Central Intelligence Agency 2009). In the absence of immigration these countries would have shrinking populations. In the United States the total fertility rate has remained higher, at about 2.0 since the 1980s. To a large degree this reflects the higher fertility of Hispanics (Hamilton et al. 2009). These differential fertility rates suggest significant ethnic and racial group differences in family eldercare capacity in years to come (Angel and Angel 1997).

Growing older populations and lower fertility even affect the developing world. South American populations are aging rapidly and will continue to age well into the twenty-first century (Chamie 2005; Palloni et al. 2002). This growth in older populations in both developed and developing countries will in all likelihood be accompanied by a continuing fiscal austerity that will strain the ability of governments to provide for all of their citizens' needs (Pierson 2001). This new demographic reality of aging populations and lower fertility, in combination with other social transformations such as increasing divorce rates and the decline of the traditional family requires novel approaches to the care of older adults. For most of human history tradition has largely determined who would care for the frail elderly, but tradition no longer provides firm answers and we are in a new world that will require new institutional arrangements including a greater role for civil society and NGOs. Understanding how nonfamily and nongovernmental sources of elder support might be employed in eldercare represents a core intellectual and practical question for future research and policy design.

Posttraditional Society and Old Age Support Systems

We might usefully ask what the term "tradition" refers to and how has it changed with reference to the care of the elderly. Tradition lies at the core of human social interaction and defines our major social institutions like marriage and the family. Tradition, often codified in law, provides the rules that determine inheritance and dictate the nature and extent of responsibility among generations. Even today tradition dictates that family members assume primary responsibility for the care of aging parents (Bullock et al. 2003; Chatters et al. 1986; Dilworth-Anderson et al. 1999; Jolicoeur and Madden 2002; Stone 2006). In the absence of informal family care greater public expenditures for formal care would be necessary (Bolin et al. 2007; Hayward et al. 2004; Himes and Reidy 2000). Yet when basic structures change radically traditions cannot remain unchanged. Given limited time and energy budgets, there may be an inevitable tradeoff for potential caregivers between caring for older family members and other commitments, including employment. Some studies find that employed women provide less informal care than unemployed women (Fast et al. 1999; Kotsadam 2009). Caregiving responsibilities can interfere with the ability of caregivers to look for work (Bullock et al. 2003).

Tradition, by its very nature resists change since it is undone by change. But change occurs regardless of tradition's dictates. Today in the developed world we are living in what Anthony Giddens has described as "posttraditional" society (Giddens 1991, 1994). Giddens and others use this term to emphasize the fact that traditional norms and practices have weakened and that individuals today cannot, or have the option of choosing not to, look to tradition for the basic instructions of life. Traditions clearly still exist and remain powerful. Because of the traditional social value placed in the institution or marriage, as well as other practical advantages, same-sex couples wish to partake of the tradition. The fact that marriage can be construed as a union between same-sex individuals underscores the reality that the rules governing the social institution of marriage are in the process of change. Today individuals choose and reinterpret traditions to reflect changing circumstances and newer social realities. Daughters and daughters-in-law are not constrained by strong community expectations to stay at home to care for their aging parents or in-laws.

Traditions and norms do not exist independent of history, and in the domain of eldercare history has moved on. Structurally, though, there remain a limited number of possibilities in terms of the long-term care of the elderly. Financial, instrumental, and emotional support can be provided by some combination of the family, the State, and civil society. By civil society I refer to the entire range of nongovernmental groups and organizations that provide support and services to older individuals. These include faith-based organizations and congregations, NGOs like On Lok in San Francisco, HelpAge India, and many others, some of which I mention below. Unfortunately, there is little systematic research on the role of NGOs and other civil society organizations in the support of the elderly. In what follows, then, I offer a theoretical framework for understanding the potential role of these organizations in eldercare and review the relatively sparse empirical data available. I conclude by proposing a research agenda focused on the potential role of such organizations in the mix of care providers. The core question relates to the extent to which civil society organizations, including NGOs, can complement the State in providing support without further eroding the role of the family or contributing to the State's neglect of its basic responsibility for guaranteeing the basic social rights of vulnerable elderly citizens.

Addressing this question requires an examination of the role of civil society organizations in terms of the mix of elderly support services. Despite the changes the family has undergone family members continue to provide much of the care older parents need. One might justifiably conclude that the family is the most desirable source of care given the lifelong emotional bonds that exist between parents and children. As desirable as family care might be, though, in posttraditional society

children, and especially those with higher levels of education, move away from their parents for career reasons and cannot assume the daily responsibility for dealing with their parent's immediate needs (Rogerson et al. 1993). Adult children can, of course, provide financial support, and if they or their parents can afford the cost they may chose to move their aging parents to assisted living arrangements nearer by (Silverstein 1995; Silverstein and Angelelli 1998). For adult children with demanding careers having an older parent move in to their homes, especially once the parent suffers serious functional and cognitive decline, may not be realistic.

In addition to the family, or perhaps in place of the family, today the State assumes a major role in the financial care of the elderly. Public pensions, health care, and other supports for the elderly largely define the welfare state. In the United States Social Security, Medicare, and Medicaid have basically socialized the financial responsibility for the elderly. What remains, then, is to examine the actual and potential roles of the nongovernmental and voluntary sector in eldercare.

The New Focus on Nongovernmental Solutions to Social Problems

In order to begin to develop a better sense of the role of NGOs and similar organizations in eldercare it is necessary to briefly review the growing importance of NGOs in the modern world. Although NGOs have been involved in various social issues since the nineteenth century and even earlier, the period since the Second World War has seen a rapid growth in their number. Today NGOs are involved in health, education, human rights, women's issues, the environment, sustainable development, and much more (Boli and Thomas 1997, 1999; Carroll 1992; Hudock 1999; Keck and Sikkink 1998; Robinson and Riddell 1995; Salamon 2003; Salamon and Anheir 1996). They have assumed an important and growing role as advisors to the United Nations (Global Policy Forum 2010). Many explanations for this growth have been offered and a large literature focused on NGOs as expressions of new social movements has appeared (Albrow et al. 2008; Boli and Thomas 1999; Keck and Sikkink 1998; Pichardo 1997). Some observers view the rapid growth of NGOs in the post-WWII era as a reflection of the spread of a global culture that is supranational in character and largely Western in values (Boli and Thomas 1997). Others see it as reflecting the global demand by poor countries for greater global social justice and a new collective consciousness (Bendaña 2006; Grzybowski 2000). Whatever the causes of the increase in the number and role of NGOs they are more salient actors internationally and locally and their presence calls for a more complex approach to understanding how society operates at all levels (Fisher 1997; Ruggie 1998).

The domains in which NGOs and other civil society organizations operate differ greatly along many dimensions. NGOs that deal with environmental issues and those dealing with human rights, women's rights, and the rights of native peoples differ in mission and structure from those that provide medical, educational, and emergency services to specific groups. Understanding the potential utility of such organizations requires not only a focus on their structure and organization, but also an understanding of the needs of the populations they serve. In terms of addressing the needs of the elderly the relevant questions relate to how well such organizations function as advocates and service providers.

NGO activities can be characterized in terms of two broad categories, advocacy and service delivery (Pereira and Angel 2009). Advocacy refers to activities that are aimed at improving the situation of a particular group though legislation, public awareness campaigns, and other activities that draw attention to the structural and system factors that produce and perpetuate disadvantage. Organizations like Amnesty International that focus on human rights or organizations like Greenpeace that oppose the exploitation of animal species engage primarily in advocacy. Other organizations like Habitat for Humanity, Doctors without Borders, Oxfam, and the Red Cross focus more on service delivery and the response to crises. Many, if not most, NGOs engage in both activities

to one degree or another, providing services while they engage in advocacy and political action aimed at changing laws and practices to encourage democracy, safeguard civil rights, or develop local capacities to deal with longer-term needs.

One of the reasons for the renewed interest in NGOs as service providers is that they often have certain advantages in dealing with the more routine and manageable needs of specific populations (Pereira and Angel 2009; Pereira et al. 2007). For example, although complex and expensive high-tech medicine can only be paid for or provided by the State, routine and relatively inexpensive services, such as basic primary care, assistance with activities of daily living, and companionship are often more effectively and economically provided by NGOs and other local groups. Ideally in the case of eldercare such groups can complement the State in supporting older individuals in the community and enhancing the quality of their lives. Because of their more detailed knowledge of the legal, transportation, nutritional, and other needs of the elderly they could potentially act as both service providers and advocates.

Relatively little research has been carried out focused on the role of civil society organizations in eldercare. A large body of research documents the importance of social networks and social support in later life and offers indirect evidence that nonfamily support could be important in assuring the well-being of isolated older persons (Krause 2006; Moren-Cross and Lin 2006). It is clear that social engagement and human contact are vital to the well-being of the elderly and the potential of nonfamily and nongovernmental sources to provide such contact may be high. Studies of volunteerism, including a recent study in Mexico, reveal that in situations of high need many individuals provide significant amounts of support and assistance to needy neighbors and others either through formal groups, such as churches or voluntary organizations, or informally as personal assistance (Burcher 2008).

Service to the Elderly

The organizations and affiliative groups that make up civil society not only help individuals in need, but they also provide their members opportunities to engage in pro-social activities ultimately strengthening communities (Etzioni 1993, 1995). Churches and religious groups have historically cared for the poor and infirm and as part of that mission they provide much needed companionship and care to the elderly (Idler 2006). Faith-based international NGOs such as *CARITAS, Catholic Charities, and Lutheran Social Services* provide assistance to the elderly as part of their general missions. The Red Cross and many of the other major international and local relief agencies identify the elderly as a vulnerable population in need of special attention in their relief and support missions. A quick perusal of NGO directories on the Web yields hundreds of such organizations in every country with some focus on the elderly as a vulnerable population.

In addition to NGOs that offer assistance to elderly persons with special needs or in times of crisis, many other international, national, and local organizations of differing sizes and reach provide care to the elderly. Again their number is too large for even a partial enumeration but some examples are informative. What follows is clearly not a systematic sample of NGOs that deal with the elderly. Rather the cases I present represent very well-known organizations or those that illustrate the point that eldercare and issues related to the elderly are drawing greater attention from civil society organizations. For the elderly, of course, companionship and visitation are important needs that volunteers can readily provide. Companionship and the prevention of isolation are major objectives of these organizations.

The *Meals on Wheels Association of America* (http://www.mowaa.org) is the oldest and best known nongovernmental nutrition program for the elderly in the country. Founded during World War II the organization has grown in size and mission and today is dedicated to ending hunger

among the elderly. In addition to providing nutritious meals, volunteers provide clearly important human contact to older persons. The less well-known *Little Brothers – Friends of the Elderly (LBFE)* (http://www.littlebrothers.org), an international network of nonprofit, volunteer-based organization with branches in the U.S. provides companionship to elderly people to reduce isolation and loneliness. The organization is a member of a larger international organization, the Fédération Internationale des petits frères des Pauvres (International Federation of Little Brothers of the Poor, http://www.petitsfreres.org). Another international organization is the *Fédération Internationale des Associations de Personnes Agées* (International Federation of Associations of Older Persons, FIAPA: http://www.fiapa.org) headquartered in Paris. The organization's mission is also to prevent isolation and improve the quality of life (QOL) for older individuals.

Many other examples of specific NGO activities in various countries are easily found on the internet. Three examples illustrate the potential of NGOs in eldercare in less developed countries. India, like most of the rest of the world, is facing a serious problem related to the care of an older population. Even as developing nations with high fertility rates remain comparatively young, their older populations are growing in absolute and relative size. In India NGOs are important advocates for and service providers to the elderly (Sawhney 2003). *Dignity Foundation* (http://www.dignityfoundation.com), a member of the American Association of Retired Persons (AARP) Global Network, provides housing, companionship, recreation, and other services to elderly individuals in several Indian cities. *HelpAge India* (http://www.helpageindia.org) has a similar service mission. This NGO provides financial, medical, and emotional support to poor elderly Indians. The organization has introduced new programs and is extending its services to previously underserved areas. One example highlighted on the organization's website is a Mobile Medicare Unit (MMU) program that provides basic health care and is introducing new initiatives such as disability aids, shelter assistance, yoga, specialized home visits, and psychological therapy.

The cases of Dignity Foundation and HelpAge India are examples of eldercare NGOs moving into resource starved areas in which formal supports are rare. Another example in a nation that is far more developed relates to the eldercare functions of *Hogar de Cristo* (Christ's Home: http://www.hogardecristo.cl) in Chile (Pereira et al. 2007). Hogar de Cristo is a Catholic organization in a highly Catholic country, a fact that no doubt has contributed to its success. Begun in 1944 by a Catholic priest named Alberto Hurtado, from its founding the organization has focused on the needs of poor Chileans. Given the specific vulnerabilities of the elderly, especially the seriously curtailed social services that were part of the neoliberal reforms introduced by the Pinochet dictatorship, Hogar's mission has expanded to provide the full range of services to poor elderly individuals. These services include day care, nutritional programs, and even housing. In the absence of an adequate old-age welfare state Hogar de Cristo fills a void that is created by limited government commitments or capacities to address serious social problems.

In the United States a similar comprehensive care approach named *On Lok*, a Cantonese term which means "peaceful, happy abode," was begun in the early 1970s in San Francisco to provide services to frail Asian elderly individuals in certain Bay area communities in order to allow them to remain in their own homes (http://www.onlok.org) (Bodenheimer 1999). This success of the program led to its formal adoption by Congress as a model for the *PACE* program (Program of All-inclusive Care for the Elderly: http://www.cms.hhs.gov/pace), which provides comprehensive services paid for primarily by Medicare and Medicaid to high-need frail elderly individuals (Gross et al. 2004). The On Lok experience serves as an example of how private nongovernmental initiatives can serve as laboratories in which best practices related to the care of older persons can be tried and eventually inform State initiatives. Currently 70 PACE programs employ interdisciplinary teams of care providers who develop care plans for each individual and monitor their progress with the objective of allowing them to enjoy the highest possible QOL. In addition to primary care the programs offer specialist care, home health aides, transportation, recreation and companionship (Gross et al. 2004).

Hundreds of examples similar to those I have presented can be found in all nations of the world and it would be impossible to summarize the activities of even a few. As the PACE example shows, there is often a blurring of the definition of nongovernmental. PACE programs rely heavily on Medicaid and Medicare for financing their operations. The category of nongovernmental, therefore, includes many different degrees of government/civil society cooperation. As I mentioned before, in addition to organizations focused specifically on the needs of the elderly, many other nongovernmental and faith-based groups include assistance to the elderly as part of their missions. Service delivery, though, is not the only mission of NGOs. Adequate pensions and other legal guarantees require changing laws and that objective requires different approaches and organization than short-term crisis interventions.

Advocacy for the Elderly

As important as services are for vulnerable elderly individuals especially in developing nations, basic assistance does not change the fundamental vulnerabilities that undermine the welfare of older persons. While basic assistance with food, medical care, and housing might alleviate some of the most immediate problems that older individuals face they are no substitutes for more comprehensive and continuous social security programs (HelpAge International 2009; Willimore 2006). In addition to service delivery, then, a major role of NGOs is advocacy for the elderly. In the United States the *AARP* is undoubtedly the most well-known and effective advocate for its membership (Binstock 2004). Other advocacy organizations include the *National Committee to Preserve Social Security and Medicare* (NCPSSM: http://www.ncpssm.org/), the *Alliance for Retired Americans* (ARA: http://www.retiredamericans.org), and the *National Hispanic Council on Aging* (NHCOA: http://www.nhcoa.org/).

According to its Web page NHCOA's mission includes advocacy, the support of research, the funding of community-based projects, as well as the creation of support networks, capacity-building in Hispanic communities and the support and strengthening of Hispanic community-based organizations. The organization's core objective is to "empower Hispanic community organizations and agencies, as well as Hispanic older adults and their families."

The organization offers educational programs focused on the major health risks to Hispanics, like diabetes and it has developed an e-course on cultural competence that educates health care professionals concerning the culture of their patients (http://edu.nhcoa.org).

Smaller local organizations, such as Family Eldercare of Austin, Texas (http://www.familyeldercare.org), the author's home town, provide important legal services and perform what are basically case-management services in coordinating a wide range of services that the organization's poor and largely minority clientele needs in terms of housing, instrumental support, and more. The organization participates in a summer fan drive which collects fans and money to purchase them to provide vital cooling to older people who live in a part of the country in which the heat of summer can be life threatening. These activities are replicated in various forms by any number of NGOs all over the country.

Potential Downsides to Nongovernmental Approaches

It is quite possible, of course, to romanticize civil society and nongovernmental approaches to complex social problems or to overestimate the ability of voluntary collective action to empower the powerless. Local approaches to the care and support of vulnerable individuals are appealing

because they appear to be more personal and on more human scale than services provided by large impersonal bureaucracies. The new Neoliberalism that has informed public policy in recent decades reflects a deep distrust of big government and the welfare state, a large part of which consists of old-age supports (Binstock 2004). Although support for public pensions remains high in most countries, fiscal constraints and the recent economic crisis have furthered efforts to control the growth of such public programs (Chap. 20). Thatcherism in Great Britain, the Regan revolution in the United States, and new Third Way philosophies in other developed nations reflect a growing anti-welfare state rhetoric and the adoption of policies intended to cap or even reduce social expenditures and the paternalistic role of the state (Andrews 1999; Faux 1999). Public antiwelfare state sentiment and neoliberal social and economic policies have serious implications for the material and social welfare of the elderly, and especially those with limited resources including the elderly, women, African-Americans, and Hispanics (Angel and Angel 1997, 2009).

There can be little doubt that the elderly benefit from local programs that provide companionship and assistance with activities of daily living. The On Lok model and the PACE program clearly demonstrate the benefits of intensive involvement in providing frail older individuals with limited resources the full range of services and supports they need in order to remain in the community. Yet there are serious dangers in placing too much faith in the ability of local communities and organizations to provide all of the supports that older citizens need. Social Security and Medicare are fundamental and indispensable support programs without which millions of older individuals would fall into poverty and be denied the medical care they need. As we attempt to mobilize family and local resources for the care of the elderly we confront the very real danger that the supposed superiority of nongovernmental approaches will be used to justify excessive and harmful cuts in Social Security, Medicare, and Medicaid. Among the big losers would be single and poor older African-American and Hispanic females and other vulnerable individuals. The life-long labor force disadvantages faced by minority Americans leaves them particularly dependent on publicly funded programs in old age. If an unrealistic belief in the support capacities of local organizations and community groups were to encourage reductions in funding for formal services the results could be devastating.

As appealing and noncontroversial as civil society approaches to dealing with human needs might seem at first glance, then (after all who can argue with generosity and civic engagement), there are serious criticisms of NGOs and the nongovernmental approach generally that potentially apply to civil society solutions to dealing with the elderly. In the area of development and assistance to poor countries NGOs have been criticized for often being too apolitical and unwilling or unable to deal with basic social structural factors that account for the powerlessness and exclusion of particular groups. They are seen as part of the neoliberal agenda of privatizing what are in fact public responsibilities (Clarke 1998; Sangeeta 2004; Srinivas 2009). Development NGOs are criticized for having an excessively narrow focus on specific projects and fostering dependency rather than furthering sustainable development. They are criticized for being too accountable to their funders and less concerned with the perspectives of those they supposedly intend to help.

NGOs and the civil society focus more generally are also criticized for their often narrow and excessive focus on subgroups defined in terms of gender, race, ethnicity, disability status, specific illnesses, and more. An excessively narrow focus on particular subgroups or problem areas undermines efforts to address collective political issues. Supporters of the international labor movement, for example, continue to believe that the major locus of disadvantage and struggle in the world that in principle unifies workers in developed and developing nations is that between labor and capital. From this perspective an excessive focus on gender, race, or other narrow interests undermines the possibility for the sort of collective political action necessary to better the lot of all citizens (Roman 2004). Whatever the merits of the various criticisms of a civil society approach in general it seems clear that the core danger to the interests of the elderly lies in the potential justification of the devolution of federal responsibilities for income support and health care or drastic reductions in funding for such programs on the basis of the supposed superiority of local nongovernmental approaches.

A Research Agenda Focused on Civil Society and Eldercare

NGOs have become major international players in developing and implementing environmental policy, furthering women's rights, redefining development policy, and much more. They are major players at local levels in dealing with problems of poverty, homelessness, teenage pregnancy among others. In this chapter I have posed the question as to whether civil society organizations, including NGOs might meaningfully supplement the family and the State in addressing the needs of growing older populations. It is clear that solutions to the major social problems that developed and developing societies face are extremely complex and that civil society is at best a complement to the State, which remains as important as ever in guaranteeing basic political and social rights to all citizens. Indeed it is probably not possible for NGOs to operate at all in the absence of an effective and strong State. Unfortunately, there is little published empirical research on the potential effectiveness of civil society activity in providing services to or advocating for elderly groups. This lack of research is accompanied by a lack of theory to assist in understanding the complex interaction of various layers of government, private enterprise, the family, and the nongovernmental sector in addressing the needs of aging populations.

At the most general, level the most theoretically and practically important questions relate to the actual possibilities for civil society action in eldercare and advocacy and the forms that they might take. Specifically it is important to know how the role of civil society organizations in eldercare service provision and advocacy is constrained by state policy and funding sources at multiple levels in different political, economic, and cultural contexts. Addressing these questions requires a comparative approach based on national, state, provincial, municipal, and other differences of significance in policy design and implementation. Such analyses, for example, could examine differences in elder support policies in countries like Argentina, Chile, and Mexico which differ in terms of degree of national federalization, public policies, political structures, and more. Such research could provide useful information on how levels of development interact with state policies and civil society activity to influence policy to affect the comparative welfare of the elderly. It would also answer questions as to the range of possibilities for dealing with generational equity in a time of universal fiscal austerity.

Other theoretically important questions relate to the potential of eldercare and elder advocacy to take on characteristics of a social movement that may even be transnational in character. Other questions entail the complex and difficult assessment of the potential negative aspects of civil society involvement. As I mentioned earlier, to the extent that the devolution of services and supports results in State abandonment of its basic responsibilities and shifting of those responsibilities to levels of government and the nongovernmental sectors with inadequate capacities the results may well be negative. These overarching theoretical questions call for several dissertations and serious focused theorizing and empirical research.

At a more practical level the questions of interest relate to a better understanding of how formal State supports for the elderly can be coordinated with civil society efforts to more efficiently and economically address the needs of the elderly and insure their optimal QOL. The objective of a research agenda with such a focus would be to identify the best organizational forms and best administrative practices for insuring older individuals' personal autonomy, dignity, social participation, and life satisfaction. Since the potential utility and success of civil society approaches depends on the nature of the social problems they address an assessment of the role of NGO's in elder support must begin with a detailed understanding of the clientele and its needs, including its diversity in terms of race, ethnicity, social class, gender, religious orientation, immigration status and more. Since NGOs and other civil society organizations, to the extent they are more than just casual associations, have some sort of organizational form it would be useful to ask what organizational forms are associated with the greatest success. Of course, defining success represents an important part of the research agenda in and of itself.

Let me suggest a limited set of general questions that might form part of a larger research agenda focused on NGOs as organizations and their roles as advocates for and service providers to the elderly. There are, of course, many more questions and I invite the reader to criticize these and propose others. The list implies a qualitative approach, which is necessary to understand specific organizations and their cultures and internal workings. It would be useful of course to do larger-scale comparative and quantitative analyses to compare different organizations. The questions I propose include the following:

- How significant is NGO and other civil society activity in advocacy or service provision to the elderly? How many organizations are there with significant elder agenda and how rapidly has this movement grown?
- To what extent does the entry of new organizations into the field or the redirection of the missions of older organizations toward elder advocacy and service represent a new social movement? What are the demographic, social, and political forces that might propel such a movement and how might these contribute to the definition of the objectives of specific governmental and nongovernmental actors, including those in the for-profit sector?
- How is the mission of the movement as a whole and the missions of individual organizations involved in eldercare or advocacy determined and by whom? Are the clients of these organizations passive recipients of services or are they involved in framing the mission statement, monitoring progress, and evaluating effectiveness?
- How is effectiveness defined and measured, and by whom? Are serious QOL criteria applied in the evaluation of effectiveness?
- How are individual organization's missions "framed" for presentation to larger audiences, including funders? Does the framing of issues related to eldercare and support truly reflect the needs of this population or subpopulations?
- How do the political, legal, and regulatory environments in which various civil society organizations operate affect their operation and effectiveness? This question is particularly relevant in comparative research.
- How are the target populations of specific organizations defined and identified? What sort of outreach efforts, if any, do various organizations employ? Are issues of access and payment addressed adequately?
- What are the major funding sources for different organizations? To what extent do specific organizations rely on grants, public fundraising drives, or client fees? How do different sources of funding affect accountability and the targeting of services? What is their mix of service provision and advocacy for the elderly in specific organizations? Is the advocacy role of specific organizations or the movement as a whole effective or is it constrained or co-opted by political and financial factors?
- To whom do specific organizational leaders feel the organization is accountable? How are funders' and clients' differing conceptions of what the clients need reconciled? Does the need to be accountable to funders distort the intended mission of these organizations?
- How do organizations' basic structures, in terms of information flows, gender, racial, and ethnic composition of staff and clientele, decision making, the role of board members, etc. influence the ability of organizations to identify and respond to the needs of their clienteles?
- How professionalized is the organization and the movement as a whole? What is the mix of paid staff to volunteers and how does this mix relate to the operation of the organization? Do volunteers have meaningful input into the definition of the mission and the design of service delivery?
- Does the organization communicate and coordinate its efforts with other organizations engaged in similar activities?

There are of course many additional questions that we might ask concerning all aspects of the eldercare movement and the social, political, and economic forces that determine its organizational expression.

Addressing these questions would provide useful theoretical and practical knowledge concerning the potential role of NGOs and other civil society answers in dealing with aging populations in the U.S. and elsewhere.

Conclusion

For the majority of human history change has occurred relatively slowly and one generation's life course and the traditions it followed were similar to those of generations that had come before and those that came after. That world of stability and tradition has passed in a relatively short time in historical terms. Baby boomers lives have been governed by a very different set of traditions than those that constrained their grandparent's lives. Their children's lives will no doubt be more different in ways that we cannot yet predict. It is in this context of demographic and social change that old age must be reconceptualized and new social arrangements suited to the new posttraditional order developed. Most likely that menu of options will contain many variants of traditional institutional arrangements and some groups, especially those with high fertility or those that reject what they see as the moral decay of the modern world, may continue in ways that look very similar to the past.

There is no doubt, though, that the dramatic decline in fertility and the decline of the traditional family though late marriage and divorce mean that families will simply not have the personnel to take care of aging parents, especially as lifespans increase. Some people in second and third marriages may find themselves having to deal with several aging parents at the same time. As baby boomers age they have already found out from their parent's experience that early old age can be a very independent time of life if one is in good health and has sufficient income and wealth. Older boomers, though, are already finding out that when physical and cognitive capacities decline the care burden for older parents can become overwhelming. Some arrangement other than caring for those parents oneself often becomes necessary. Assisted living in one form or another is a possibility if a family has sufficient resources. With the high cost of assisted living that option eludes many families. For those families Medicaid will become even more important than it is today and the questions addressed in this chapter become especially salient: How can civil society organizations complement Medicaid-financed community or institutional care to optimize the QOL for frail older individuals with limited resources while not breaking the bank? There are probably several answers to the basic question, but the only way to begin to address it is to develop a more sophisticated and informed understanding of the role of civil society organizations in the mix of help providers and advocates for the elderly.

The question is particularly salient in a period that is likely to be characterized by protracted fiscal austerity, limitations on State budgets in all developing and developed nations, and the continued inroads of neoliberal policy aimed specifically at social security programs. This new research agenda must be informed by a sophisticated understanding of the fact that the elderly are not a homogeneous population either in terms of social characteristics, needs, or political profiles. The elderly differ in terms of such politically and economically relevant dimensions as gender, race, ethnicity, immigration status, rural/urban residence, and more. Even as we advocate for the rights of the elderly as a group, more targeted civil society approaches allow us to deal with the great heterogeneity that characterizes aging in the world today.

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Chapter 35
Population Aging, Health Systems, and Equity: Shared Challenges for the United States and Canada

Amélie Quesnel-Vallée, Jean-Simon Farrah, and Tania Jenkins

In the wake of growing concern with social determinants of health, health systems and their potential contribution to health disparities have often been overlooked. Yet, as the WHO Commission on Social Determinants of Health (CDSH 2008) report compellingly reminds us, health systems' organization likely play a role in the development and the persistence of social inequalities in health. These effects are exacerbated among populations with frequent need for care: children, individuals with chronic diseases, and the elderly, and where service provision and funding are fragmented in a mix of public and private sources.

In this chapter we show how population aging creates common challenges for the U.S., an entrepreneurial health system, and Canada, a national health system. We will make this argument on the basis of cross-national comparison of three categories of health services that are most prominently used, or have seen their growth most affected by aging populations: prescription drugs, long-term care (LTC), and end-of-life (EOL) care.

As the United States considers the implementation of a plan for mandated health insurance coverage, and while Canada ponders carving out a greater responsibility of private health insurance in its national health insurance system, it may not be surprising to observe convergence between these two countries in coming years. Yet, the convergence in policies that affect most the aging population has deeper roots, which we examine with a particular focus on the considerations for equity that are raised by this comparison. More specifically, we will show that the organization of these services poses equity challenges for both countries in terms of geographical disparities and even within jurisdictions, in terms of socioeconomic inequalities in access and outcomes.

In the next section we will present a brief comparison of the aging of the Canadian and U.S. populations, followed by an overview of these health systems. We will then look in turn at the situation concerning prescription drugs, LTC, and EOL care, contrasting for each the Canadian and U.S. specificities and drawing out common challenges. Finally, we conclude with broader concerns about the impact of these trends on socioeconomic equity in access to care.

Population Aging and Intergenerational Equity

In a comparison of population aging in Canada and the U.S., LaPierre and Hughes (2009) show that those populations are currently quite similar in terms of their age distribution. However, due to lower fertility rates in the past couple of decades (and the associated decline in the proportion under 15),

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projections suggest that Canada could experience a slightly steeper rate of increase in population aging that would result in a greater proportion of 65+ individuals in this country starting in the 2030s (23.4% in Canada vs. 19.7% in the U.S.). Interestingly though, these trends do not seem to differentially affect the proportion of the oldest-old, those aged 85 years and over, which remains fairly similar, and increases at the same pace in both countries well into the 2050s (LaPierre and Hughes 2009).

The growth in this group of people, which is projected to reach about 5% of the total population in both Canada and the United States by 2050 (in contrast with less than 2% today), is a source of concern for policymakers across the developed world (Lafortune et al. 2007). Indeed, given that 20% of Americans aged 85 years and over report some limitation to their activities of daily life (ADL) – as opposed to only 3% of those aged 65–74 the ensuing multiplication of needs may require profound changes in the way services are provided to these populations (Lafortune et al. 2007).

As we will see in the next section both Canadian and U.S. systems share the historical heritage of Liberal Welfare States whereby the elderly (workers) were designated as a group particularly worthy of social protection. But this perspective emerged in a very different demographic context where the working-age population far outnumbered the elderly, thus allowing for the sustainability of a social insurance system. Similarly, as medical interventions were fairly limited, so were the associated costs (to the system, not to individuals, for whom they were always prohibitively high). While population aging per se is not the main driver of health care costs, the fact that most of an individual's lifetime health care costs are incurred in the last 6–12 months of life entails that the bulk of health care spending goes to elderly individuals. Any consideration of health systems, the elderly and equity must therefore first address the issue of intergenerational equity.

With the aging of their population and parallel (though not unrelated) changes in medical technology and patient demands, concerns are periodically raised regarding the financial sustainability of both Canadian and U.S. health systems, and particularly, about the risks for intergenerational equity and solidarity (Thurow 1996). However, while these "calls to arms" have not ceased, their dire predictions have not materialized either. Foner (2000) argues that this lack of age-based schism stems first from two essential features of social life: (1) The most basic social structure that individuals belong to, namely families, are age-heterogeneous, which tends to promote intergenerational solidarity; (2) Aging is an inevitable process, and thus programs directed at the elderly may still receive support from the working-age population that stands to eventually benefit from them. Moreover, public subsidies to the elderly can benefit younger family members through direct transfers, and indirectly, by removing the obligation to provide financial support to elderly relatives. Finally, as it is typically the family who cares for elderly relatives, this ensures an intimate, emotional awareness of aging-related issues and the availability (or need) of public support to surmount those challenges.

Therefore, Foner (2000) argues, the concerns with "age wars" are overstated, and serve to mask the more important social rift of social class, where public programs are supported by the working and middle class, but increasingly less so by more fortunate classes. While we do not adopt a class perspective in this paper, we follow in Foner's (2000) perspective to argue that the major challenge that both Canadian and U.S. health systems tackle with regards to eldercare does not so much have to do with public support sustainability, but rather with eroding social equity in access to services.

In the next section we replace health systems and notions of the "deservingness" of the elderly in the broader context of the development of the Welfare State (WS). This will provide the context for our contrast of the Canadian and U.S. health systems organization, and the more in-depth examination of the three cases of prescription drugs, LTC, and EOL care.

Welfare States, Health Systems, and the Elderly

Health systems are perhaps one of the most emblematic symbols of WS provision in the twentieth century. They are indeed commanding massive amounts of human and financial resources, and often represent the first and most obvious point of contact of the individual with the social system.

Following Briggs's (2000) seminal historical account, we can trace this preeminent position back to the very origins of the WS. Indeed, Briggs argues that WS are organizations whose primary function is the deliberate use of organized power (through politics and administration) in an effort to modify the play of market forces. This has historically been done through a guarantee of minimum income; by limiting insecurity in the face of both unexpected and unavoidable risks (such as sickness, unemployment, and old age); and by making the *best standards* (and not merely a minimum standard) of the above available to all citizens (within a certain agreed upon range of options, of course). Organized modern health systems – largely publicly funded and under some form of governmental regulation if not provision – obviously play a large role in fulfilling the second objective of WS.

Thus, the development of modern health systems closely mirrors that of the WS in Western societies, starting with the establishment in 1883 of the first government-mandated social health insurance program by Otto Von Bismarck, first Chancellor of the German Empire. In this landmark piece of legislation that was subsequently widely copied and adopted around the world, Bismarck enacted a law requiring employer (one-third) and employee (two-thirds) contributions to a sickness fund (World Health Organization 2000). The moral underpinnings of this legislation was that workers, or perhaps more cynically, their work capacity, was most deserving of social insurance. Thus, while there is strong evidence that this policy was passed at least in part to appease social tensions resulting from the woes of industrialization (and to stave off the growth of socialist ideology), this was also explicitly done in the name of insuring national productivity (Briggs 2000).

Old age insurance was soon to follow in the German Empire (in 1889), but as the age limit of 70 years substantially exceeded the average life expectancy of 41 years old at the time (Gapminder Foundation 2010; Social Security Online 2010), we can safely assume that this program was obviously not designed to pay pension annuities to a large segment of the population, or for lengthy periods of time into retirement. Nevertheless, this legislation stemmed from a slightly different moral imperative than the first, where the elderly and disabled (as a result of work) were explicitly designated as deserving of social protection from the state, ostensibly by virtue of their past contribution to the country's productivity.

While the first part of the twentieth century is marked by the extension of similar programs to larger segments of the population within countries and to more countries around the world, the second part of this past century sees the emergence of new principles of social protection. Often linked to the seminal Beveridge (1942) report, reforms that followed broadened the focus of state protection from the worker to all citizens, and "from cradle to grave."

The Canadian health system is generally thought to reflect a Beveridgean approach to social protection following the orienting principle of equity, while the U.S. health system is generally more reflective of a Bismarckian perspective upholding the values of free choice and individual responsibility (Roemer 1991). However, because of historical contingencies in the development of these systems (Maioni 1998), as we will see later, this overall assessment is not entirely reflective of eldercare in those two countries. Indeed, in Canada, some of the services most crucially needed by the elderly were not explicitly listed under the Canada Health Act of 1984, and have thus remained unevenly covered by a mix of public and poorly regulated private sources. In contrast, in the U.S., the elderly are eligible for universal social security coverage under Medicare, though not without out-of-pocket expenses, also with a substantial contribution from private sources.

Thus, while at *prima facie* one might expect more substantial differences with regards to these countries' health systems' capacity for handling these changes equitably, we will show below that the challenges they face are in fact very similar, though they emanate from radically different orienting principles. In the following section we provide a brief overview of these systems' organization, with a focus on a comparative perspective and on those services that are most relevant to an aging population.

Canadian and U.S. Health Systems in Comparative Perspective

The Canadian Health System(s)

Canada's "health system" in fact consists of multiple provincial and territorial single-payer national health systems (Marchildon 2005). Indeed, the Canadian constitution dictates that health matters are primarily under the jurisdiction of the provinces and thus hampers the federal government's capacity to intervene in the delivery of health care services.

There are, however, some commonalities from coast to coast. In the 1950s, in an effort to standardize plans across the country, the federal government pledged to subsidize half of each province's total costs in establishing universal health care systems around a consistent set of guidelines (Maioni 1997). As this initiative still left some substantial variation across the country, more recently, the Canada Health Act was passed in 1984 to consolidate (reduced) federal grants to provincial health care systems on the condition that the provinces and territories comply with five basic principles: universality, public administration, comprehensiveness, portability, and accessibility (Canadian Healthcare Association 2009). However, these conditions are only imposed on "medically necessary hospital, physician and surgical-dental services," thus leaving a substantial range of health services unregulated at the federal level. This has resulted in, at best, provincial variations in the populations covered and the extent to which this coverage is free, and, at worse, substantial proportions of the Canadian population being uninsured across all provinces.

In particular, the Canadian system developed during a period where population aging was not yet a preoccupation, and this is reflected in the publicly insured basket of services, which is inadequate to address the needs of this population. Moreover, Canada also faces a common challenge of national health systems, which is a lack of responsiveness to patients' needs. Indeed, a centralized organization and a single-payer funding scheme are typically ill-suited to fulfill individualized health service needs, which are often the hallmark of elderly care. For instance, prescription drugs were left out of the Canada Health Act in 1984, because it was deemed these costs would quickly rise out of control due to the substantial demand and high potential for individual access to these services (Boychuk and Banting 2008).

As we will see later, in some instances, as for prescription medication, a supplementary private health insurance market has developed to patch these holes in public coverage. Yet in other cases, the insurance market is still only at the incipient stages of development, with very little public regulation of the offer. This situation leaves these areas open to private speculation and very muchvulnerable to the development of socioeconomic inequalities, which is the case for LTC and EOL services.

The U.S. Health System

As a classic example of an entrepreneurial health system (Roemer 1991), the U.S. health care system is diametrically opposed to Canada's in many ways, as it does not mandate health insurance coverage to its general population, let alone fund care through a single-payer system. However, these differences are much less significant when it comes to the elderly population, which is covered

through Medicare (Maioni 1997; Wiener and Tilly 2002). This program, which covers most expenses for seniors' acute needs, is primarily financed through social security funds collected at the federal level, and to which every American worker contributes. Also, Medicaid, a state–federal public program, targets the needs of the poor and the severely disabled according to a minimum standard set by the federal government. Beyond this minimum level, states are entitled to extend coverage as they see fit. Therefore, the federal government fulfills the crucial role of maintaining the public sector so as to protect the neediest Americans.

The postwar public health care system was designed to respond to the needs of seniors by endowing the federal government with the legal responsibility of regulating this sector. However, as more Americans are getting older and living longer and healthier lives, seniors' needs are also changing. Thus, the prevailing approach of acute care adopted thus far by Medicare and Medicaid may no longer constitute an appropriate response. Yet, Washington is mainly preoccupied with funding issues as the central administration is slowly realizing that Medicare's financing is going to be difficult to sustain in the short term. Financial constraints, then, are one of the major roadblocks in adapting the public system to the needs of an older population, along with organizational constraints stemming from a fragmented system. At the state level, pressure is mounting to provide more assistance through Medicaid and to develop initiatives within their jurisdictions that will allow older Americans to remain at home later in life.

Having very summarily introduced the particular challenges faced by these systems as a result of their idiosyncratic organization, we will now turn to the similar challenges they face with regards to three categories of services: prescription drugs, LTC, and EOL care.

Prescription Drug Coverage for Seniors in Canada and the United States

Prescription drug coverage for seniors is an issue of growing importance for both Canadian and American policymakers, as evidenced by dramatic reforms in this area in recent years. Indeed, drug expenditures have risen dramatically in the past decades across the world. The United States in particular constituted over 50.2% of the global market sales of drugs in 2004, whereas Canada only accounted for 2.9% (Gray 2005). This translates into per capita expenditures of $752 (US PPP) in the United States compared to $559 (US PPP) in Canada (OECD 2004). Expenses on drugs for seniors have grown exponentially in the United States, from $10 billion in 1987 to over $52 billion in 2004 (Hartman et al. 2008) – an increase which has been attributed in the literature to changes in that country's demographic characteristics (i.e., the aging population) as well as to technology (Shah et al. 2006). In contrast, Morgan et al. (2004) have found that between 1991 and 2001, prescription drug expenditures for the Canadian elderly have increased from $149 to $320 million – but that less than half this variation can be explained by increases in the number of seniors or the rate at which they use these drugs. Instead, studies have found that increases in expenditures are best explained by changes in the types of therapies employed (Morgan 2006; Morgan et al. 2004).

What follows is an overview of prescription drug insurance coverage in both countries, as well as a discussion on rising drug expenditures and some of the techniques employed to curb those costs. We will then examine some of the repercussions associated with rendering these plans cost-effective, namely the issue of cost-related noncompliance (CRNC) amongst seniors, and finally conclude with some recommendations for both countries.

Prescription Drug Coverage for Seniors in Canada

Interestingly, despite universal access to health care in Canada and the Canada Health Act's guarantee to cover medically necessary services, public coverage for prescription drug medication varies

wildly from province to province and by individual characteristics (Anis et al. 2001; Demers et al. 2008; Grootendorst 2002). For example, Demers et al. (2008) found that the same elderly patient would pay anywhere between 0 and 100% of the costs of their medications, depending on the province in which they reside. This means that an elderly man, earning an average income with an annual prescription burden of $1,283, would pay anywhere between $60 for those prescriptions in New Brunswick to $1,332 in Manitoba, when the cost of yearly premiums is factored in (Demers et al. 2008).

Not all Canadian seniors are eligible for public coverage, either. Seniors in Saskatchewan, Manitoba, and Newfoundland are only covered if they have low income, whereas Ontario, Quebec, and Nova Scotia offer reimbursements proportional to costs and income level (Demers et al. 2008). Quebec is the only province in the country to have what is known as mandated health insurance for prescription drugs (Pomey et al. 2007). As such, it requires all residents to be covered by either a private plan (which is usually obtained through an employer) or the Régie de l'assurance maladie du Québec (RAMQ) public plan. Low-income seniors who receive the Canadian government's Guaranteed Income Supplement (along with children and individuals receiving social welfare) are not required to pay a premium to this public plan (Régie de l'assurance maladie du Québec 2009).

In sum, prescription drug insurance coverage in Canada is characterized by a fragmented system both across the various provinces and within them, with coverage and costs varying substantially according to individual income and supplementary private health insurance coverage.

Prescription Drug Coverage for Seniors in the United States

Prior to 2006, American seniors had to obtain their prescription medication by either purchasing private health insurance (independently or through a retirement benefit plan), paying out-of-pocket, or receiving some form of supplemental Medicare coverage (Frencher and Glied 2006). However, as a result of ever-growing expenditures on drugs, uneven coverage across social groups, impressive lobbying efforts on behalf of various public actors, and the population's general discontent with the status quo, the Bush administration introduced the Medicare Prescription Drug, Improvement, and Modernization Act in December of 2003 (Pomey et al. 2007). This resulted in the development of Medicare Prescription Drug Coverage (also known as Medicare Part D) in 2006, the country's first drug plan universally available to all seniors, regardless of income or health status (Centers for Medicare and Medicaid Services and U.S. Department of Health and Human Services 2009). Over 25 million Medicare beneficiaries now enjoy Medicare drug coverage (Hoadley et al. 2008).

There is still substantial variation in plan offerings, however, such that individuals can select among a total of 1,824 stand-alone plans in all 50 states which can vary in coverage and cost (Hoadley et al. 2008). That said, the federal government sets a minimum standard level for all plans, such that the balance of coverage and beneficiary contributions is somewhat standard across individuals (Centers for Medicare and Medicaid Services and U.S. Department of Health and Human Services 2009). This means that virtually all plans (with some exceptions for low-income individuals) include user contributions in the form of monthly premiums, yearly deductibles, copayments or coinsurance, and a coverage gap.

In addition, many Medicare plans in the United States include a so-called "doughnut hole" or $3,454 coverage gap, which requires beneficiaries to pay 100% of their drug costs once they've already spent $2,700 in total drug expenditures for the year (Kaiser Family Foundation 2009). After $6,154 dollars in total annual prescription costs, seniors then can benefit from what is known as catastrophic coverage, whereby they only contribute a 5% co-payment and Medicare and their insurance plan cover the other 95% of the cost. The coverage gap does not apply to everyone; however, eligible low-income individuals are entitled to coverage regardless of year-to-date costs, and

some plans even offer limited coverage during the gap, but these often charge higher premiums to enrollees (Centers for Medicare and Medicaid Services and U.S. Department of Health and Human Services 2009). In recognition of the financial and health risks that this coverage gap entailed, President Obama's Affordable Care Act proposed to fill this "donut hole" (U.S. Department of Health and Human Services 2011). However, as these initiatives were only implemented starting in 2010 and are set to progressively address this gap in coverage until 2020, it is still too early to evaluate the impact of this policy.

Thus, Medicare drug coverage requires some out-of-pocket expenditures for most people (Frencher et al. 2006). Some individuals can help offset the costs of these expenses through supplementary private cover. For others, publicly funded "extra help" is now available for eligible low-income seniors to offset some of the costs which fall under the beneficiary's responsibility. Seniors with incomes below $21,855 and resources less than $25,010 in 2009 are entitled to assistance with paying their drug plan's monthly premium, yearly deductible, coinsurance, or copayments, and are not subject to coverage gaps. Yet, many individuals who cannot afford private insurance but are not needy enough to be eligible for "extra help" are at risk of incurring substantial out-of-pocket costs related to their prescription drug needs, despite this universal drug coverage (Hoadley et al. 2008).

Implications of Out-of-Pocket Expenses: Cost-Related Drug Noncompliance

In sum, governments in both countries expect seniors to pay out-of-pocket expenses for prescription drugs. One important consequence of requiring seniors to contribute to their drug insurance plans is CRNC. Despite almost universal drug coverage in the United States, older patients with chronic diseases are still susceptible to cost-related nonadherence to prescription medication, even when enrolled in a prescription insurance plan (Briesacher et al. 2007; Maio et al. 2005). Low-income, higher out-of-pocket costs, lower drug benefits, and poorer health are all associated with higher risks of CRNC (Kennedy et al. 2004; Poisal and Murray 2001; Rector and Venus 2004). As a result, Medicare's gap in coverage may have a particularly alarming effect on those individuals who suffer from chronic illnesses but do not have a low enough income to qualify for assistance, as they may be left with little incentive to take newly prescribed medications which would push them over the edge of the "doughnut hole" in terms of year-to-date expenditures (Gellad et al. 2006). Gellad et al. (2006) also found that the near-poor who do not quite qualify for subsidies but do not have private drug coverage tend to pay more for their prescriptions than wealthier seniors because of the gaps in coverage. And since individuals who do not comply with their medication are more likely to experience worse health and visit the emergency department more frequently, this perversely generates higher medical costs in general (Heisler et al. 2004; Olshaker et al. 1999).

Americans of all ages are consistently less likely to comply with their drug regimens because of cost than Canadians (Kennedy and Morgan 2006, 2009). Thanks to the recent changes in Medicare part D; however, seniors in both countries are now less likely than nonseniors to experience CRNC (9.2 vs. 25.8% in the United States, $p<0.001$ and 4.6 vs. 8.7% in Canada, $p<0.001$) (Kennedy and Morgan 2009).

Long-Term Care

LTC refers to a broad range of services encompassing skilled nursing care, assisted-living facilities, home care, hospice care, respite care, adult day care, and different in-home living arrangements (Sultz and Young 2009). These services provide a long-term response to chronic increases

in disability brought about by functional limitations inherent in the process of individual aging (Feder 2000).

Even in the absence of comprehensive publicly funded LTC services, this sector has experienced constant growth since the Second World War (Grabowski 2008). However, while the formal provision of these services was once concentrated in institutions, demand appears to be shifting towards assistance aimed at remaining in the community as long as possible: from 1994 to 2005, the 85+ age group showed a decrease of 9% in the report of at least one ADL limitation for those living in institutions, while an increase of 3% took place among those living in the community (Lafortune et al. 2007). This suggests that there is an increasing proportion of those aged 85 and over who are in need of LTC services and now remain in the community.

This trend is probably not unrelated to the fact that governments across the board in developed countries have been, since the 1970s, championing a view of seniors as being more independent, more involved in their community and living as long as possible outside of institutional settings (World Health Organization 2002). However, this demand and the funding for it have so far been borne mostly by families and informal caregivers. Therefore, as we will see below, disparities in access to these services will be increasingly highlighted as the oldest cohorts grow in number and governments have to face issues of social justice in the provision of LTC services (World Health Organization 2002).

Long-Term Care in Canada

In Canada (as in the United States), local authorities are recognized as having a better perception of the LTC services and funding required in their area (Liebig 1993). Moreover, Canadian public LTC services are available to *complement* families' role in caregiving (Chappell et al. 2004). Requests for assistance thus usually stem from the family unit – a process that is often far from straightforward – and local health authorities deal with each case depending on available resources. Consequently, there is a great variation in access to publicly funded LTC services between and within provinces and territories in Canada.

Thus, the Federal government's influence on LTC remains minimal and is currently limited (at best) to promoting inter-provincial dialog and horizontal emulation of best LTC practices in the federation. As such, the potential for innovation at the sub-national level is greater than in the United States because provinces have complete freedom in the allocation of resources to LTC services. However, a standardization of practices may be harder to achieve across all provinces since the central government – assuming it had sufficient unifying strength *and* the will to act on this issue – currently lacks formal means through which it could exert influence on LTC-related policy.

Long-Term Care in the United States

In the United States, Medicare does not cover LTC services, with the exception of home care needed in the weeks following an episode of acute care (rehabilitative care). Thus, Medicare contributed only 19% to total spending for LTC for the elderly in 2004 (Komisar and Thompson 2007). In contrast, Medicaid, a federal–state shared program, does target the LTC needs of the poorest elderly Americans, accounting for 49% of national LTC expenditures in 2004 and is, therefore, one of the main players in the field (Komisar and Thompson 2007). States are responsible for implementing (and are free to expand) Medicaid services as they wish, but remain constrained by federal guidelines in doing so.

Typically, this program has tended towards the institutionalization of patients in Medicaid-approved facilities for LTC services. In fact, most states still spend 70–80% of their LTC funds in nursing facilities (Polivka and Zayac 2008). This fact led many scholars to criticize the "institutional bias" of Medicaid programs on the basis that it does not respond to growing demands from seniors to receive community and home care, or simply put, to facilitate aging in the community.

Thus, in contrast to Canada, the U.S. federal government has high stakes in the development of LTC services, since a large share of the formal LTC system operated in the country is funded, regulated, and assessed at the state and federal governmental levels through Medicare and Medicaid. Still, because of its financially shared nature, Medicaid has led to important geographical variations in coverage; states that are more conservative and less open to public coverage of LTC will simply meet the minimum requirements of the program, whereas those that are more progressive (and potentially those that contain a larger proportion of voting seniors) may extend the coverage to citizens who are further away from the poverty-line threshold, for example (Feder 2000).

Challenges to Equity in Long-Term Care in North America

The current state of the delivery of LTC services in both Canada and the United States tends to reflect the contemporary conception of individual aging in the private market; indeed, this is where elderly people, as consumers, can spend considerable amounts of money to receive the necessary support which enables them to remain active. The shift from an institutionalization-centered medical model of LTC to a patient-directed model has yet to fully penetrate the public system in North America, which constitutes one of the greatest challenges to policy, and particularly to Medicaid, in coming decades (Robinson and Reinhard 2009).

In fact, to this day, most long-term caregiving is still undertaken by informal providers and paid for out-of-pocket, particularly with regards to care in the community. With the implementation of a senior-oriented WS in the United States and a universal public health care system in Canada, this informal care network came to be complemented by formal caregiving options, either through scarce and means-tested publicly subsidized services and/or a plethora of private providers (Wiener and Tilly 2002). Drawbacks to such a loose health sector include lack of information-sharing on available public services, an unstable workforce, little follow-up on elderly people's health and social issues, and greater inequities regarding access to these services (Rantz et al. 2000).

This generates unmet needs which, at the individual level, accelerate the deterioration of health and promote institutionalization which could have been otherwise prevented with efficient and integrated LTC coordination (Keefe et al. 2007). In the United States, a Commonwealth Fund study reported that 58% of the elderly respondents of a 1999 cross-state survey declared having unmet needs (Komisar et al. 2005). In Canada, a Statistics Canada study drawing on the 2003 wave of the Canadian Community Health Survey showed that 42% of seniors requiring help with moving about in their home did not receive any help and that even among those who received a mix of formal and informal home care, 19% of seniors expressed unmet home care needs (Carriere 2006). This sheds light on the fact that even limited and fragmented public provision of LTC services may not be sufficient to ameliorate or even maintain patients' health status.

Many scholars and practitioners recognized the need to change this and designed experimental integrated care systems for the elderly as a way of influencing policy-making (Hollander et al. 2007). So far, efforts to generalize these local experiments to a larger policy scope have largely failed. Another avenue for reform may come from LTC insurance, which exists in both countries, but whose growth has been relatively limited. At the American federal level, the Health, Education, Labor and Pensions Committee (HELPC) has been active in testing ideas underlying a hypothetical national LTC insurance scheme. Known as the CLASS Act sponsored by the late Senator Edward Kennedy

(former HELPC chairman), this federal policy would automatically enroll workers in the insurance scheme, with the option of opting out (Gleckman 2009). If enacted as part of the Obama administration's health care reform bill, this program could potentially provide all Americans with one alternative to Medicare and Medicaid in accessing LTC services (O'Malley Watts 2009). Currently, only a handful of insurers in Canada offer these services, but these offerings may grow in the future, as they are being heavily marketed to both employers and young senior citizens by the industry.

Finally, there is substantial evidence from both countries showing that elderly people and their families – especially those from lower socioeconomic classes without an informal caregiving network – do not possess sufficient resources or control over their LTC needs (Feder 2000; Messinger-Rapport 2009). Indeed, while a vast array of private care options exist, ranging from home care services to high-end retirement communities or elder care centers (Grabowski 2008), many elderly persons lack the means to consume the variety of LTC products offered by the market and yet fall below the stringent requirements to access publicly covered, means-tested LTC services. It is difficult to envision how such strongly ingrained views that see LTC as an entitlement reserved to the poor in the United States, and as a family responsibility in Canada (Chappell et al. 2004), could be circumvented to ensure care for those lower middle-class elderly people who, for various reasons (geographical mobility or smaller families, for example), lack informal care support. Yet, along with the issues of integrating LTC for individual patients, and providing alternatives to institutionalization, this is without a doubt a challenge that both countries will be facing in the years to come.

End-of-Life Care in Canada and the United States

As seniors continue to live ever longer, there is a growing need for what has come to be known as "end-of-life" (EOL) care, or "the services that may be needed by dying persons and their family or friends in the last year of life, as well as bereavement services following death" (Wilson et al. 2008:323). It seems that there have been changes in the locus of EOL care in recent decades in both Canada and the United States, away from hospitals and towards the home or LTC facilities. Let us take a closer look at the broader trends in EOL care in Canada and the United States as well as the trends regarding the expenditures associated with this type of care. We will then examine how socioeconomic status (SES) and place of death are closely related, in the context of two healthcare systems where health care proffered outside of an institution is scarcely covered by health insurance.

End-of-Life Care Trends in Canada

Across Canada, hospital deaths have declined from 77.7% in 1994 to 60.6% in 2004 (Wilson et al. 2009). In a separate study of Canadians who died during 2001–2002, it was found that 49.2% of those sampled died in hospitals, 30.5% in LTC facilities, 9.6% died at home while receiving home care, and 10.7% died at home without any home care (Motiwala et al. 2006). Place of death is known to be determined by various factors. Certain morbidities have been found to be the strongest predictors of location of death, such that cancer for example, increased chances of home death, while dementia made death in a LTC facility more likely, and major acute conditions increased the probability of death in a hospital (Motiwala et al. 2006). Regarding home care more specifically, other researchers have found that older individuals,

women, people residing in urban regions, and individuals of higher SES are all more likely to receive care at home during their last year of life (Brackley and Penning 2009). Similarly, Wilson et al. (2008) have noted that access to hospice and palliative care programs is unevenly distributed across Canada because these services tend not to be covered by provincial health plans, and as such, not all Canadians have equal opportunity when it comes to choosing their place of death.

End-of-Life Care Trends in the United States

In trends that parallel those in Canada, Flory et al. (2004) found that from 1980 to 1998, the percentage of Americans dying in hospitals decreased from 54 to 41%, whereas home deaths increased from 17 to 22%. Similarly, nursing home deaths increased from 16 to 22% from 1990 to1998. Parallel to this, Dy et al. (2007) showed that the proportion of Medicare recipients hospitalized during their last year of life remained stable from 1989 to 1999, but that the use of institutionalization in LTC facilities increased. They also found that changes in the place of death had occurred during this period, towards increases in LTC facilities and decreases in the proportion of those dying in the hospital. Fried et al. (1999) have also noted this diversification in places of death in their study on dying at home. They found that 49% of people in their sample died in hospital, 21% at home, and 27% in a LTC facility, numbers that essentially mirror the Canadian ones.

Expenditures on End-of-Life Care

In sum, it seems that both countries have experienced a general trend towards the deinstitutionalization of death in recent decades – a policy which seems to have been adopted almost internationally (Merlis 2000). This shift could reflect a more humane approach to dying, as well as respond to patient preferences; Buntin and Huskamp (2002) indeed found that if the care were available or accessible, many more patients would choose to die at home than elsewhere. However, a closer look at expenditures in EOL care suggest that this qualitative improvement in services places a higher cost burden on older decedents and their families, and is not distributed evenly in the population.

Indeed, despite the aging of the population, governmental expenditures on EOL care have remained stable over time in both countries (Buntin and Huskamp 2002; Canadian Institute for Health Information 2007; Emanuel 1996; Hogan et al. 2001). In the United States, approximately 25% of all Medicare spending occurs during the last year of life (Buntin and Huskamp 2002; Hogan et al. 2001), whereas in both countries, between 10 and 12% of all health care expenditures are dedicated to EOL care (Buntin and Huskamp 2002; Canadian Institute for Health Information 2007; Emanuel 1996).

Expenditures on EOL care in both countries generally decrease as age of death increases. In the United States, for all sexes, races, levels of co-morbidity, type of care, and cause and site of death, Medicare expenditures decreased consistently with age at death (Bird et al. 2002; Levinsky et al. 2001; Lubitz and Riley 1993). In explaining this pattern, Levinsky et al. (2001) estimated that declining aggressiveness of care in the United States accounted for approximately 80% of the decrease in medical expenditures with age. These trends were found in Canada as well (Demers 1998).

However, in all these cases, the focus is on measurable *government* spending during an individual's last year of life. Thus, some authors have argued that these figures exclude many services which are not covered through government health plans such as home or hospice care, and may thus be

underestimated (Buntin and Huskamp 2002; Scitovsky 1994). Indeed, Hoover et al. (2002) confirmed that EOL expenditures covered by Medicare were lower for those dying at older ages, but also that nonMedicare-covered expenditures were in fact higher for those dying at older ages than at younger ages. Similarly, Scitovsky's review of the literature (1994) finds that although the aggressiveness of care decreases with age of death, these savings are often offset by rising LTC costs. So it appears that while governments spend less on the oldest decedents, individuals and their families are bearing a relatively greater burden than for younger decedents. As we have shown above that one of the greatest (shared) challenges for both countries will be the significant increase in the oldest-old (85+), these patterns beg the question of who will bear the additional burden of these older decedents.

Inequalities in Place of Death

Moreover, health coverage during the last year of life affects patients' "trajectories of death" (Buntin and Huskamp 2002), and nowhere is this relationship clearer than when examining the link between SES and place of death. As Gruneir et al. (2007) found in the United States, ethnic minority status, lower levels of educational attainment, and less access to resources and social support were associated with a higher probability of hospital death, despite patient preference to die at home. In Canada, higher SES was also found to increase chances of dying at home (Motiwala et al. 2006). More specifically, it has been noted that the expenses incurred by Canadian families at the end of life are quite substantial, and that as a result, a two-tiered system of EOL care has developed, such that only those with the most resources can afford to die at home (Chochinov and Janson 1998). These social inequalities in death may in fact be only the tip of the iceberg of an emerging trend: in the United States in 1980, there were no racial differences between the proportion of whites and blacks dying in hospital. In 1998, however, fewer whites died as inpatients in hospital than did African Americans (Flory et al. 2004).

Several studies have specifically examined the relationship between government policies and social inequalities in EOL care. For example, high government investment in LTC, measured by regional density of nursing home beds and state Medicaid payment rate, was associated with higher probability of nursing home death in the United States (Gruneir et al. 2007). In another American study, Muramatsu et al. (2008) found that state spending on home and community-based services indirectly increased the chances of dying at home by reducing the risk of nursing home relocation near death. In Canada, however, this relationship is not quite as clear. Despite specific policy reforms designed to make home and community care more accessible in British Columbia in the 1990s, the results of one study suggest that equity in access to this type of care did not improve during that period, nor did home care service utilization increase (Brackley and Penning 2009). So despite deinstitutionalization efforts on behalf of the government, it may be because community care requires out-of-pocket resources that fewer people are opting for home deaths than expected.

Common Challenges for Equity: Different Solutions for the U.S. and Canada?

There is often an expectation that the Canadian system is inherently more equitable than the American one (World Health Organization 2000). Yet, in our examination of three types of services that are particularly salient to aging populations, namely prescription drugs, LTC, and EOL care, we have shown that, due to various historical contingencies in the development of the Canadian and U.S. health

systems, population aging poses comparable challenges to equity on both sides of the border. Below we summarize the main points of common challenges shared by Canada and the United States.

Prescription Drugs Coverage

In an interesting departure from most cross-national trends between these two countries, prescription drug insurance coverage for the elderly in the United States is in fact more homogenous than in Canada, thanks to the recently implemented Medicare Part D. Indeed, as this was never a category of services covered under Canada's national insurance plan (deliberately so; see Boychuk and Banting 2008), coverage evolved into a fragmented patchwork system of public and private coverage with strong inter-provincial variations in both levels and mechanisms of coverage. As a result, levels of out-of-pocket contributions vary widely in Canada, depending on a number of factors including an individuals' income level. Of course, variations in coverage are endemic in the United States as well, with more than 1,824 stand-alone plans offered (Hoadley et al. 2008). This fragmentation may at least partly explain why American seniors still experience far greater CRNC than Canadians (25.8% in the United States vs. 4.6% in Canada), though these data were gathered only a year after the implementation of Medicare Part D, and thus may transient health inequalities between the two nations that will diminish over time (Kennedy and Morgan 2009). Another contributor probably lies in the so-called "doughnut-hole" that leaves some seniors vulnerable to all but the most catastrophic medication expenses. One unintended consequence of these out-of-pocket payments in both countries could be additional costs to the health care system, since medication noncompliance is known to lead to worse health and increased emergency department visits.

Long-Term Care

Two main parallel trends are unavoidable for students of health care systems in our graying countries: a fairly high demand in LTC services on the one hand, and an increase in service fragmentation within and between states and provinces – as opposed to an integrated system carefully monitored by governments – on the other. Most explanations of these two opposite trends tend to point to the fact that the increasingly rapid aging of the population tests the institutional limits established at the inception of both Canadian and American Medicare programs. Therefore, LTC largely falls outside the purview of these programs.

Perhaps more than any other type of health service, the delivery of LTC (and particularly home care) must contend with highly individual issues of human dignity and privacy, as well as the social consequences of disability for caregivers and the broader community. Moreover, because of the multifactorial nature of disability, these services are difficult to standardize according to a unique clinical protocol, and are most efficacious when the response varies according to individual needs. This complexity in service delivery means that a social consensus has yet to be reached on achieving equitable access to and better quality of LTC, as this entails both integrating diverse resources (a number of them falling outside of the purview of the medical system) to provide a continuum of care to elderly patients and enhancing support for informal caregivers (Merlis 2000).

Some degree of fragmentation may be unavoidable, considering the needs unique to each patient's idiosyncratic experience of aging; however, experiments in both countries *facilitating* a continuum of care across diverse LTC service providers have yielded interesting results, though they are still confined to local settings, such as the SIPA and PRISMA programs (Béland et al. 2006; Hébert et al. 2003). A large part of the current demand for LTC has so far been absorbed by informal

caregivers, and funded through out-of-pocket payments. However, the stakes are likely to grow in the face of baby boomers' increasing demand on these services, longer life expectancy, and smaller families (with the commensurate decreases in informal caregivers this may entail). Thus, the calls for reform are likely to grow as disparities among elderly individuals with disabilities will become an apparent consequence of the steady rise in unmet LTC needs in this population.

End-of-Life Care

Our review indicated that not only are trends in EOL changing in both countries, but so are out-of-pocket expenditures for services not covered by public health insurance. In both countries, these expenses tend to be offset by family members, which means that EOL care in general and the location of death in particular are now becoming socially stratified. This should serve as a reminder that social inequalities in health exist not only in life, but death as well. In light of these findings, it may be useful to draw from Wilson et al.'s (2008) recommendations for best practices in EOL care. In their exhaustive review of the data and literature, these authors identified four essential components of an ideal EOL model of care which include: universality, care coordination, assured access to a broad range of basic and advanced EOL services, and EOL care provision regardless of care setting. By being mindful of the potential inequalities that can be caused by governmental policies such as deinstitutionalization, we can grow towards greater equity in public health – even in death.

Avenues for Policy Reform

The examples above illustrate that, while stemming from very different institutional sources, we observe similar challenges across Canada and the United States with regards to equity in prescription drug coverage, LTC, and EOL care.

In Canada these challenges are born out of a national health insurance system that was developed around the insurance and provision of physician and hospital services. Services falling out of this strict biomedical purview have been left to be funded and provided by the private market for the most part, with the concomitant fragmentation and inequities in access that ensued. This, despite being a universal health system as far as hospitalization and physician services are concerned, Canada leaves domains that are not covered by these categories essentially unregulated, and open to private markets. This tends to disproportionately affect the elderly, as many of the services most salient for this population are either highly individualized – and thus poorly addressed by central organizations – or fall in a gray zone that bridges the social and medical policy realms.

In the United States a social consensus around the importance of providing care for the elderly was reached, in part thanks to the notion that this population "deserves" these services for having paid into the system for most of their working lives. This has led to the coverage of the elderly population through a public system that is funded through social security, and is therefore congruent in its design with the moral underpinning that justified it. Because they share many of the characteristics of a single-payer model, Medicare and Medicaid must also address the issues of responsiveness that were highlighted above for Canada. Of course, because of the overall orientation of the U.S. health system, the private market is also by design never very far, and low levels of public regulation contribute to inequity among the elderly population, as with LTC and EOL. Yet, where the private market is publicly regulated, as with prescription drug coverage, the United States has the potential to reach a higher uniformity of coverage than in Canada.

The challenges of a centralized organization of services for LTC and EOL we outlined earlier, along with the sometimes difficult to reconcile social and medical goals of these services may complicate the extension of these services under a strictly publicly funded model. In other words, the private offering of these services is likely to persist, and perhaps for good reasons. However, governments can and must intervene to regulate these markets to ensure equitable access and fairness of financial contribution, two of the primary goals of high-performing health systems (World Health Organization 2000). To be clear, we are not arguing here necessarily for increased public funding (although that would certainly help) but rather for greater public regulation of the existing private markets.

Thus, both countries could benefit from a greater emphasis towards a publicly regulated, mandated insurance market for the services we studied here. The mandate for individual insurance (i.e., that all elderly must obtain insurance of some form) is an important condition here, as it ensures adequate pooling of (financial) risk between those who need the least and those who need the most care. Furthermore, a necessary condition to attaining the goals stated above would be to ensure greater public regulation of private contracts. Notably, as health conditions can deteriorate rapidly from one year to the next among the elderly, this would entail public protection from frequent renewals of contracts (and the afferent hike in rates as actuarial risk increases), or even lifetime cover as is currently being considered in Australia (Palangkaraya and Yong 2007). Finally, public insurance options that offer more flexibility than the existing public services, and that would be made available on a means-tested or even universal (for the whole population of the elderly) basis constitute a pillar of a responsive policy aimed at equitable access.

In terms of the likelihood of these reforms, Canada and the United States both suffer from inequitable regional variations and benefit from the fragmentation of power between the federal and sub-national units. Indeed, while this fragmentation can bring challenges in reaching a uniform national policy, it also allows for innovation and later diffusion (as was the case in Canada with national insurance, for instance). Comparatively, as Medicare Part D shows, the United States may have more structures already in place to enact a sweeping reform, such as the progressive "closing of the doughnut hole" that was indeed proposed in the Affordable Care Act passed in March 2010 (U.S. Department of Health and Human Services 2011). However, as the epic challenges waged against this bill since it was passed tellingly remind us the U.S. political system in and of itself can also constitute a significant roadblock that can trump the implementation of evidence-based policies.

Thus, beyond organizational capacity and political context, perhaps the most important criteria for reform in these countries would be a social consensus around the need for more equitable access and fairness of financing of those services for the elderly. At a cultural level, stronger public regulation of private contracts (for the elderly) should be fairly viable in both countries. A mandate for insurance may be slightly more contentious in the United States than in Canada, but given the existence of Medicare (in itself a mandated program), it may be more palatable among the elderly than the working-age population. Finally, while a public option has met strong resistance from the working-age population in the U.S., again, the existence of Medicare in the United States and of a national health system in Canada may provide the necessary cultural and organizational foundations for this in those countries. The case of Quebec, a province which requires mandatory health insurance coverage for prescription drugs and consequently has the lowest CRNC rate in both countries, shows to what extent mandatory insurance can help mitigate social inequalities (Kennedy and Morgan 2009).

In terms of the challenges specific to each country, Canada probably needs to supplement its general population health and equity perspective with a stronger focus on certain underserved subpopulations, including the elderly (Frohlich and Potvin 2008). Indeed, provisions are already made in a number of provinces to protect this population from out-of-pocket expenses for prescription drugs for instance, but the basket of services offered by the public medical system still overwhelmingly consists of curative medicine, which is not optimal for a population dealing primarily with

chronic diseases, and managing disability. In turn, the United States has covered, and keeps covering, the elderly on the premise that they deserve this support (while working-age individuals do not deserve such support, as per the principle of individual responsibility), but there, the population needs to realize that health must be also nurtured across the life course, and not just starting at 65.

What Next for Sociological Research?

One of the main challenges to studying the impact of policy is lack of variation in the population's exposure to national legislation. Yet, by virtue of the fragmentation of our health systems, natural policy experiments are happening everywhere in Canada and the United States. The shared challenges we have uncovered in this chapter mean that we can learn from one another, and that cross-nationally comparative research would prove to be a particularly advantageous strategy here.

Moreover, as sociologists, we are uniquely positioned to make a significant contribution in this field. Indeed, the focus in evaluating the impact of those policy interventions (to the extent that there is any evaluation at all) is often towards health outcomes, which obscures the existence, persistence, or even development of social inequalities. Yet, as Foner (2000) reminds us, sociologists are uniquely poised (and tooled) to uncover those processes.

Thus, through these very different institutional pathways, both of these countries find themselves with very similar needs for adaptation posed by this common demographic process of population aging. The ball is now in our camp to evaluate ongoing interventions and their impact on equitable access and fairness of financing among the elderly so that evidence-based policies that seek those goals may eventually prevail.

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Chapter 36
Long-Term Care: Tradition and Innovation

Eva Kahana, Loren Lovegreen, and Boaz Kahana

The goal of this chapter is to explore both conceptual and empirical advances in understanding the nature, determinants, social processes, and impact of long-term care (LTC) provided to elders in the United States. We call attention to relevant conceptual and research literature that can help readers connect current ideas and approaches to prior seminal research and theoretical formulations.

It is well established that most older persons prefer to age in place (Wagnild 2001) and enter institutional facilities only when other options are unavailable (Kane 2001). LTC institutions serve an important function by offering medical and residential services to older adults who suffer from chronic illnesses, accompanied by physical, sensory, or cognitive impairments (Stone 2006). Such care becomes necessary when informal assistance by family (or friends and neighbors) is not available or is insufficient to meet the care needs of an older adult (Charles and Sevak 2005). The concept of LTC designates services for meeting the ongoing needs of older adults for assistance with activities of daily living. Such services are not limited to residential care but can also include home care or day care. However, the focus of this chapter is on institutional LTC which is the predominant approach in meeting the needs of frail elders in the US (Kane 2009).

With the rapid aging of the population and increases in the ranks of the very old, demand for LTC is accelerating (Johnson et al. 2007) and the delivery of such care poses a major challenge to social policy and practice in the United States and around the world (Kane 2009; Settersten 2007). Key unresolved policy issues in this field include the balance between institutional and noninstitutional alternatives, coordination of state with federal financing of care, coordination between acute care and LTC, and providing access without excessive burdens to consumers (Feder et al. 2000). In addition, a major challenge relates to finding mechanisms for ensuring provision of high-quality care. Such care allows for maintenance of good quality-of-life among residents, even in the face of their physical and/or cognitive limitations (Kane 2003). We focus on social processes that shape the daily lives of elderly persons who are care recipients along the spectrum of LTC settings.

Our discussion calls attention to important early work that can serve as scaffolding for future research and practice to insure that foundational sociological approaches are not obscured or forgotten. We consider perspectives of diverse stakeholders in LTC, ranging from families of elders to direct service providers, professional staff, and policy makers. Even as we attempt to take a broad view of LTC, our central interest remains with the older care-receiver whose lived experience is most fundamentally shaped by LTC (Kahana et al. 2009). Taking a sociological approach, we highlight the complexities, the human dimensions, and the countervailing values involved in caring for frail older adults.

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One useful approach for organizing our understanding of LTC for the aged has been provided by Stone (2006). She refers to the triple knot of LTC – financing, type of setting, and work force issues – as the defining features of care delivery. A second useful organizing framework has been offered in the work of Kane (2001) who considers important linkages between quality of LTC and residents' quality-of-life. She relates structural and organizational features of LTC to indicators of multidimensional quality-of-life articulated in the gerontological literature (Abeles et al. 1994). Although we recognize the value of structural approaches that contribute to quality of care, we direct our major attention to the social processes that link quality of care to residents' quality-of-life that are rooted in prior sociological theorizing (Goffman 1961; Sommer and Osmond 1961) but have been less central in recent treatises on LTC.

Important emerging themes in the literature on LTC reflect efforts at reform, directed at enhancing both the quality of care and quality of resident life. The most prominent among the recently implemented approaches is the culture change movement (for a review and critique see Rahman and Schnelle 2008). There is also a growing literature focused on more homelike alternatives in LTC such as assisted living facilities (ALFs) (Kane and Cutler 2009; Zimmerman et al. 2001) and continuing care retirement communities (CCRCs) (Sherwood 1997; Shippee 2009).

The theme of our discussion is *tradition and innovation*, as we explore the impact of LTC on care-receivers' quality-of-life. The structural model guiding this discussion is depicted in Fig. 36.1. In our model, we relate personal characteristics of the resident (component A) to the type of LTC settings in which the older adult resides (component B). We also briefly consider the environmental context of LTC settings (component C) that shape the quality of care delivered (component D). Based on our interest in social processes that define residents' lived experience, we next focus on linkages between quality of care (component D) and resident quality-of-life (component E). We argue that the type of LTC setting influences the quality of care provided, indirectly via the

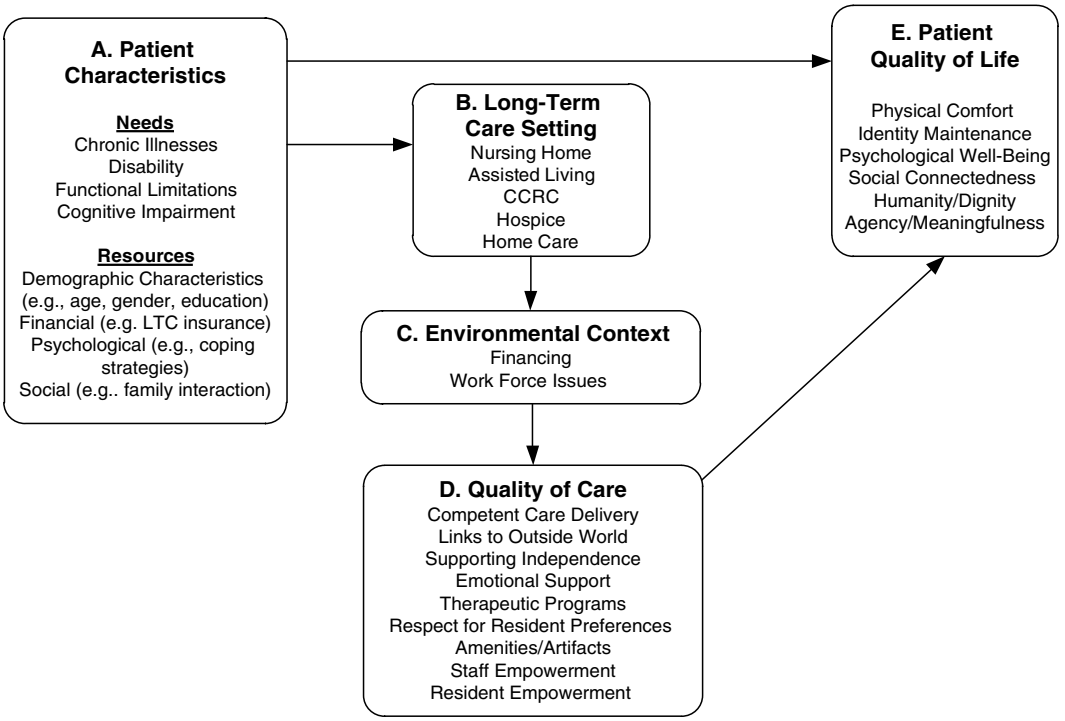

Fig. 36.1 Structural model of long-term care impact

environmental and social milieu (e.g., financing, workforce issues). Our structural model also recognizes that beyond residents' quality of care, their quality-of-life is also affected by their own needs and resources. Thus, component A has a direct impact on component E. These characteristics cut across diverse theoretical models and may receive greater or lesser emphasis in alternative conceptualizations. Our model depicts a range of LTC settings including nursing homes, along with newer LTC options of ALF, CCRCs, and hospice programs. Notably, the majority of work focusing on LTC from the perspective of sociology relates to nursing home care (Goffman 1961; Gubrium 1975; Kahana 1973).

In the discussion of our structural model (Fig. 36.1) we offer a brief description of alternative LTC settings and the key environmental characteristics of financing of care and workforce issues. We then turn to a review of social processes that link quality of care with quality-of-life in LTC facilities. The latter discussion is organized utilizing a concept map presented in Table 36.1. This map specifies theoretical orientations used in the study of social processes in LTC primarily in sociology, but also includes relevant models from other disciplines. We also identify programs, policies, and practices associated with each model that proponents of conceptual models or others have developed.

Table 36.1 Concept map: processes of quality of care and quality-of-life

Theoretical/conceptual model	Quality of care: environmental and social processes	Quality-of-life: impact on resident's physical and psychosocial well-being and identity	Program, policy, and practice implications
1. Medical Model			
The Sick Role (Parsons 1951, 1975)	Efficient physical care delivery Ensure patient safety	"Patient" identity Conformity	Patient assessment Patient monitoring Reporting of adverse events
2. Institutional Analysis Models			
Total Institution (Goffman 1961; Sommer and Osmond 1961; Kleemeier 1963)	Congregate Segregate Institutional control	Mortification of self Stripping De-individuation	Homelike environment Age integration Humanizing care
Dependency Inducing Environments (Langer 1975; Baltes et al. 1980)	Reinforcement of dependency Staff control of environment	Learned helplessness Loss of control	Culture change movement Environmental flexibility Support personhood Aid self-determination Enhance patient control
3. Ecological Models			
Stress Model (Schooler 1982)	Threats and hazards	Diminished health and well-being	Reduce stressors Improve coping skills Increase social support
Environment Press/Adaptation (Lawton 1982)	Adaptive capacities of resident taxed by environment	Environmental docility	Therapeutic programs to enhance competence Environmental design
Congruence Model of Person Environment Fit (P–E Fit) (Kahana 1982)	Lack of P–E Fit	Low morale Residential dissatisfaction	Increase P–E Fit
4. Ethnographic Model			
Social Construction of Everyday Life (Clark and Anderson 1967; Henry 1963; Gubrium 1975)	Indignities of daily life Assaults on the self Front stage and back stage of care	Suffering Negative transformations of identity Broken social connections	Life review to restore selfhood Community building in LTC Personal testimony to effect legislation

(continued)

Table 36.1 (continued)

Theoretical/conceptual model	Quality of care: environmental and social processes	Quality-of-life: impact on resident's physical and psychosocial well-being and identity	Program, policy, and practice implications
5. Political Economy Model			
Structures of Domination (Estes 1979)	Commodification of care Exploitation of staff Patient abuse/neglect	Physical harm Alienation	Staff empowerment Collective bargaining Regulation
6. Advocacy Models			
Consumerism/Self-advocacy (Haug and Lavin 1983)	Demand patient rights Self-care	Responsive care getting	Skill-building for self-advocacy
Empowerment/Family Advocacy (Cox and Parsons 1994)	Family involvement Accountability in care	Self-esteem Self-efficacy	Family/staff collaboration Family/staff confrontation
Activism/Community Advocacy (Kane 2009)	Community presence	Self-actualization	Action group alliances Stakeholders demand legislative changes

Long-Term Care Settings

Our discussion covers key LTC settings noted in our structural model. However, additional LTC options include adult foster care (Kane et al. 1991), small board and care homes (Carder et al. 2008), and home-sharing arrangements (Pritchard 1983). Furthermore, naturally occurring retirement communities (NORCs) have also received attention as growing options in LTC (Bookman 2008; Hunt and Gunter-Hunt 1985). Even though different types of LTC settings are often treated as distinct entities, there is growing concern about the overlap between traditional nursing homes and ALF settings, with the latter assuming more institutional properties (Kane and Cutler 2009). Moreover, LTC settings are increasingly diversified in the types of care provided. For example, within each type of setting there may be special units, such as dementia care, rehabilitation, or hospice that constitute distinct entities.

Nursing Homes

Nursing homes have served as the primary source of institutional care for older adults since the 1930s (Mollica 2001). They provide a broad spectrum of services for people who often have multiple disabilities and who suffer from physical, sensory, and cognitive impairments. These residents also need extensive assistance with activities of daily living (e.g., bathing, eating, and dressing) (Jones et al. 2009). Typically those with severe dementia are now cared for in special units that provide environmental support and therapeutic programs (Zeisel et al. 2003). Nursing homes also provide short-term rehabilitation for discharged hospital patients (Kane 2005).

In 2004, there were 16,100 nursing homes in the United States, with a majority operating as a for-profit organization (Jones et al. 2009). Rates of institutionalization for the very old are high, with 17% for those aged 75 years and older residing in nursing homes in 2005 (Jones et al. 2009). However, the overall proportion of elderly persons (over age 65) in nursing homes has declined in recent years, from 7.5% in 1982 to 4% in 2005 (Manton et al. 2006). This may reflect decreasing disability rates among older adults and a wider range of LTC options. Based on 2008 U.S. Census data, 68% of nursing home residents are Caucasian women and the median age is 83.2 years (Jones et al. 2009). The under-representation of minority elders in diverse LTC facilities reflects structural constraints in access to care (Quadagno 1999).

Assisted Living Facilities

Since the 1990s assisted living has become an increasingly popular alternative in LTC in the United States for older adults with financial means (Zimmerman et al. 2001). At present there are approximately 39,500 ALFs in the U.S (AAHSA 2009). The rise of ALFs is largely a response to the desire among older adults to avoid nursing home placement and reflects the medical model of care (Kane and Cutler 2009). ALFs, at least in principle, support an "aging in place" philosophy. Resident autonomy and privacy within a homelike setting are two central goals of ALFs (Hawes et al. 1999). Housing and nonmedically oriented services are provided to mildly or moderately frail and/or cognitively impaired older adults in ALFs. Older adults typically expect to continue living in these facilities for an extended period of time, even as their needs for care may change (Golant and Hyde 2008). However, restrictive policies at some ALFs require relocation by frailer residents to nursing home settings.

Continuing Care Retirement Community

CCRCs offer a broad range of services within a single setting. Most residents enter into independent living while they are still in good health. They live in private apartments and are provided with meals and recreational services. They are provided with more extensive services sponsored by the same facility when greater service needs arise (Sherwood 1997). Residents with some ADL and IADL needs typically first transfer to ALFs and later, those with more extensive needs, enter the nursing home within the same comprehensive facility (Shippee 2009). Many well-functioning older adults are attracted by the independent living options of CCRCs, while planning ahead for increasingly complex services without burdening family members as they become frailer (Lovegreen, 2010). As of 2009, approximately 1,850 CCRCs were operating in the United States with most (82%) operating as not-for-profit organizations (AAHSA 2009).

Hospice

Hospice care is aimed at meeting the needs of patients (including the elderly) close to the end of life (Saunders 1978). Developed originally in England, the hospice philosophy embraces patient-centered, compassionate care. Incorporating principles of palliative care, the tenets of hospice care include comfort, dignity, meaning, and connectedness for the dying person and their family. Pain management, emotional and spiritual support, family education, counseling, advocacy and bereavement support, are all central goals of hospice care (Saunders 1978). Hospice was originally focused on terminally ill cancer patients; though its clientele has been expanded over time and now includes patients with varying diagnoses including Alzheimer's disease and Parkinson's (Han et al. 2006). However, hospice services are still underutilized, particularly in LTC institutional settings (Miller et al. 2002).

Environmental Context: Financing of LTC

The LTC settings reviewed reflect growing options for older adults requiring assistance with activities of daily living. However, access to such options is often based on financial resources (Stone 2006). States also play a major role in access to LTC through a variety of control mechanisms.

These include regulation of the number of nursing home beds allowed at a given time and reimbursement rates paid to nursing homes for Medicare-eligible residents. States also exert control over home health services (e.g., setting certification criteria for reimbursement), which influences the need for nursing home alternatives. However, state and federal coordination of LTC financing has been limited. As in 2004, Medicaid served as the major source (64%) of LTC financing for nursing home residents (Mollica and Johnson-Lamarche 2005). Many of these individuals initially financed their own care, and Medicaid assumed responsibility only after personal funds were "spent down." Medicaid finances care from the outset for those who completely lack resources. It is important to recognize that the homelike options of CCRCs and ALFs are not readily available to older adults of limited financial means. Those elders with the greatest need and most limited resources have narrower choices and rely predominately on nursing home care (Stone 2006).

Environmental Context: Work Force Issues

The quality-of-life of residents in LTC facilities is largely shaped by the quality of care that they receive from staff working in such settings (Stone 2006). The adequacy of staff has been recognized to play a key role in insuring high quality of LTC. The Institute of Medicine (IOM) report (2001) on improvements in quality of LTC calls for improved compensation and training of staff in LTC facilities. The report emphasizes staff supervision and training, working conditions, and good management practices as important influences on quality of care to residents.

Registered nurses serve primarily in supervisory roles in LTC, whereas paraprofessionals provide hands on care. Many of the challenges for providing good quality of care in LTC facilities have been associated with problems facing direct care workers (DCWs) (Ejaz et al. 2008). In the sociological literature, low job satisfaction and high turnover of DCWs have been associated with the feminization of poverty (Armstrong et al. 2008). Direct care is provided primarily by underpaid, poorly educated women (Harris-Kojetin et al. 2004). Personal stressors experienced by workers, along with job-related stressors and lack of social support, are among the primary factors accounting for low job satisfaction in this group (Ejaz et al. 2008).

Nevertheless, there have been some noteworthy advances in workforce development within LTC, attributable to the increased professionalization of nursing. Nurses have assumed key leadership roles in developing research and training programs relevant to LTC. Indeed, much of the research on specific interventions to enhance caring and to reduce patient suffering has appeared in the nursing literature (Watson 2005). In terms of management of patients in LTC, nursing professionals have been charged with individualized care plans that address both physical and social needs. Care plans are designed to maximize patient functioning through therapeutic programs (Kane 2005).

Processes Linking Quality of Care and Quality-of-Life

In Table 36.1 we provide a concept map that serves as a guide to understanding alternative theoretical formulations about social processes linking quality of care and resident quality-of-life in LTC. It is useful to recognize that this work spans disciplinary boundaries. While our major interest is in sociological orientations, we recognize that theoretical models used in the field of LTC often draw on traditions of other disciplines, including medicine, psychology, anthropology, and nursing. Different orientations are illustrated by the divergent terms used for labeling care-receivers. They are alternatively referred to as the patient (medical model), client (social work/psychology), resident (social models), or consumer (business and advocacy models). The assisted living movement

assigns the label of resident as a defining aspect of their form of care. In our recent work we identify the older care recipient as a "care-getter" emphasizing the role of agency in marshaling support in late life (Kahana et al. 2009).

Our discussion of environmental and social processes that influence quality of care in LTC and the resulting impact of residents' quality-of-life follow our concept map. In Table 36.1 we present six broad theoretical models which have shaped our understanding of social processes in delivery of LTC in the United States. The six models include: (1) Medical Model, (2) Institutional Analysis Model, (3) Ecological Model, (4) Ethnographic Tradition (5) Political Economy Model, and (6) Advocacy Model. These are broad models reflecting distinctions in theory, methods, and/or disciplinary orientation. In some cases, related conceptualizations are noted within the broader model. We also briefly note implications of each model for practice, policy, program development, or improvement of care. We recognize that there is some overlap among models, and that some program initiatives such as culture change may address quality of care issues identified in several models. The references in our concept map identify each tradition through some of the leading proponents or foundational scholars who are associated with conceptualizing the model. Influential theorists, whose work paved the way for different models, outside of aging, medical sociology, or LTC are noted in the text describing each model. We also reference contributions to research and program initiatives in the text rather than the concept map.

The Medical Model

The medical model is the most prevalent paradigm in the delivery of LTC. The nursing home industry has modeled care delivery to patients on the acute care medical model. Indeed, many nursing home residents are transferred to LTC after hospitalization (Kane 2005). Although the medical model of nursing home care mimics many aspects of hospital care, it is noteworthy that physicians are largely absent in LTC facilities (Katz and Karuza 2005). Nurses who are linked to the very identity of the nursing home are also in short supply and are largely responsible for administrative and supervisory functions. Nursing assistants represent the key direct caretakers in LTC facilities (Ejaz et al. 2008).

Parsons' formulations regarding the sick role represent a sociological foundation for the medical model (Parsons 1951). These propositions about the sick individual's obligation to assume a "patient" identity and to seek competent professional care also have implications for responsibilities of care settings to offer good care. The medical model in general, and Parsons' sick role model in particular (1975), have been primarily associated with acute illness and situations where a cure is possible. This model has been critiqued as having only partial applicability to chronic illness and to LTC (Haug and Lavin 1983). In considering assumptions about older patients in the medical model, it is also possible to draw linkages to disengagement theory (Cumming and Henry 1961). The expected withdrawal of elderly persons from society proposed by this theory is consistent with limited interest in patients' social needs by caretakers espousing the medical model.

Sociological analyses linking quality of care and quality-of-life in LTC seldom explicitly discuss the medical model. Yet, this model is implicitly criticized for neglecting the social needs of elderly patients (Cockerham and Scambler 2010). Based on the medical model, the goals of high-quality care in nursing homes include efficient physical care of patients and avoidance of accidents and of iatrogenic illnesses. To guarantee patients' safety, regulations must be carefully followed by staff and compliance by patients is also required. Any efforts to attend to the psychosocial needs of residents represent superficial enhancements to the basic bed and body work characterizing the culture of patient care (Henderson 1995). The emphasis of the medical model on safety often deters staff from respecting resident's desires or preferences and offers few opportunities for self-directed activities (Baltes et al. 1980).

An elaborate system of regulation has evolved to ensure uniform delivery of care and to guard against medical mistakes. This regulatory system is based on mandatory assessments of residents' physical condition and functional abilities, such as the minimum data set (MDS) (Hawes et al. 1999). The resultant "report cards" note each facility's adherence to expected standards. This information may be utilized by prospective patients and their families in choosing a nursing home. By 2005, in order to overcome adverse medical events in nursing homes, interventions were developed to reduce infections, pressure sores, and incontinence (Mody et al. 2005). However, the lack of attention to social needs of patients and to the maintenance of personhood that inheres in the medical model limits the impact of programs to improve the quality of patient life (Kahana et al. 1999).

Institutional Analysis Model

Total Institution

Sociological understandings of LTC have a strong theoretical anchor in the incisive analyses of Erving Goffman (1961) and his exposition of the total institution. Goffman's original work on asylums outlined a framework, based on mental hospitals, that has provided a prototype for characterizing residential care in nursing homes. Asylums were described by Goffman as highly restrictive and even as punitive social milieus. The impact of totalistic environments on residents is described by Goffman as including stripping, mortification of self, and de-individuation. The negative impact of institutionalization in such facilities was further detailed by Sommer and Osmond (1961) who noted processes of de-individuation, disculturation, psychological damage, estrangement, isolation, and stimulus deprivation.

Such total institutions inflicted assaults on the self, based on congregate, segregate, and institutionally controlled features of the environment (Kleemeier 1961). Nursing homes, where physically frail and cognitively impaired elders are cared for today, possess many of the environmental features of the total institution. Furthermore, nursing home residents typically exhibit even greater vulnerability than the mentally ill, as many suffer from both physical frailty and dementia (Kane 2001).

Concerns about social processes in nursing home care were explored by early gerontological researchers (Townsend 1962; Bennett 1963; Kleemeier 1963). Research by Coe (1965) found that commercial facilities exhibited more totalistic features than nonprofit ones. Furthermore, higher institutional totality was related to withdrawal and depersonalization by residents. Gerontologists called for humane treatment of older people in institutions through reducing totalistic features that create barriers between residents and the outside world (Kahana 1973; Vladek 1980).

Dependency Inducing Environments

During the 1970s, social psychologists became intrigued by the mechanisms contributing to individuals' sense of control and dependency (Langer 1975).This orientation was consistent with views of Seligman (1975), based on studies of younger persons, suggesting that environments can create learned helplessness. The mechanisms by which care processes foster dependency among aged residents of LTC were identified by Baltes et al. (1980). They found that independent behavior of residents was ignored by nursing home staff, while dependent behavior was supported (Baltes et al. 1980). Successful interventions were designed by Langer and Rodin (1976) to enhance personal control of residents through provision of meaningful choices and responsibility.

A desire to restore control and self-determination (Ryan and Deci 2000) to nursing home residents became the conceptual foundations of the culture change movement (Thomas 1999). We will return to a more detailed discussion of this important movement that has become a foundation for nursing home reform. Conceptualizations of control and helplessness in LTC have also been linked to broader ecological issues of person–environment transactions (Kahana et al. 1989). These issues are discussed next.

Ecological Model

There is a rich theoretical tradition applicable to the study of LTC environments that relates to person and environment transactions in the context of aging. Gerontologists interested in the physical and social environments have developed creative frameworks, guided by the intellectual leadership of Powell Lawton. These diverse ideas were first published in *Aging and the Environment, Theoretical Approaches* (Lawton et al. 1982). This book presents three conceptual frameworks that are of particular interest for understanding social processes in LTC. These include: Kermit Schooler's stress theoretical perspective, Powell Lawton's environmental press and adaptation model, and Eva Kahana's congruence model of person–environment interaction. We will briefly review each of these models as they relate to quality of care and its impact on quality-of-life in LTC settings.

Stress Model

Schooler's (1982) stress theoretical model provides a framework for understanding threats and hazards posed by factors such as forced relocation, lack of privacy, and crowding associated with life in LTC facilities. The stress model, earlier articulated by Lazarus (1966) has been further developed in the field of sociology by Pearlin (1989). It associates adverse social and environmental characteristics with subsequent loss of morale and other poor quality-of-life outcomes. The model also recognizes the potential benefits of effective coping strategies and of social supports in ameliorating adverse effects of stress on quality-of-life. Stress models have guided both subsequent research and interventions in LTC settings. Instrumental coping strategies were found to be useful for promoting well-being of institutionalized aged (Kahana et al. 1987). The effectiveness of social supports offered by family involvement has also been noted (Lieberman and Tobin 1983). However, LTC institutions have not always welcomed family participation (Kahana 2007). Important work in evaluating residential facilities using stress-based theoretical frameworks was conducted by Moos and Lemke (1996).

Environmental Press/Adaptation Model

Lawton's (1982) model is concerned with environmental demands that are placed on the older individual in relation to personal competence to handle those demands. When environmental demands exceed personal capacities, adverse consequences to quality-of-life occur. Lawton's concept of environmental docility proposes that the frailest elderly residents are at greatest risk for adverse quality-of-life outcomes in institutions. Lawton also recognized the dual roles of the individual as both a responder and an initiator in interacting with the environment (Lawton and Nahemow 1973).

Lawton's work has led to improvements in architectural design of LTC settings. These designs help overcome environmental docility of frail and cognitively impaired older adults by focusing on negotiability, personalization, orientation, and safety (Calkins 2003). Lawton's recognition of the need for enhancing personal competence is consistent with therapeutic programs that aim to enhance cognitive functioning (Lichtenberg 1990).

Congruence Model of Person–Environment Interaction

Kahana's (1982) congruence model of person environment interaction has its roots in Murray's (1938) "need-press" formulation regarding human behavior. The model recognizes individual differences in both needs and preferences of older adults and the consequent importance of matching LTC environments to the unique needs of individual residents. It is hypothesized that in institutional settings, congruence is particularly important along segregate, congregate, and institutional control dimensions. These dimensions are based on Goffman's (1961) and Kleemeier's (1961) concepts of institutional totality. Additional dimensions include stimulation and tolerance of affective expression. Poor quality of care, according to the congruence model, would be demonstrated in LTC institutions that disregard resident preferences. Lack of person environment fit is expected to result in diminished resident morale. Research by Kahana et al. (1980) confirmed the contribution of selected aspects of congruence to morale among residents in homes for the aged. Recent approaches of the culture change movement that tailor schedules and programming to individual preferences of residents are consistent with the congruence model (Thomas 1999).

All three of the ecological models reviewed share in common an interest in both physical and social environmental features and in quantitative orientations to assessing resident psychological well-being. Each of these models has been influential in offering conceptual scaffolding for later research and intervention.

Ethnographic Model

Ethnographic models may be classified as methodological rather than conceptual orientations. Yet, the focus of ethnographers on micro-processes involved in the social construction of everyday life offers unique perspectives and raises conceptual issues that cannot be readily subsumed by other models. It is also notable that books representing ethnographic studies of nursing homes are among the most widely disseminated works on LTC by sociologists. This tradition originates in anthropological research focusing on the lived experience of older persons (Clark and Anderson 1967). The ethnographic tradition is based on participant observations and on detailed unstructured interviews with informants that allow for understanding quality of care and quality-of-life as defined by the lived experience of key participants: residents and staff. The complex realities of daily life appreciated from the perspectives of patients, and nursing assistants (as well as visiting family members and volunteers), allow the ethnographer to describe the inter-subjective reality that is referred to as culture (Henderson and Vesperi 1995). By offering multiple perspectives, ethnographers gain a more textured understanding that allows for an appreciation of both patients' and staff members' predicaments.

A pioneering, ethnographic study of nursing home life is offered in Jules Henry's classic (1963) book, *Culture against Man*. Henry eloquently describes the valiant efforts of nursing home residents to defend and sustain their core identity in the face of indignities suffered. This theme of the nursing home residents' struggle against assaults on their sense of self is consistent with the symbolic

interactionist framework in sociology (Mead 1934). It allows for use of the interpretive tradition that considers nursing home residents as social actors who live in social worlds that are characterized by different "front stage" and "back stage" interaction patterns (Goffman 1961).

The perspectives of ethnographers reflect a diversity of connections to the nursing homes they describe and study. Savishinsky (1991) initiated his study as a volunteer helping with a pet program that was aimed to humanize nursing home care. Diamond (1992) made his incisive observations about disempowered staff while working as a nursing assistant in a LTC facility. This tradition is also exemplified in *Limbo*, the autobiography of Carolbeth Laird (1979), an anthropologist, who writes about her first-hand experiences in living in a nursing home. Similarly Kahana (2007) articulated perspectives of a daughter spending time daily with her mother who was living in a nursing home.

One of the most important works of modern nursing home ethnography is Gubrium's (1975), *Living and Dying in Murray Manor*. This book reflects orientations of the new ethnography that considers residents' narratives not only as the reflections of the social realities of nursing home life, but views residents as active participants who construct the realities of their worlds (Gubrium and Holstein 1997). This orientation foreshadows later developments in participatory action research with nursing home residents (Dannefer et al. 2008). Such research views narratives as a valuable tool for bringing about policy changes that may improve quality of care and quality-of-life in nursing homes and other health care settings.

Political Economy: Structures of Domination

LTC has been viewed as a confluence of failures; on the part of the older person (e.g., being frail rather than vibrant), family members (e.g., placing their loved one in a nursing home rather than caring for them at home), and on the part of LTC staff (e.g., working for low wages) (Armstrong et al. 2008). Sociologists have attributed these failures to larger forces operating in society (i.e., historical, economic, political, and social). Using this lens, political economists have sought to understand and identify sources of oppression, conflict, and power imbalance in LTC settings (Estes 1979). Work by Close and Estes (1994), Diamond (1992), and Harrington (1991) exemplify research on LTC in a political economy tradition and call our attention to how structures of domination, based on class, gender, ethnicity, and race permeate the delivery and receipt of LTC. These influences are generally discussed by proponents of the political economy model, in terms of the commodification of care and workforce issues.

The concept of the commodification of care is rooted in Marxist theory (Marx 1904) and relates to historical shifts from caring at home for the old to placement in an institution. As a result, the nature of caring changed, as it was no longer a part of daily life where the ebb and flow of living and dying was connected to home and hearth. This shift had a negative impact on both the delivery and receipt of care in LTC facilities. In care work, social and affective aspects (e.g., nurturing, compassion, camaraderie) are discouraged and replaced by the dispensing of medical work units that can be timed, measured, and observed (Estes 1979). Staff may become helpless cogs in a hierarchical and inflexible health care machine. Diamond uses the example of staff having to give cold showers to residents, when hot water is unavailable, during their specified bath time (Diamond 1992).

With the commodification of care, corporate LTC institutions strive for efficiency and cost-containment strategies, at the expense of staff, and ultimately of residents (Close and Estes 1994). The political economy model has informed studies linking staff exploitation in LTC facilities to abuse and neglect of patients (Pillemer 1991) and to residents' poor quality-of-life (IOM 2003). The effectiveness of regulatory mechanism for improving quality of care has not been clearly demonstrated (IOM 2003). There has been particular concern about the success of LTC in meeting needs and preferences of increasingly diverse populations being served (Quadagno 1999). Proponents of the

political economy orientation generally serve as social critics; however, specific suggestions for change that could be implemented in the current political framework of care delivery are not generally offered. Staff empowerment may be the most concrete direction for social action within this framework. This may be accomplished through labor organizing and collective bargaining approaches (Dodson and Zincavage 2007). The improvements for working conditions for staff, in turn, would be expected to translate into better quality-of-life for residents.

Advocacy Model

There has been growing interest in considering the role of consumers and their advocates in influencing quality of care and quality-of-life in LTC facilities. This orientation has intellectual roots in sociological work on consumerism in medicine, articulated in the work of Haug and Lavin (1983). It also shares common ground with the broader consumer movement (Nader 1976), leading to changes in social policy that resulted in the Patient Self Determination Act (PSA 1990). Another relevant social movement, laying the groundwork for patient advocacy is presented by disability activism (DeJong 1984), that has culminated in the Americans with Disabilities Act (ADA 1990). A related paradigm, focused on professional advocacy, is posed by the ideology of empowerment originally articulated in the social work literature (Abramson 1985). Finally, families also serve as natural advocates of the institutionalized aged (Richard 1986). We briefly review implications of these orientations to advocacy that reflect human agency within institutional structure for linking quality of care and quality-of-life in LTC facilities.

The health care consumerism paradigm (Haug and Lavin 1983) calls for increased power, wrested by patients from representatives of the health care system. Based on an approach of "doubt and caution rather than faith and trust" patients are urged to resist coercive components of care delivery through lack of compliance with medical regimens and alternative focus on self-care (Haug and Lavin 1983:10). Independence and self-confidence, resulting from consumerism, may benefit both the health status and self-concept of the patient. It is important to note, however, that many elderly persons receiving LTC may lack the personal and social resources needed for engaging in self-care or in active consumerism.

Family may serve as advocates for LTC residents by challenging authority when they observe poor quality of care by lodging complaints (Kahana 2007). When family advocates find staff to be unreceptive, they may enlist formal advocates (e.g., ombudsmen) or they may file lawsuits to improve quality-of-life of a loved one. However, advocacy may be limited by fear of retaliation against the family member living in a LTC facility (Nelson 2000). It is useful to note that patient and family advocacy need not be adversarial and can also succeed through building alliances with staff.

Community presence can also serve useful advocacy functions in LTC (Wiener 2003). The nursing home reform act of OBRA (1987) established the right of residents and family members to organize resident councils in LTC. Consumer advocacy groups have been successful in generating state-level policy changes to benefit LTC residents, but often lack the organizational infrastructure to maintain long-term operations (Phillips et al. 2008). The nursing home ombudsmen program created by the Older Americans Act represents the most successful public initiative to improve the quality of care and quality-of-life in nursing homes (Kahana 1994).

In addition to the role of advocacy in improving quality of care in existing LTC facilities, more dramatic paradigm changes through advocacy have been recently proposed by gerontologists (Haber 2009). These bold ideas recognize the potential of new cohorts of older adults to advocate for social policies that could minimize placement in LTC facilities following the models of disability activism. Elders could thus purchase alternative community-based and self-directed housing

services (Kane 2009). Some critiques of "agency" based approaches attribute self-serving motives to proponents of advocacy (King and Calasanti 2009). Nevertheless, social movements that wrest power from existing hierarchies of LTC are among the major practical solutions toward the improvement of quality-of-care for frail elders. The Pioneer Network represents a promising social movement working toward a humane, meaningful, and life-affirming orientation to LTC (Pioneer Network 2008).

Synergy Among Models and Directions for Change: From Tradition to Innovation

In the final section of the paper we challenge ourselves to consider implications of the alternative models we presented for understanding likely future directions linking quality of care and quality-of-life in nursing homes. In so doing, we consider divergence as well as common ground across sociological and other disciplinary orientations that could lead to improvement in quality of LTC. We also explore linkages between tradition and innovation.

A perusal of the six models of care that we presented reveals some noteworthy similarities as well as differences. Three models (the medical model, the ecological model, and the ethnographic model) reflect primarily micro level phenomena. Focus is on individual actors and interactions between individual patients and staff. The institutional analysis model is a mezzo level model reflecting Goffman's interests in the reality of the total institution. The advocacy model incorporates both micro and macro components. On the level of individual consumerism and family empowerment it is a micro model. However, its focus on community activism calls for legislative and society-level change. Finally, the political economy model is a macro level model that represents a critique of societal forces beyond the nursing home.

The diverse models presented also reflect different disciplinary orientations. They underscore that it is useful to have multiple disciplines engaged with issues linking quality of care and quality-of-life with the goal of improving LTC. This synergy is well illustrated as we consider the institutional analysis model. We consider Goffman, a sociologist, to be the founder of this approach, but acknowledge that his research was based on anthropological traditions of ethnographic analysis. Goffman's (1961) work was further elaborated and brought into mainstream gerontology by Kleemeier, a psychologist specializing in aging (1963). Institutional control components of the total institution became influential concepts in the field of social psychology in the 1970s. New work on personal and environmental control was published in prestigious social psychology journals by Langer (1975). Concepts of learned helplessness (Seligman 1975) and self-determination theory (Ryan and Deci 2000) bolstered initiatives based on these concepts to improve quality-of-life of nursing home residents. Some of these initiatives were conducted within the framework of an experimental paradigm by Langer and Rodin (1976). The understanding of underlying social processes was further advanced by the work of German psychologist Margaret Baltes and colleagues. (1980). They identified behavioral patterns by staff that reinforced resident dependency in nursing homes settings and called for both environmental and behavioral interventions to break maladaptive patterns.

Subsequently, in the 1980s, there were fledgling social movements developing to address, in a more holistic way, needs for fundamental change in the culture of nursing home care. Work of the "nursing home pioneers" a group of utopian reformers, converged with the vision of geriatrician and family physician William Thomas (1999), who designed the "Eden Alternative" for nursing care reform and culture change. There is a clear connection between the holistic approaches of culture change and Goffman's brilliant critique of organizations that stripped away the very humanity of their inmates. The attention by these reformers to counteract indignities suffered by patients in every

mundane aspect of their daily lives echoes observations of ethnographers about the importance of everyday interactions that define the social world of the individual who lives in an institution (Gubrium 1975).

The new movement of culture change thus becomes part of continuing efforts by gerontologists to offer policies and practices that reduce totalistic features of institutions. The nursing home reform movement also follows notable early work conducted by Coons and Reichel (1988) to create homelike residences for elderly patients in mental hospitals. Ecological principles have also been advocated and implemented in the work of proponents of the Eden Alternative (Bergman-Evans 2004).

The environmental side of the culture change movement is an important area for future innovation. Innovative building design may be allied with changes in federally mandated life safety code regulations. It is recognized that striving for safety must be counterbalanced with consideration of resident preferences for homelike and independence supporting environments (Bowman 2008). Consequently, there are continuing efforts to create "home" in the nursing home. Thus, we see promising government and industry alliances in promoting culture change. However, grass-roots efforts by recipients of care and their families are also needed for enhancing options in LTC. One promising direction can be seen in the growing NORC movement. NORCs are rental or condominium housing sites that were not specifically planned and designed for older adults, but over time, as residents age in place acquire features of retirement communities (Hunt and Gunter-Hunt 1985:4). Services to support care needs that typically arise in such settings tend to be resident-generated. Advocates of this approach state that participation in the development of services provides an opportunity for older residents to build social capital, allowing elders to become empowered "community citizens" rather than passive and dependent "clients" (Bookman 2008). As we consider other avenues for grass-roots initiatives by older adults, the world of technology also offers creative alternatives to traditional LTC options. For example, frail elders are increasingly open to installing intelligent home monitoring systems or "smart home" technology in their homes as a means maintaining independent living arrangements (Mahmood et al. 2008).

Other proponents of nursing home reform, based on culture change, call for realigning structures of nursing homes so as to improve the life experience of both staff and residents (Fagan et al. 1997). These staff empowerment initiatives that are aimed at removing hierarchical features of staff organization are consistent with aspects of the political economy model. The reform movement that created the Pioneer Network in Long Term Care was noted as an example of community action in our discussion of the Advocacy Model.

The culture change movement calls for offering nursing home environments that reflect life-supporting habitats, incorporating animals and plants into a more livable environment (Thomas 1999). This innovative approach goes beyond orientations of the ecological model and is uniquely attributable to the culture change movement. While this focus was not listed in our concept map, we acknowledge its importance through inclusion in our structural model where we have added "artifacts" and "amenities" as key components of quality of care. Culture change also offers greater resident participation and control (Langer 1975). Furthermore, by involving family members and other community representatives, they reduce the isolation of residents from the outside world (Goffman 1961). Approaches to culture change in nursing homes reflect a humanistic orientation and aim to maintain the personhood and identity of frail residents (Kahana 1973). Their holistic efforts of redesign hold many promising insights. The evaluation of the success of such efforts, however, is limited, and is largely based on qualitative and ethnographic studies conducted in not-for-profit facilities (Rahman and Schnelle 2008).

As the culture change movement has gained momentum in the United States, the federal government is now facilitating the implementation of culture change (CMS 2008). This is part of broader initiatives exemplified in efforts to restructure Medicare in order to improve chronic care (Wolff and Boult 2005). It is noteworthy that sociologists are playing an important role in conducting research based on the culture change movement. They have enriched the movement by introducing the

concept of participatory action research, which enhances resident control and self-determination (Dannefer et al. 2008).

Consideration of totalistic features of LTC had long evoked indignation and calls for reform by gerontologists. These efforts primarily aim to reduce institutional control features. Congregate and segregate features of institutional care are more entrenched and are more difficult to change. Consequently, these features are likely to continue to characterize institutional life even when good quality of care is provided. It is for this reason that beyond efforts to counteract institutional totality through culture change, activists call for social movements that can lead to deinstitutionalization of LTC residents (Kane 2009).

Promising initiatives are also focused on changing the managerial culture of nursing homes and point to the value of labor–management partnerships in facilitating person-centered care (Leutz et al. 2009). Our focus on the culture change movement has served to illustrate the synergies that often go unrecognized, between tradition and innovation. Those working at present, within the boundaries of any given conceptual orientation, may be too close to their own work; and may overlook linkages to the past and alternative orientations that reflect competing ideologies.

It is useful to consider recent developments in program innovation as an alternative pathway for analyzing the intellectual origins of creative new approaches. Thus, recent approaches to translational research advocating the rapid adoption of innovative programs deserve attention (Bradley et al. 2004). Indeed, federal agencies have shown a growing interest in supporting translational initiatives to improve quality in LTC. Examples of such initiatives include the Wellspring model for improving the quality of clinical care in nursing homes (Kehoe and Heesch 2003). This is accomplished by multidisciplinary care resource teams that include nursing assistants who are empowered to develop and carry out interventions (Bradley et al. 2004). Other successful innovations include communication interventions that involve cooperation between nursing home staff and family members, yielding positive outcomes for both family and staff (Pillemer et al. 2003).

There are many useful approaches that we could not include in our discussion, as we focused primarily on sociological traditions. Readers could create concept maps that unpack contributions in the field of organizational behavior and innovation as they relate to LTC (Anderson et al. 2003). Similarly, there are many promising developments in evidence-based interventions that can also lead to enhancing the lives of LTC residents (Cummings and Kropf 2009). Promising insights could also be gained by focusing on diversity as a lens for understanding staff and resident experiences of life in LTC (Ball et al. 2009). There is a growing literature on palliative and end-of-life care, anchored largely in the nursing literature that offers lessons about beneficence and caring (Watson 2005).

Scholarly work that promotes the understanding of social factors that can humanize LTC has exciting traditions in sociology. Yet, there is much room for innovation in this field that can make life better for each of us who will eventually cross the threshold of a LTC facility.

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Chapter 37
Caregiving and the Life Course: Connecting the Personal and the Public

Eliza K. Pavalko

At some point in our adult lives, most of us will face challenges of caregiving. For many, the issue will come up several times, either when we need to be cared for by others or when a parent, spouse, sibling or adult child becomes ill or disabled and needs care. National studies estimate that currently 44 million, or 21% of the adult population, representing 21% of U.S. households, are providing unpaid care to an ill or disabled adult (AARP 2005). The need for informal, unpaid care work has grown in recent decades and is expected to continue to grow with an aging population. For example, between 1987 and 1998 the population 65 and older increased from approximately 28 to 34 million. Corresponding with this increase, the number of individuals providing care rose from 7.8 to 22% of adults (Wagner 1997). The need for care has been tempered by declining rates of disability, but there is some evidence that disability rates may be on the upswing because of increasing rates of obesity (Lakdawalla et al. 2004). Informal (and unpaid) care is also a critical component of the U.S. health care system, particularly long-term care. Among those needing long-term care, 40% rely solely on informal, unpaid care and 25% use a combination of informal and formal care (Uhlenberg and Cheuk 2008).

Caregiving is an ideal illustration of C. Wright Mills's (1959) distinction between personal troubles and public issues, and the importance of using the sociological imagination to connect the two. Caregiving is first and foremost a personal issue that challenges individuals and families as they balance providing care with other work and family roles, and much of the research on caregiving has necessarily focused on providing information that both documents and informs these personal challenges. Understanding who provides care, the effects of care work on the health and well-being of caregivers, and developing strategies for reducing these stresses are critical for understanding care work. Bringing a sociological imagination to caregiving issues, however, seeks to understand and locate the personal struggles and rewards of caregiving within the broader context of the organization and financing of health care, the organization of work, and the role of gender, race and class in framing both public issues and personal lives. Linking the personal and public, biography and history sheds light on why concerns about providing care are becoming more acute. Individual illness and disability is not a new phenomenon, nor is reliance on family members to provide that care. It is the larger institutional and historical context, including demographic changes in family size, social changes in patterns of labor force participation, and the organization of work and health care systems that increasingly make caregiving a public issue as well as personal trouble.

Social scientists have been at the forefront of efforts to document, understand, and inform caregiving issues. In this chapter, I draw on several decades of social science research on care work to examine the intersection of caregiving as a personal and public issue, and to identify areas where

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more research is needed. I use the terms "caregiving" and "care work" (Harrington Meyer 2000) interchangeably to convey the complex nature of informal care work as potentially rewarding and something people want to provide, but also work, albeit unpaid. A major strength of caregiving research is that it has been informed by interdisciplinary and cross-disciplinary research, and that caregiving concerns span the entire life course, from concerns about caring for young children who may or may not have severe health problems to caring for ill or disabled parents. This breadth provides not only an opportunity to identify the unique challenges and opportunities of different types of care work, but also the potential to inform broader questions about family and gender relationships across the life course.

I organize research on care work into three broad areas. *First*, much research on caregiving documents the extent of the problem, including identifying how many people are providing informal care, rates and changes in disability, and the extent to which informal care is being used by persons who are ill or disabled (AARP 2005; Manton and Gu 2001). I begin by examining in more detail why care work is a growing public issue in the United States, tracing the roots of the problem not only to the changing demographics of an aging society, but also to changes in family structure, patterns of paid work, structural lag in the organization of work, and changes in the health care system. I argue that the intersection of these demographic and social trends not only heighten the personal challenges of care work but also create a public issue – a "caregiving squeeze" – where we have more persons who need care but fewer with time to provide that care.

A *second* somewhat smaller body of research examines individual and family decisions about who provides care. Theories of gender, family dynamics and rational choice inform and are informed by the unique complexities of caregiving. I thus review some of the main findings and theoretical perspectives relevant to questions about who provides care.

Third, the largest body of research on caregiving focuses on the short- and long-term consequences of care work for the caregiver. Much of our understanding of the personal consequences of caregiving has been shaped by stress theory, but role theory and political-economy and gender perspectives have also been important for our understanding of the consequences of caring. In the remaining sections, I review each of these three domains of research on caregiving in more detail and discuss what different theoretical perspectives add to our understanding of who provides care and the short- and long-term consequences of doing so. I conclude the chapters by proposing several directions for future research on caregiving that connect the public and personal issues of care work.

The Caregiving Squeeze: Intersecting Demographic and Social Trends

Changing demographics, rates of disability, patterns of work, and health care all influence the number of people needing care and the number of persons providing care. A recent study by the National Alliance for Caregiving (NAC) and the American Association of Retired Persons (AARP) estimates that 21% of the U.S. population, or 44.4 million people, provide unpaid help to an adult on at least one activity of daily living (help getting in or out of bed or a chair, getting dressed, getting to and from the toilet, bathing, eating, etc.) or one instrumental activity of daily living (help with finances, grocery shopping, medications, housework, etc.) (AARP 2005). This study estimates that 61% of caregivers are women; the average caregiver age is 46, and 37% report a child under 18 living in the household. Most caregivers are employed, with 48% employed full time and 11% employed part-time. More than half (52%) of the caregivers surveyed reported spending 9 or more hours per week providing care (AARP 2005).

The NAC survey provides one of the best recent profiles of caregivers in the United States, but we know less about trends in caregiving and informal care over time. Recent trends are important,

however, as they are our best indicator of future directions of caregiving. The National Long Term Care Surveys document trends in disability among Medicare beneficiaries 65 and older and provide information on types of care used by the disabled elderly and how patterns of care have changed since the mid-1980s (Spillman and Black 2005; Spillman and Pezzin 2000). One consistent finding is that the disabled elderly rely heavily on informal family care. Through the 1980s and 1990s, more than 90% of long-term care users relied on at least some informal care, either solely or in combination with paid formal care. However, from 1984 to 1999 the percent of disabled elderly relying on any informal care dropped from 95% in 1984 to 91.5% in 1999. At the same time, and particularly from 1994 to 1999, the use of formal care also declined, resulting in an increase in the percent of care recipients relying entirely on informal care. By 1999, 66% of care recipients relied entirely on informal care (Spillman and Black 2005).

Trends in care receipt among the disabled elderly and in care work are complex because they are influenced by demographic and social trends that shape both the need for informal care and the supply of family members who can provide that care. Despite this complexity, one thing is clear. Even with some encouraging trends suggesting a decline in disability, as we look forward to future levels of demand for and supply of care, the intersection of an aging population, changes in family size, our health care system and patterns of work suggest we will be increasingly facing a "caregiving squeeze" – an increasing need for informal care at the same time that there is a declining supply of persons who can provide that care. In order to understand that squeeze, and ultimately to minimize its impact, we first review changes influencing the need for care and then those most likely to affect the supply of available caregivers.

Changes in the Need for Care

A major, and often cited, factor fueling a growing need for care is the aging of the population, driven largely by the aging of the baby boom cohort. In 1995, 33.5 million people, or 12.8% of the U.S. population was 65 and older. By 2050, the Census Bureau estimates that 79 million Americans, or one-fifth of the population, will be 65 or older (Day 1996). The largest increases in the 65 and older group will begin in 2010 and continue to 2030. Expected growth in the population 85 and older is especially dramatic both because of the aging of the population and increases in life expectancy. In 1995, 3.6 million Americans were 85 or older with an expected increase to 18.2 million by 2050 (Day 1996). The growth in the oldest old suggests an increase in need for care since it is this segment of the population most in need of acute and long-term care for illness and disability. Among those aged 65–74 only about 7% receive care for an ADL or IADL disability, compared to 63% of those 90 or older who need care (Uhlenberg and Cheuk 2008).

While trends in the aging of the population are clear, the extent to which population aging will translate into increased need for care also depends on trends in disability among the elderly. Recent trends in disability have suggested some decline in rates of disability among the elderly (Freedman et al. 2004). In general, in the mid to late 1990s, the percent of persons 70 and older who had difficulty with daily activities such as bathing, eating, or walking across a room declined 1–2.5% per year (Freedman et al. 2004). Any decline in disability rates among the elderly will offset some of the demand for care. There are a number of reasons to be optimistic that reductions in disability and need for care will continue, particularly as levels of education rise among more recent cohorts of elderly and availability and use of assistive technology expands (Freedman et al. 2004; Uhlenberg and Cheuk 2008). However, other trends suggest less optimism in disability projections because of increases in rates of obesity (Reynolds et al. 2005). Lakdawalla et al. (2004) report, for example, that during the 1980s and 1990s when disability was declining among the elderly, it was increasing for adults under age 60 and these are also the cohorts that have experienced large increases in

obesity. These findings suggest that we cannot assume that recent declines in disability among elderly Americans will continue for future cohorts.

In addition to population aging and disability, the need for care is also shaped by the structure and financing of health care. Changes in the availability and cost of formal care alter reliance on informal care. Length of hospital stays have declined dramatically, from an average of 7.5 days in 1980 to 4.7 days in 2006 (National Center for Health Statistics 2009). Declines in hospital and other institutional care increase reliance on informal caregivers for skilled nursing tasks, such as changing IVs and catheters (Glazer 1990). Likewise, increases in the number of persons who are uninsured or underinsured, restrictions on covered services, and increases in out of pocket expenses are all likely to increase the reliance on unpaid and informal care. For example, Spillman and Black (2005) find a significant decline in use of formal care and an increase in use of informal care from 1994 to 1999, a change they attribute in part to the changes in Medicare home health payments after the Balanced Budget Act of 1997. As health care reform is implemented, increased access to care may reduce some pressure on need for informal care. However, the countervailing pressure to reduce costs of health care are likely to offset these gains as we increasingly look to informal care to provide care for those who are ill or disabled.

Changes in the Supply of Informal Care

The caregiving squeeze is not only created by trends in the need for care, but also changes that reduce the available supply of people to provide that care. The decline in family size is a major factor influencing the supply of informal caregivers. Compared to earlier cohorts, the baby boom cohort significantly reduced their average number of children. Unlike their parents' generation which had a fertility rate of over 3.0, baby boom cohorts had a total fertility rate of 2.0 (National Center for Health Statistics 2009). As noted by Uhlenberg and Cheuk (2008), "when mothers of the baby boom are in greatest need of caregiving (i.e., when they are over age 80 around 2020), more than a fourth of them will have at least four children. However, 20 years later when baby boomers are over 80, only 10% of them will have four or more children" (p. 27). Smaller families not only reduce the number of available children to provide informal care to elderly adults, but also reduce the number of siblings and other extended kin who might provide care. Uhlenberg and Cheuk argue, however, that the decline in family size, while important, should not be overstated. Much of the decline in family size is due to a drop in large families and the bigger risk to informal care is among older adults who are childless. While there projected an increase in women 80 and older who are childless between 2020 and 2040, the proportion of women 80 and older who are childless is expected to drop between 2000 and 2020. By 2040, the proportions of childless elderly women is thus expected to be similar to levels seen in 2000 (Uhlenberg and Cheuk 2008).

A much more significant challenge to the available supply in informal caregivers is the well documented change in women's labor force participation. Between 1980 and 2000, the proportion of women aged 45–54 in the labor force increased from 60 to 77, and it is expected to remain at roughly that level through 2016 (U.S. Census Bureau 2008). As of 2007, 55% of married couples in the United States were a part of dual-earner households. Increases in dual-earner households shrink the reserve of nonemployed family members who can step in to provide care and increase the pool of men and women who face caregiving decisions when they are employed. The National Alliance/AARP 2004 survey of U.S. caregivers estimates that 59% of caregivers are employed, up from 52% in a similar study conducted in 1997 (National Alliance for Caregiving and American Association of Retired Persons (NAC/AARP) (1997)). At least among earlier cohorts, when employed women were faced with an ill or disabled family member who needed care, they were not less likely to than the nonemployed to provide that care, but doing so did put them at greater risk of

reducing or stopping work (Pavalko and Henderson 2006; Pavalko and Artis 1997). Although we know far less about men's employment and caregiving, a study of care work among married men in Massachusetts found that neither their own employment, nor that of their wives, affected the amount or kind of help they provided to parents, in-laws, adult children or friends (Gerstel and Gallagher 2001).

Confounding the increase in employment among potential caregivers is the limited availability of workplace or government policies that support workers needing flexibility to balance care needs with employment. We will return to this issue below. It remains unknown whether we will see similar choices among more recent cohorts of women and men as gender attitudes and patterns labor force participation change. However, the more consistent labor force attachment among women with young children in recent years suggests that more recent cohorts may be less likely to take on intensive caregiving that would require them to reduce or stop work.

In sum, we have a range of demographic and social trends that suggest we will see an increasing need for informal care in the coming decades at the same time we have a decreasing supply of available caregivers. This caregiving squeeze has implications for the quality and type of care received by those who are ill or disabled. Those who have fewer sources of informal care are more likely to be cared for in institutions and to rely on paid care (Uhlenberg and Cheuk 2008). At the same time, as potential care providers, family members are more likely to face difficult choices about who will provide care and the challenges of balancing employment with care work. The caregiving squeeze is also problematic for employers who will have larger numbers of employees caring for an ill or disabled family member.

Who Cares?

Demographic and social changes in social roles, disability and health care resources suggest a pending caregiving squeeze, but how that squeeze plays out will depend on how individuals, families and communities negotiate who will provide that care. As noted earlier, the majority of long-term care is informal care provided in the community, and the bulk of that care is provided by adult children and spouses (Johnson 2008; Spillman and Pezzin 2000). We also know that in the short-run, employed women are not less likely to provide care (Pavalko and Artis 1997), although if they do provide care they are more likely to stop employment (Pavalko and Henderson 2006). However, to date we know little about whether broader cultural and economic pressures have altered the ability of more recent cohorts of men and women to provide care.

Research investigating who provides care most commonly views the provision of care as a choice made by individuals and families. In line with this assumption, a vast body of research seeks to better understand how men and women make these difficult choices about care. The relationship between the care recipient and care provider is a key factor in these decisions, and for both men and women there appears to be a care hierarchy (Gerstel and Gallagher 2001). Spouses are generally most likely to care for one another, and they tend to continue providing care until they can no longer do so because of their own health problems (Johnson 2008; Stoller and Miklowski 2008). Care for children is also high in men and women's care hierarchy, followed by care for extended kin, and finally care for friends is generally last (Gerstel and Gallagher 2001).

Beyond one's relationship to the care recipient, a *rational choice perspective* theorizes that when a family member needs care, decisions about who will provide that care are made rationally by families as various family members weigh the emotional and financial costs and incentives for providing care (Becker 1991). Economically, families are theorized to weigh the opportunity costs of each potential caregiver and the likely wages they would lose if not caregiving, along with other factors such as geographical proximity to the care recipient. Empirical findings suggest that wage

opportunity considerations are important in how families choose to provide long-term care. For example, in analyses of data from the 2002 wave of the Health and Retirement Study, Johnson (2008) finds that "frail older adults received less unpaid help from their children and more unpaid help from paid sources, both at home and in nursing homes, when all of their offspring could earn relatively high wages in the labor market than when some had relatively poor labor market prospects." Economic considerations may be part of the decision process in the type of support children provide to parents. For example, in one study, children earning high wages were more likely to give parents money but spend less time providing care work (Couch et al. 1999). However, there are alternative noneconomic influences, such as cultural differences across social class that could also account for many of these patterns (Johnson 2008). Finally, we know little about how (or even whether) the larger structural context, such as workplace or community structures that are more supportive of work–family balance, influence care decisions. To the extent that care decisions are based even partially on economic opportunity costs, increases in women's labor force participation and the increasing movement of women into higher paying professional and managerial positions will have widespread implications for those who provide care.

While economic opportunity costs may be part of the decision process, it is clear that a number of other influences also play a role in care decisions. *Gender theories* point to the complex cultural and emotional pressures and rewards for women to provide care, and there is little question that gender plays a central role in the amount and type of care provided. Although the proportion of male caregivers has increased in recent years, women continue to provide the majority of unpaid care. While opportunity costs, and particularly women's lower pay and labor force participation, account for some of the gender disparities in care, it does not account for the consistent finding that gender differences in care remain even as women's labor force participation and occupational status rival that of men. For example, in a large, multigenerational study, Silverstein et al. (2008) find that, when comparing the amount of care provided for mothers within families, daughters continue to provide more care than sons. Notably, these gender differences remain after controlling for each sibling's income, and indeed income itself is not a significant predictor of care in these intra-family comparisons.

An underlying assumption of many choice-based models of caregiving, including those weighing opportunity costs, is that potential caregivers substitute for one another in a zero-sum fashion. Thus, as one family member increases care, others will reduce their share. In this substitution model, as opportunities of women's paid work increase their opportunity costs, men would be expected to increase their involvement in care work. Both in the case of care for children and care for ill or disabled family members, this does not always appear to be the case (Gerstel and Gallagher 2001). An alternative is that, especially within families, men's and women's care work is complimentary, and that women pull men into caregiving rather than being replaced by them (Gerstel and Gallagher 2001). In a study of married couples, Gerstel and Gallagher (2001) find that the strongest factor increasing men's help to in-laws and adult children was a wife who also provided care. In contrast, wives' contributions to family income and overlap in work schedules made little difference in how much care men provided. However, the same study did find a substitution effect between men and their sisters. Men with more sisters spend less time providing parental care, although brothers had no effect. These findings suggest that while wives pull men into parental care, sisters replace care that otherwise would be provided by men.

Network theories also enlighten the complexity of care decisions by examining how the allocation of care within families operates as a series of interrelated decisions made by a network of potential care providers. Care networks may expand and contract over time and different members of the care network may provide different types of support. While network approaches to care work are in their infancy, attention to caregiving networks and efforts to unravel their changes can provide unique insights into why caregiving networks change and how those changes unfold. Early research on care networks confirms that changes in these networks over a 2-year period were more common than not.

Interestingly, change in networks is more common if that network includes male caregivers, particularly if that network included both male and female caregivers (Davey and Szinovacz 2008). Attention to network changes also provides potential insights into broader questions about how gender, job opportunity and other factors influence which network members provide care and the factors prompting changes in the caregiving network.

Understanding who provides care and why they do so, or why they do not, is essential for projecting how changes in work and family life may impact the availability of caregivers for future generations. At the same time the complexity of care decisions offers ample opportunities for research on caregiving to inform fundamental questions about family dynamics, gender, and economic choice.

Consequences of Caring

The consequences of caregiving have been widely studied and consistently documented. There is little doubt that caregiving affects the health and well-being of the caregiver. Studies from a wide range of samples and a numerous levels and types of care have found that caregivers have higher rates of depression and psychological distress than noncaregivers (Schulz et al. 1990, 1995). However, there are also notable benefits to caring, such as opportunities for personal growth and enhanced relationships with others (Abel 1986; Chesley and Moen 2006; Tarlow et al. 2004). The effect of caregiving on physical health is more varied, but studies have found that caregivers have more disease symptoms, physical limitations, chronic conditions, or poorer immune function (Kiecolt-Glaser et al. 1991; Pavalko and Woodbury 2000; Seltzer et al. 2009). There is growing evidence that, at least for women, there are significant short- and long-term economic consequences of caring (Pavalko and Henderson 2006; Wakabayashi and Donato 2006). A number of theoretical perspectives are useful for understanding why caregiving has such broad implications for the caregiver, and the mechanisms through which caregiving influences unfold. While these theories are not mutually exclusive, each does identify and highlight different dimensions of the caregiving experience.

Stress theory has served as the major orientating framework for understanding the consequences of caring for health (Aneshensel et al. 1995; Pearlin 1989). Stressors, such as caring for an ill or disabled family member, are problematic or difficult circumstances that have the potential to affect one's health and well-being. The stress process model theorizes that these effects are not automatic or experienced in the same way for all people, in large part because these effects are moderated by social, personal and material resources, such as economic resources that may allow one to purchase more or better health care services, educational resources that provide more knowledge about disease processes or their management, and social-psychological resources that provide more avenues for social support (Pearlin 1989). Attention to stress mediators is particularly important because it locates the stress process within a larger social-structural context and helps identify interventions that might reduce the impact of stressors (Aneshensel 2009). The stress process model also distinguishes between primary and secondary stressors associated with caregiving (Aneshensel et al. 1995). Primary stressors are those associated with objective conditions surrounding caregiving, such as managing the care recipient's behavioral problems or helping with physical or instrumental tasks. Secondary stressors stem from problems in other roles, such as work and family, produced because of the temporal, physical and emotional demands of caring. Thus, caregivers may experience stress proliferation as primary and secondary stressors accumulate over time (Pearlin et al. 1990). Moderators may influence the extent to which both primary and secondary stressors translate into adverse health outcomes. Research over the last several decades has documented the overall impact of caregiving stressors and a wide range of mediators in caregiving stress processes.

One direction in more recent research has been to identify how caregiving stressors "get under the skin" by influencing various influence on various biomarkers such as cortisol and telomere shortening (Epel et al. 2004; Kiecolt-Glaser et al. 1991; Seltzer et al. 2009). For example, Seltzer et al. (2009) found that parents of children with disabilities had elevated levels of stress and different diurnal rhythms of cortisol expression than a matched comparison groups, particularly on days when they were spending more time with their children. Alternatively, researchers have also begun to identify distinct stressors associated with having a parent who is ill or disabled as well as those stemming from the stressors of providing care (Amirkhanyan and Wolf 2006).

The importance of stress theory for our understanding of caregiving experiences has largely emphasized the negative consequences of caring, but a growing body of research has expanded the traditional stress-coping model to assess the positive effects of care work. While the specific challenges and benefits of caring vary by the type of illness or disability and the relationship between the caregiver and care recipient, a wide range of caregivers report benefits of caring. For example, research based on a national study of Alzheimer's caregivers found that they frequently reported that caring for someone with dementia made them feel needed and good about themselves, and that caring increased their ability to appreciate life more and strengthened their relationships with others (Tarlow et al. 2004). Likewise, a study of mothers caring for children with disabilities found that most mothers perceived benefits such as a greater awareness of what is important in life and a greater sense of personal strength because of their parenting experiences (Green 2007). There is also growing evidence of gender differences in benefits of caring. Several studies suggest that men experience more positive benefits of caring, such as increased sense of personal growth, than do women (Chesley and Moen 2006; Marks 1998).

Role theory has also been used to understand, and been informed by research on caregiving. While stress theory views roles and role conflicts as an important part of the stress process, it largely assumes that multiple roles contribute to the stress process. In contrast, role theory examines the ways in which the multiplicity of social roles may conflict or enhance one another. Early research on multiple roles questioned whether role combinations such as wife, parent, and worker were harmful or enhanced health (Thoits 1987), while more recent work documents how the strains and benefits of role combinations are contextualized by the nature of those roles and the larger structural conditions in which they are imbedded (Moen et al. 1995; Waldron et al. 1998).

One important line of research on caregiving that has been informed by role theory has been attention to the "sandwiched generation." The sandwiched generation refers to the challenges faced by full-time workers who have the responsibility of caring for both elderly parents and minor children (Ingersoll-Dayton et al. 2001; Spillman and Pezzin 2000). While there is some debate over how many persons are faced with simultaneously caring for young children and aging parents and whether this has increased over time, because care work is most likely to fall during midlife, there is little question that caregivers are often squeezed by conflicting roles from both work and family.

Role theory has also been valuable for framing our understanding of how, or whether, role conflicts, particularly between caregiving and employment, affect health. Most caregivers are employed and employment does not appear to reduce the likelihood that women will take on caregiving tasks (Pavalko and Artis 1997). Despite many concerns about role conflicts, a considerable body of research indicates that multiple roles combined with caregiving enhance rather than hurt health (Hong and Seltzer 1995; Pavalko and Woodbury 2000). Employment appears to be a particularly protective role for caregivers, with most studies finding that employed caregivers fare better than nonemployed caregivers. However, it remains unclear the extent to which this is a protective effect of employment and how much it reflects the selection of those with the greatest caregiving demands out of the labor force. We know that employed women who take on caregiving tasks are at greater risk of leaving the labor force (Pavalko and Henderson 2006; Pavalko and Artis 1997) and that women who remain employed while caregiving differ in several ways from those who stop work while caring (Pavalko and Woodbury 2000).

Understanding the role conflicts and enhancements of caregiving with other roles highlights an important lesson for role theory. Combining employment and caregiving is neither uniformly positive nor uniformly negative, in part because people are not just passive recipients of roles. Individuals are "role makers" who actively manage and negotiate roles to maximize their benefits and minimize costs (Stryker and Statham 1985; Thoits 2006; Thoits and Hewitt 2001). Caregiving differs from many other roles because it is, on average, shorter duration than most work and family roles, but decisions whether or when to start or stop caregiving are often beyond an individual's immediate control. Caregiving thus offers a unique lens for understanding the health implications of adding or losing a major role and for observing the agency individuals bring in taking on or shedding roles (Pavalko and Woodbury 2000).

Role making and stress proliferation have contributed to another theoretical development important for understanding care work, the *caregiving career* (Aneshensel et al. 1995; Pavalko and Woodbury 2000). Attention to the caregiving career emphasizes the dynamic nature of caregiving experiences and incorporates insights into how people actively manage their roles, even when faced with role demands over which they have little control, such as the health of a family member. Caregiving is dynamic in many respects. On average, spells of caregiving last 2 years or less (Moen et al. 1994) and the experiences of caregiving are likely to vary as caregivers adjust and adapt to the role, as the care needs of the care recipient change, and as caregivers take on and shed other roles. While a handful of studies have mapped health changes across the caregiving career, some find that initial periods of caregiving stress plateau or even drop as caregiving continues (Whitlatch et al. 1997) while others find a steadier pattern of stress proliferation (Pearlin et al. 1997). Pavalko and Woodbury (2000) found that psychological distress increased as women moved into caregiving and also for those who had been caregiving and continued to do so. Caregiving had less of an influence on changes in physical health, but women who did experience an increase in physical limitations when caregiving were more likely to stop providing care. Caregiver health across the caregiving career also differed depending on whether or not they were also employed. Employment appears to offer a greater buffer against health decline in the early stages of the caregiving career, but there was also evidence that combining caregiving and employment was unhealthy for some women, prompting them to stop employment.

Stopping or reducing hours of employment is a strategy for managing the demands of caregiving employed by significant numbers of women. Employed women who take on caregiving are more likely to stop work (Pavalko and Henderson 2006; Pavalko and Artis 1997). While this may help manage role demands in short run, it produces another notable consequence of caring – short- and long-term economic risk. Stopping employment to provide care reduces immediate income and access to employer benefits such as health insurance, but it also risks the long-term economic security of the caregiver. For example, spells out of employment affect primary insurance amounts, which serve as the basis for determining Social Security benefits in later life (Kingson and O'Grady-LeShane 1993). It is thus not surprising that a recent study finds that caregivers who spent 20 hours per week assisting parents with personal care were subsequently 25% more likely to live in poverty, 27% more likely to receive public assistance, and 46% more likely to receive Medicare (Wakabayashi and Donato 2006).

A *political economy perspective* calls attention to the economic consequences of caring but also notes that neither the health nor the economic consequences of caring occur in a vacuum. A growing body of research has begun to identify workplace policies that are effective in helping employees remain employed when they take on caregiving tasks. Three policies – family leave, sick and vacation days and flexible hours – show the most promise for improving work–family balance, labor market outcomes and work commitment (Chesley and Moen 2006; Kossek 2005; Pavalko and Henderson 2006). In one recent study, women working at jobs with flexible hours, unpaid family leave and paid sick and vacation days were more likely to remain employed and maintain their prior level of work hours even if they were not currently caregiving (Pavalko and Henderson 2006). Women who had begun caregiving in the previous 2 years and who had access to unpaid family

leave were far more likely to remain employed than caregivers without family leave. A study of dual-earner couples reports that women caregivers with flexible work arrangements report better emotional health (Chesley and Moen 2006).

Theoretically, these studies of workplace policies suggest that how individuals manage roles and the consequences of doing so are contextualized by structural supports and constraints that make it more or less difficult to combine roles. More immediate policy contexts, such as whether a workplace is "family friendly" and has policies available for workers such as flexible hours and paid leave is also contextualized by broader policy and cultural contexts. These broader contexts, such as whether a country locates responsibility for work–family policies in the workplace, as is the case in the United States, or with the state, as in many Western European countries, most likely has implications for how people combine work and family roles and the consequences of doing so for health and economic well-being. Cultural contexts which define appropriate strategies balancing work and family roles are also likely to be important for shaping many of the stressors that arise from caregiving. The political economy perspective can thus be valuable for contextualizing the individual decisions and consequences about care work within the broader political and economic context.

New Directions for Understanding Care Work

Questions about family dynamics, gender inequities, and the division of labor, as well as those about roles and stress processes, continue to be informed by the unique context of caregiving. While the study of caregiving has much to offer these theories, there remains much that we do not understand about care work. At its core, care work is a personal issue faced by individuals and families with an ill or disabled family member but it is also a public issue. Individuals and families have always been faced with illness and disability and the personal challenges for families to provide that care are certainly not unique to the twenty-first century. What is unique is the particular intersection of demographic trends, institutional structures and social trends which make caregiving a public issue of concern to health care providers, employers and communities as well as individuals and families facing an immediate need for care. The public issue – a growing "caregiving squeeze," – means that increased needs for care occur at a time when we have fewer people with time to provide that care. While research on caregiving has done much to inform the personal experiences of care and to identify the public issues of care work, our understanding of the *intersection* of personal and public is more limited. Comparative research, whether the comparisons are across personal contexts such as racial/ethnic groups, temporal, institutional, and even country-level contexts, can provide unique insights into the public dimensions of care. However, each of these comparisons offers different opportunities to improve our understanding of how care needs, decisions and consequences vary across contexts. Below I highlight several contextual comparisons that may be particularly fruitful in broadening our understanding of the personal and institutional contexts of care work.

One important, but understudied, context of care work is race/ethnicity. Much of what we know about caregiving has been based on the experiences of racial/ethnic majority families in the United States, but there are a number of reasons to expect that the need for care, the decisions about care providers, and the consequences of care work varies across racial/ethnic groups. Variations in life expectancy, morbidity and disability across racial/ethnic groups are well documented. African-Americans generally have higher rates of mortality and morbidity than whites, but U.S.-born Hispanics and Asian-Americans are generally healthier and live longer than U.S.-born whites (Singh and Siahpush 2002). Immigrants to the United States, including foreign-born blacks, Hispanics, and Asian/Pacific Islanders, however, have lower mortality and morbidity rates than U.S.-born whites (Singh and Siahpush 2002). While greater longevity is clearly a positive goal,

it does increase the probability that especially women will develop osteoporosis, which places them at a greater risk of disability in later life (Angel and Angel 2006). Greater longevity may thus increase the need for some types of care, which are further complicated by racial/ethnic differences in access to health care and health insurance. Health care reform in the United States will likely reduce some of the more immediate disparities in access to health care, but it will take far longer to reduce disparities that may have accumulated from differential access to care across the life course. Current health care reforms that increase access to insurance and health also exclude immigrants from much of the coverage. All of these changes suggest a changing landscape of racial/ethnic disparities in the need for care. Family decisions and resources for providing care also vary across racial/ethnic groups, as U.S.-born and immigrant racial/ethnic groups differ in family size, cultural norms about family support and gender roles. Comparative research across racial/ethnic groups will thus be increasingly important for understanding the caregiving squeeze and the varying cultural contexts of care decisions within families.

We also know surprisingly little about how historical contexts shape both decisions and consequences of care work. Given rapid changes in women's employment, the role of opportunity costs and employment in care decisions among contemporary cohorts of men and women may differ from that found among cohorts born even a decade or two before. Likewise, the gendered nature of care decisions is likely to differ as attitudes about gender, family and work change and as more women are engaged in full-time employment. However, we know relatively little about how decisions about care by men and women vary across birth cohorts or the life course (but see Moen et al. 1994; Robison et al. 1995). It is plausible that more recent cohorts of men and women may make different decisions, or face different consequences, of care work than prior cohorts and these differences could have consequences for the extent of the caregiving squeeze. However, to date we know relatively little about cohort and historical shifts in care work.

A third important point of comparison is the institutional context in which care work takes place. These types of comparisons are particularly valuable for assessing influences of policies and programs on care decisions and consequences. Local communities are one source of institutional context, but few communities, at least in the United States, provide comprehensive resources for long-term care. Workplaces provide another institutional context, allowing us to assess whether company policies affect caregiving decisions and consequences for employed caregivers. For example, do employed caregivers with access to "family friendly" policies such as paid leave, sick and vacation time, or flexible hours have less psychological distress or are they more likely to remain in the labor force than employed caregivers who do not have access to these policies? Recent evidence suggests that they may (Chesley and Moen 2006; Pavalko and Henderson 2006). An innovative assessment of the effects of flexible hours on employees uses an experimental design to assess the effects of a new policy implemented by a large employer that gives workers control over when, where, and how they work (i.e., flexibility and control). Preliminary results suggest that after adopting this policy, workers report fewer turnover intentions, more organizational commitment, and greater job satisfaction than those in the control group (Moen and Kelly 2007). While these results suggest the power of workplace policies for reducing the stresses of care work, more work is needed to identify which policies have the greatest impact and whether the effects vary across different types of workplaces or occupations. These comparisons will be particularly valuable for understanding whether specific policies or institutional contexts influence the personal experience and effects of care.

Finally, cross-national comparisons provide a more macro lens for assessing the institutional contexts surrounding personal and public dimensions of care. There is little question that the institutional and policy context of caregiving in the United States differs from that found in other western industrialized countries. Although policy-makers often invoke language of family values, policies that make it possible for workers to balance work and provide care for family members are far more scattered and modest in the United States than other industrialized countries (Gornick and Meyers 2003).

While the United States only recently mandated that workers receive 12 weeks *unpaid* family leave with the FMLA act passed in 1993, most industrialized countries provide at least 2–3 months of *paid* leave after childbirth (Ruhm 2005). In contrast, most of the protections for family care available to workers in the United States are provided by individual employers, thus making those protections far more variable and highly dependent on specific employment contexts. Cultural norms about family care and gender roles also vary across countries. Cross-national comparisons of caregiving decisions, experiences, and short- and long-term effects on income and employment could provide a much broader scope for understanding how the personal experience of caregiving is, and is not, shaped by cultural and institutional contexts in which the care takes place.

At some point in our lives, most of us will face personal challenges of care work. Many of us will face it multiple times, both as someone in need of care and as potential providers of care for an ill or disabled family member. Sociologists have an important role to play in preparing individuals and communities for the emerging challenges associated with care and assessing ways that care work can most effectively be balanced with other work and family roles. Bringing a sociological imagination to these personal challenges will be essential for understanding how and why contemporary challenges of care work may differ from those faced by previous and future generations. Attention to both the personal and the public dimensions of care work is also essential for imagining, and thus creating, the contexts where care work is more likely to enhance rather than compete with other work and family roles.

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Part X
Sociological Lives: Personal Reflections on the Sociology of Aging

Chapter 38
Gerontology with a "J": Personal Reflections on Theory-Building in the Sociology of Aging

Vern L. Bengtson

Geh-Ron-Tology or Jeh-Ron-Tology?

My introduction to the field of gerontology was not auspicious. I was sitting in the office of Bernice Neugarten at the University of Chicago, scared silly. I was a senior in college applying to graduate schools and Dr. Neugarten (I still can't bring myself to call her "Bernice") was interrogating me. Why should I, a philosophy major from a very small and undistinguished college, feel myself qualified to join the Human Development and Aging program at the great University of Chicago? "Well," I began, "I think I would be interested in *Geh*-ren-tology, pronouncing the 'G' as in 'guest.'" "*NO!*," she shouted. "It is pronounced *Jeh*-ren-tology!" This was the first time I had heard anyone *say* the word. The study of aging was very new in 1963.

Successful Aging: Activity or Disengagement or Both?

Theories of aging have a very short history compared to theories in other areas of science. I arrived at Chicago after the start of the first big theoretical controversy in what later came to be called the sociology of aging. In the previous decade, Robert Havighurst and his students had collected survey data that linked "successful aging," indicated by high life satisfaction scores, to the maintenance of high levels of activity and social engagement (Havighurst and Albrecht 1953). This came to be known as the "activity theory" of aging. It became immediately popular with gerontological practitioners working with the aged, because it justified what they had been doing to keep elderly patients active.

Then to Chicago came two young and ambitious researchers, Elaine Cumming and Bill Henry, who proposed exactly the opposite in their "disengagement theory of aging" (Cumming and Henry 1961). This theory boldly proposed that withdrawal was the normal pattern of aging, and that both the individual and the society benefited when aging persons disengaged from roles and activities in which they had previously been engaged. Such disengagement is universal as well as functional: satisfying for the aging individual, because it enhances life satisfaction by freeing him/her from increasingly unrealistic demands of mid-life and useful for the social system, because it helps the group maintain equilibrium while preparing younger members to fit into the retiree's position. However, disengagement theory very quickly became unpopular (Achenbaum and Bengtson 1994). The advocates of "activity theory" felt disengagement theory was overgeneralized and deterministic

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(Rose 1964). Furthermore gerontological practitioners, therapists, and nursing home administrators were alarmed because it undercut activity-based therapies. And then there was the sense that advocating disengagement from productive activities was, in a vague sort of way, un-American.

Into this theoretical fray I sailed with my dissertation research, an attempt to test (and, I thought, to refute) the postulate of "universality" in the theory of disengagement. The data, from middle-aged and retired steel workers and teachers in several nations, did not provide any support for the majority of disengagement theory's postulates. Nor did the data support activity theory. In fact, high life satisfaction varied wildly with social engagement across the two occupational groups and the eight national settings involved in the study, in no consistent "pattern of aging" (Bengtson 1969). While the retired Americans showed a high correlation between activity and life satisfaction in ways supporting activity theory, the Dutch and the Italians showed low activity and high satisfaction – supporting disengagement theory. Later, in my first research project following graduate school I developed a more systematic test of activity theory (Lemon et al. 1972). The data provided little support for the axiom that high activity produces greater well-being in aging. There was just too much variation between individuals, income groups, or men and women to support such a sweeping, one-size-fits-all theory.

I learned some important lessons about theory from my first attempts to grapple with explanations of aging, lessons I have tried to pass on to my students. The first was that a good theory must account for variability as well as for modal patterns. In aging there are not only individual differences but social and structural differences that must be taken into account by the theory. Second, a theory is in danger if it attempts to explain too much, if it over-generalizes. A one-size-fits-all theory of aging will not last very long. A third lesson (I thought) was that a theory not supported by data will wither and die. A theory must be testable and when data show the theory to be disconfirmed we must modify the theory or develop a new one.

By these three criteria, the activity theory of aging should now be encountered only in the footnotes of gerontology textbooks. But still, to this date, activity theory lives on, 60 years later, as the implicit theoretical base for a recent best-seller, *Successful Aging* (Rowe and Kahn 1998), touted as the prescription for a good old age. The activity-is-good formula is presented (sadly) without any indication that the authors were aware of the earlier incarnation of activity theory, or that they were conscious of the individual variations and social structural constraints that critics noted must be taken into account, or that they were aware of the *lack of empirical evidence to support activity theory* (Schmeeckle and Bengtson 1999). I had thought that such one-size-fits-all, grand theories of "successful aging" that ignore diversity, personality preferences, or structural inequalities had been put to rest a half-century ago. It seems to me that theoretical indifference has been one of the greatest limitations to the development of cumulative knowledge about aging.

The Generation Gap: Family Solidarity and the Generational Stake Theory

My first job after Chicago was with James Birren at his new Institute on Aging at the University of Southern California. I had also been recruited by John Clausen (with Glen Elder) at the University of California Berkeley, but USC got me by offering a magnificent $500 per year more than Berkeley. Those were frugal years. They were also the years of protest, with the Civil Rights Movement and the Student Rights Movement and the Anti-Vietnam War Movement and the Counter-Culture Movement each gaining more publicity month by month. It appeared that the "generation gap" was wide and deeply rooted in radically different political and economic values between youth and their elders. I saw it differently. In a review of the literature on generational differences I argued that generational contrasts were more apparent than real (Bengtson 1970), and that there were far greater differences *within* generations than *between* them. This was brought home to me 40 years later

during the heated 2010 elections with the "Tea Party" protesters, a political movement led by mostly 60ish activists. It struck me that these people are of the same "generation" that produced the Anti-War and Students Rights protests of the 1960s and 1970s. They are the *other* members of this generation, the group in their age cohort that *did not* protest back then.

I began a study to test the extent of generational differences with a study of 2,000 grandparents, parents, and young adults that would examine values, attitudes, and relationships across generational lines. I had not the foggiest notion that this study would go on for another 35 years as the Longitudinal Study of Generations (Glass et al. 1986; Bengtson et al. 2002) and that in 2005 the Wave 8 data would be collected under Merril Silverstein (Silverstein and Bengtson 1997), the new principal investigator.

In our first look through the data we did note distinct generational differences (Bengtson 1975). These were not, however, in political or social or moral perceptions or even (much to our surprise) in attitudes toward sex. They were rather in *perceptions of intergenerational relationships*, what we called "family solidarity" (Bengtson et al. 1976; Bengtson and Schrader 1982). We found differences in the perception of family solidarity that showed a consistent *generational bias* – parents rated their relationship as more warm and cohesive, for example, than the children rated it, and parents also reported more frequent rates of interaction than did their offspring. This was true whether the children were 18 or 48 and whether the parents were 48 or 88. What would explain this?

I developed the "generational stake" theory with Joe Kuypers, my buddy from graduate school (he got the Berkeley job I turned down for $500), to account for the consistent bias that continually colored the two generations' perceptions of their common relationship. We argued (Bengtson and Kuypers 1971) that each generation had an investment, in terms of emotion, time, and money (depending on the life stage) in the other generation; these investments were inevitably unequal. The parents' stake or investment in their adolescent and young adult children was huge, involving enormous commitments of time, money, love, and support in them. This investment prompted many parents to justify it by perceiving a warm and cohesive response from their child, a high degree of value similarity and frequent interaction – in other words, high solidarity. The child's lesser investment in the relationship, and higher investment in individuation, caused him/her to minimize the cohesion, similarity, and contact. Their differing developmental stakes caused a systematically different perception of their common relationship. It was an explanation that many family theorists found useful in explaining family dynamics. But it was also a theory that questioned the validity of survey data that was based on the report – potentially biased by the generational stake – of one family member alone; thus it was not nearly as popular with researchers using large-scale survey data. To adequately compensate for the generational stake bias would require collecting data from at least one other family member, an expense most surveys are not willing to undertake.

The generational stake theory was an attempt to explain differences in the perception of one age group by another in the context of the family. What about the larger society? What explains differences in the perception of age groups, and what are the consequences as an individual moves into advanced age?

Linking Macro and Micro: The Social Breakdown and Reconstruction Theories of Aging

The years from 1965 to 1980 were an amazingly innovative period in the sociology of aging. Social interactionism inspired some innovative perspectives on aging, such as Rose's (1962) subculture of aging theory, which explained (and justified?) the initial development of Leisure World retirement communities across America. Modernization theory was proposed by Cowgill and Holmes (1972)

to explain the devalued status of the elderly, also called "ageism." Riley et al. (1971) presented a theory of age stratification that linked societal change and individual change over time to processes of cohort flow and individual aging. A political economy approach that linked social structures to the experiences of the aged was outlined by Estes (1979).

Kuypers and I, with the audacity of youth, wanted to try to connect these perspectives together in a theory that linked macro- and micro-social levels. We came up with the Social Competence vs. Breakdown theory (Kuypers and Bengtson 1972), which started with symbolic interactionist concepts (what today might be called the interpretive perspective) and ended with something vaguely resembling the political economy of aging. We argued that an older individual's sense of self, his/her ability to mediate between self and society, and the society's willingness to acknowledge his/her competence are related to the kind of social labeling and valuing s/he experiences in aging.

The Social Breakdown model of aging begins (Stage 1) with the vulnerability in health or economic status that characterizes many older persons – for example, an older woman who is a new widow, experiencing failing health, and who has lost her job to a younger worker. While dealing with these personal crises at the micro-social level, she is also feeling the victimizations of ageism, a cultural or macro-social condition reflecting devaluation of elderly persons in an America that values youth over age and equates an individual's worth with his or her productivity or wealth. Then, for this woman, a vicious spiral downward is set in motion (Stage 2) with additional micro-social crises having to do with role losses (involuntary retirement, loss of social contacts through illness, loss of intimacy through widowhood), leading her to feel confused about what she should do, where to turn for support, and how to behave in responding to these losses in her life. Unless she finds new age-appropriate reference groups, she may lack social feedback concerning who she is, what roles and behaviors she can usefully perform, and what value she is to her social world. Resulting from this feedback vacuum is (Stage 3) dependence on external sources of self-labeling and identification, many of which are stereotypical images of the elderly as useless and obsolete, a characterization common in a society which places so much importance on productivity. As one woman put it, "I feel old, sick, dumb, and ugly." The individual who accepts such negative labeling is then inducted into the negative, dependent situation of the final stage of life (Stage 4), learning to act like old people are supposed to act. This reduces her social and psychological competence even more, with a corresponding atrophy of skills involving social and cognitive coping (Stage 5). This, in turn, makes her even more vulnerable to even greater debilitation, thus setting the stage for still another round of the vicious spiral of the Social Breakdown Syndrome.

How might the cycle of Social Breakdown be broken? The efforts of practitioners and policy-makers to meet the needs of an aging population represent attempts to make beneficial inputs to this end. We proposed a Social Reconstruction theory with inputs at each stage. To ameliorate problems in each stage efforts could be made to (1) liberate the individual from an age-inappropriate view of status, the functional ethic; (2) improving social services to elderly persons or lessening the debilitating environmental conditions faced by elderly persons. We also applied this model to family problems involving the elderly (Bengtson and Kuypers 1985) with what I think was a practical list of interventions for therapists and practitioners working with families and elders: (1) clarify the nature of the crisis event; (2) suggest roles of short-term involvement for each potential family caregiver; (3) discuss moralisms, unrealistic expectations, and guilt; (4) program some quick short-term successes; and (5) follow-up and develop external supports.

This attempt at linking micro- and macro-theory was very well received by gerontological social workers but virtually ignored by sociologists in the field of aging. Why? I learned some valuable lessons from this failure. The theory, while innovative and quite unique in the field of aging, tried to account for too much. It was bewilderingly eclectic, borrowing ideas from symbolic interactionism and phenomenological psychology and Marx and political economy theory. It attempted to both explain and prescribe, linking theory with its practical application (which, according to social work textbooks, it succeeded in doing). And the lesson that unfortunately impressed me the most was the

one least relevant to substantive theory: We did not publish it in the right place. We should have published in a sociology journal or the *Journal of Gerontology* instead of in human development journals and as chapters in books. As I have emphasized to my students since then, too many sociologists will not take seriously anything that is not published in a sociological journal.

Race, Ethnicity, and Differences (or Similarities) in Aging

As an assistant professor I suddenly became, by default, principal investigator of a huge National Science Foundation study of black, Mexican-American, and Anglo Los Angeles middle-aged and elderly people. This project took several unexpected turns. One, happily, was an Oscar in 1977 in the Best Picture Documentary category for *Number Our Days.* This was based on ethnographic research by Barbara Meyerhoff (1978), a member of our NSF research team, of elderly Jews in Venice, California. These older individuals had created their own culture of aging far from memories of their Holocaust losses and far from their upwardly mobile children.

Also unexpected was the suspension of the project by NSF because of charges of racism. A group of minority community activists protested that there were no minorities represented on the research staff and there were no provisions for benefits to come back to the communities that furnished the data – the USC research project was a classic case of white elites exploiting minority groups. As a result the project was re-organized, the original principal investigator resigned (replaced by a woefully inexperienced new PI, me) and recruitment began for minority staff and graduate students. A Community Research Planning Committee (note that it was not an *advisory* committee) was established. Their mandate was to vote on actions at each step of the research process, from designing the survey instrument to submitting papers for journal publication. After months of heated meetings and mutual mistrust, the minority groups and the academic researchers finally got to work designing the community survey.

The initial protests and conflicts led eventually to a third unexpected outcome of the project. We *did* end up working together. Moreover, the research that resulted turned out to be *better* because of it. The Community Planning Committee found areas in the survey we were proposing that were poorly framed or not covered at all. My favorite example is the family relationship section and the questions we had drafted about children and grandchildren, brothers and sisters. A member of the Black Caucus asked, "But what about children you raise that aren't your children?" Reluctantly, and complaining inwardly about the cost of each additional question in a 1,200-respondent survey, we added some questions about "children you have raised that are not your own." When the survey results came in we found that *over 50%* of the black respondents reported they had raised children who were not biologically theirs but who they considered family (Burton and Bengtson 1982). Had we omitted this question we would not have learned about support networks outside the children usually asked about in surveys, nor about the investments, emotional and financial, that middle-aged and elderly minority respondents were making to children not their own.

This project was the most memorable experience of my research career, and I learned more from it than from any other. This awkward experiment in community-academic collaboration proved useful for other researchers (Bengtson et al. 1977) and today community involvement in social research is taken for granted. I should add a comment about the personal support I received from the Community Research Planning group. These were difficult times for me personally because my wife had been diagnosed with leukemia and my girls were 3 and 6 years old at the time. Several members of the black and Mexican American caucuses came to her funeral a year later. I will never forget what one member, Carmella Banks, said to me: "Vern, you and your daughters will *always* be members of *our* community."

A fourth set of unexpected consequences involved the research results of the project and their implications for theory. At that time the dominant orientation was what came to be known as the multiple jeopardy theory, in which the disadvantages of, say, an elderly black woman was explained by her cumulative minority status of being black, old, poor, and a woman. I wondered about this, thinking that by contrast there may be resources available to this woman that may buffer her disadvantages – particularly family support, in contrast to white elderly's lack of family support. I wanted, with the audacity of youth, to challenge the multiple jeopardy theory. So we began analyzing the data expecting to find marked differences between the black, Mexican-American, and Anglo individuals reflecting social aspects of aging. For example, we "knew" that minority groups placed higher emphasis on familistic values and that whites' higher mobility led their elders to feel lonely and often abandoned by their families. But the data did *not* support the hypotheses of either racial–ethnic advantage *or* disadvantage in family support for the aged. We did find that Mexican Americans had higher rates of contact with and affection toward family members than blacks and Anglos, but the differences were less than expected. We found that Anglos *expected* more assistance from their children than blacks or Mexican Americans, but there were insignificant differences in the *actual* provision or receipt of care. The most important finding was this: there were more differences *within* the three groups – black, Mexican American, and Anglo – in family relations and other aspects of aging than there were differences *between* the groups (Bengtson et al. 1990). We found little evidence in the data of this cross-ethnic comparative study to support the multiple jeopardy theory of aging; but we saw little evidence of data to disconfirm it either.

The research on aging in minority communities caused me to rethink several sociological generalizations I had accepted about social inequality. Could it be that we sociologists tended to maximize *between*-group differences – at the level of race, gender, or wealth – while minimizing, or perhaps even missing, differences *within* these social categories? Then there was another thing I became aware of, something even more relevant today than it was then. In contemporary sociology we are preoccupied with social inequality, with power, conflict, empowerment, and hegemony the social forces to be examined or critiqued. But there are other social forces as well: cohesion, cooperation, supportiveness, solidarity. My hope is that in the next decade we will get back to studying what binds people together as well as what drives them apart, and that sociologists will look at aging individuals for the resilience their lives represent as much as the social inequalities that make them vulnerable.

The Future of Theory in the Sociology of Aging

Since I can claim almost 50 years of experience doing research in the sociology of aging, I think I am allowed to offer some observations about the future of our field. First, in the sociology of aging today we appear to be drifting away from science and careful observation as practiced in related fields such as the psychology and biology of aging and toward the interpretive methods of history and the study of literature. Some among us have felt that this is a welcome trend and have vigorously advocated that we move away from the reductionism of positivism and move toward the freedom and questioning of critical analysis. But such polarization is unfortunate, I think; we need both. For one thing, I think we can profit greatly by following the model of cumulative knowledge building through observation, classification, prediction, and intervention or control, a model that has characterized science and has led to so many developments for the betterment of humankind's health and well-being. At the same time, however, I believe that we who do research in aging have responsibility to work for social justice, to advocate for dependent elders, and above all to add knowledge that can be useful for interventions. To accomplish this I believe that the process of developing theory – e*xplanations* – is the best way to develop more effective *interventions* to

improve the lives of older people, interventions such as more effective health practices and more equitable social policies regarding aging.

Second, we need to develop more cross-disciplinary dialogs. Successful collaboration across fields to forge multidisciplinary models of aging and intervention is all too rare for those of us doing research in the sociology of aging. In part that may be because of an increasingly insular or antiscientific culture in sociology at large, which our colleagues in medicine, psychology, biology, and economics simply cannot understand. We need to recognize that aging is a multifaceted dynamic and requires multiple research perspectives to understand it. We need to believe in ourselves and that we have something useful to offer our research colleagues in medicine, biology, and psychology.

My third concern is that in the sociology of aging today we seem to be forgetting our history and our past attempts, whether successful and unsuccessful, to explain and to understand. Some of these old theories have been useful, others not; but each one of the attempts to build explanations, particularly those that have failed to be supported by subsequent data, can teach us a good deal about age and society or social processes of aging. Knowing their history can protect us against making their mistakes.

Finally, I believe we have an intellectually exciting future before us because of the creative cohorts of younger researchers that I see entering the sociology of aging. This is evident from the papers they present at the Gerontological Society of America and the American Sociological Association meetings. We have a responsibility to help them as they develop their professional competence and humanitarian concern. We need to encourage them to propel their research toward theory, beyond mere description and classification. We need to remind them that such explanations can be used to change things for the better, to produce more effective social policy about aging and more effective programs and health interventions for older people with problems. We need to remind them that they will do a better job of theorizing about age and aging than those of us who were in the first generation of the sociology of aging were able to do. This is because they will be able to learn from our mistakes and our successes. And because they will already know how to say "Gerontology" with a "J."

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Chapter 39
The Sociology of Aging and the Life Course Comes of Age

Stephen J. Cutler

As I thought about this chapter and the occasion it presented to reflect on my years as a sociologist and social gerontologist, two trends significant to my career repeatedly surfaced. The first is the growing legitimization of aging as a topic of investigation, and the second is the development of a research infrastructure supporting the study of aging. I make no claim that these two represent *the* most significant developments. I single them out only because of their personal importance and because of my belief that they represent critical indicators of how the field of aging has evolved over the past 4 decades. In what follows, I will place these trends in an autobiographical context.

My Michigan Years: The Study of Aging in the Mid to Late 1960s

I have often been asked how I became interested in aging and what led to a career-long interest in gerontology. (This question was especially prevalent when I was a younger sociologist; it has tapered off somewhat in my older years as the apparent connection between my personal biography and the field of study has become closer and as the field has gained legitimacy.) I expect many people thought my response would have something to do with warm, loving grandparents. I did have warm, loving grandparents, but the answer to the question is quite different (and quite possibly a disappointment to many people).

My interest in the sociology of aging dates precisely to a particular lecture in my first semester as a graduate student at the University of Michigan in the fall of 1964. I was enrolled in a course on population taught by the eminent demographer Ronald Freedman. At one point in the course, he was discussing the end of the Baby Boom – after all, it was 1964, the date generally acknowledged as the end of the baby boom era in the United States – and he was pointing out the demographic implications. He noted that the declining birth rate associated with the end of the Baby Boom would contribute to population aging. Fewer births meant a shrinking base of the population pyramid and a greater proportion of people at the older ages. Gains in life expectancy would also play a role in population aging, as would the eventual flow of Baby Boom cohorts into the older age strata, but declining fertility would be an early and critical component of the aging of our population. However, it was his next comment that caught my attention. Sociologists, he said, knew very little about aging. But between the lines he also seemed to be suggesting that sociologists cared little about aging. (In retrospect, I believe he was right on both scores.) And that was my "light bulb" moment! Something in his spoken and unspoken words clicked, and a huge intellectual gap and challenge presented itself.

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From that lecture given by Professor Freedman on an autumn afternoon 45 years ago, the seed that grew into my career-long interest in aging was planted.

The University of Michigan in the mid- to late-1960s, however, was far from the hotbed of gerontological activity that it is today. Any graduate student in sociology who wanted to do work on aging – although I am pretty sure I was the only one – had to carve relevant topics out of courses that had little if anything to do with aging. My term paper in a course on deviance, for instance, was on the topic "The Organizational Structure of the Mental Hospital and Geriatric Withdrawal." As best I could determine, and despite the presence of Wilma Donahue on campus, only one course on aging was offered in the entire university and that was in the School of Social Work. Taught by Professor Sheldon Siegel, the course brought together an eclectic group of graduate students from biology, psychology, social work, sociology, and other disciplines. There, among a group of students with a passionate but somewhat offbeat interest in aging, I got my first taste of the excitement of the multidisciplinary nature of gerontology.

As my time at Michigan progressed, I was faced with the task of developing a dissertation topic. My interest in aging had continued, and I designed what I thought would be a fascinating and significant research project, one I believed to be in the best tradition of Michigan sociology at the time (a la Amos Hawley, Otis Dudley Duncan, and others). What I proposed to study was how community functional specialization affected the prestige of older persons. Building on Burgess's notion of the "roleless" role of old people and notions about the declining status of older people with industrialization and modernization, my project viewed the status and prestige of elders not as givens but as variables, and it sought to examine how status and prestige varied as a function of the nature of community specialization. I wrote up the proposal, made an appointment with our department chair Albert J. Reiss to discuss it, and then witnessed first-hand the accuracy of Professor Freedman's assessment of the state of sociological interest in topics having to do with aging. After the requisite chit-chat, Professor Reiss said he had read the proposal, thought it was all well and good, but told me that what I really needed to do was something much more in the sociological mainstream. Apparently, aging was not. The handwriting was unmistakably on the wall. It was clear that my gerontological bent was judged to be somewhat misguided, and it was equally evident that I was not about to receive much, if any, support from the University of Michigan's Department of Sociology to carry out dissertation research on a topic having to do with aging.

Having had the error of my ways pointed out to me, I put my gerontological interests on the back burner, availed myself of some excellent data from the Detroit Area Study, and for my dissertation did a secondary analysis of the implications of voluntary association memberships for mass society. Yet, sometimes obstacles do pay off. Anyone who is at all familiar with my work will see there the beginning of two major threads to my research: first, a career-long interest in correlates and consequences of voluntary association memberships and, second, a heavy, though not exclusive, reliance on secondary analyses of survey data.

My Oberlin Years: 1969–1984

My first faculty appointment was as an Assistant Professor of Sociology-Anthropology at Oberlin College. I had made a conscious decision in my last year of graduate school that I wanted to begin my professional career at an undergraduate liberal arts college. This was a reflection of the nurturance and support I had received as an undergraduate at Dartmouth College in the early 1960s, especially from Professor Robert Sokol. The following is an excerpt from a letter I wrote in October, 1996 on the occasion of retirement festivities in Professor Sokol's honor:

> Long before the term was fashionable, you were a mentor in the very best sense of the word. You took me under your intellectual wing and gave me opportunities that few other undergraduates had. It sounds like ancient history now, but those many hours I spent running IBM cards through the counter-sorter using data sets you

> provided and calculating percentages and chi-squares on rotary calculators gave me a firm and enduring foundation for understanding the logic of sociological research. You found opportunities for me to do some interviewing and—I hope I'm not betraying anything here—you even let me try my hand at constructing multiple choice questions for an exam. As I became more and more interested in the possibility of graduate work in sociology, you gently encouraged me to test my interest by taking advantage of summer opportunities in related fields. And when I did decide that I wanted to go on to graduate school, you were there to help me think through the graduate programs that were best suited for me. I could go on at length, giving many more examples of your generosity, but the important point is how you consistently went out of your way to nurture my intellectual and professional development. In doing so, you served as a model for me and as an influence on my career in yet another way. My decision to go to Oberlin, where I taught for 15 years after getting my PhD, was a direct result of the undergraduate experience I had at Dartmouth and of which you were such a large part. I wanted to be in an environment that encouraged and valued the same type of student-faculty relationship, and I wanted to be able to work closely with undergraduates as you did. Being at Oberlin gave me the chance to work with exceptional undergraduate students, an opportunity in a real sense to carry on your legacy.

Several events during my early years at Oberlin brought my gerontological interests back to the forefront. First, in what Harvey Stearns at the University of Akron once referred to as the "Dracula complex" – or the incessant search for new blood! – the then Gerontological Society sponsored an Institute for Research and Teaching in Gerontology in August, 1970. Imagine having an opportunity to spend a week studying and talking gerontology with the likes of George Maddox, Bernice Neugarten, Ethel Shanas, Jack Botwinick, Carl Eisdorfer, and Juanita Kreps, among many others. If anything could reignite the smoldering intellectual embers, that week did.

Second, senior colleagues at Oberlin, especially George Simpson and Milton Yinger, were supportive – or, at least tolerant – of my interests in aging, even going so far as to permit me to offer a seminar on the sociology of aging every 2 or 3 years.

Third, a neighbor who was on the local Oberlin Health Commission and aware of my interests in aging informed me that the Commission was interested in doing a study of the needs and status of older persons in the community. They were looking for someone to conduct the survey and, as it turned out, I was looking for an opportunity for my research methods students to get some first-hand exposure to the survey research process. That fortunate combination of circumstances resulted in the 1970 Oberlin Survey of the Aged, a longitudinal follow-up supported by an NIMH grant 2½ years later, and several of my early presentations and articles on prestige loss, transportation, and voluntary association memberships.

Of course, time and resource constraints made it very difficult to mount major survey research projects from a setting such as Oberlin. *N*s of 170 and 106 did not go far when running first- and second-order tabular analyses (state-of-the-art at the time), and there were valid questions about the sample representativeness and generalizability of the Oberlin data. Nevertheless, over the many years I taught research methods at Oberlin, it was my belief that students profited from "doing" research. Social science data analysis packages were in their infancy, and runs still were submitted via IBM cards at input–output windows. But eager and energetic students seemed perfectly willing to try their hand at data analysis, so I soon began requiring my methods students to do an empirical research paper for their final project. (Still later I began to give my introductory sociology students the option of doing an empirical paper – somewhat streamlined, but still a chance for them to get their hands dirty.) It was because of this bent that I greeted so enthusiastically the arrival in 1972 of James Davis's brainchild, the National Opinion Research Center's (NORC) General Social Surveys (GSS). For the bargain-basement price of $100, students could access large-scale, nationally representative surveys of the adult population of the United States on topics of central sociological significance. In a review symposium on the NORC GSSs in 1978, I wrote:

> Most teachers have experienced the great pleasure of writing a letter of recommendation for that one student who comes along every five or ten years: head and shoulders above others, unsurpassed performance, and immense potential. So it is with the NORC General Social Surveys….Having used them for a variety of instructional purposes since they first became available in 1972, I have come to consider them as the single most important data resource for the teaching or undergraduate sociology (Cutler 1978:541).

But their value extended well beyond their instructional uses. For minimal cost, they gave those of us without access to on-campus survey research centers the possibility of working with an exceptionally rich source of current, nationally representative data. Moreover, an additional feature proved to be of inestimable value. From the outset, many of the questions included in the GSSs were replications of items asked in earlier surveys. Coupled then with the growing availability and accessibility of data archives (e.g., the Roper Center, NORC, the Inter-University Consortium for Political and Social Research [ICPSR]), the GSSs lent themselves to various sorts of diachronic analyses. For example, along with Robert Kaufman (an exceptional undergraduate student and now Chair of the Department of Sociology at Temple University), we were able to pair measures of tolerance of ideological nonconformity in the 1972 GSS with the very same measures in Samuel Stouffer's 1954 surveys of attitudes about civil liberties. The availability of those two sets of items asked over an 18-year period allowed us to conduct a cross-sequential analysis of cohort changes in attitudes about civil liberties (Cutler and Kaufman 1975), the first in a series of several studies showing both the occurrence of attitude change among older cohorts as well as shifts over time that often were in a liberal direction. Both findings countered prevalent stereotypes of aging as being a time of growing attitudinal rigidity or a time of adopting increasingly conservative social and political attitudes. Other collaborative studies with outstanding undergraduates took advantage of this replicated item design feature (e.g., Cutler et al. 1980, in which we examined cohort changes in attitudes about the legalization of abortion using NORC data from 1965 and six GSSs between 1972 and 1977). Still other projects began to take advantage of the cumulative aspect of the GSSs themselves. Because of the initial annual and subsequent biannual administration of the surveys, the GSSs alone increasingly provided the basis for trend analyses. The most recent example of this is a comprehensive examination of change in sociopolitical attitudes using 33 items asked in anywhere from 14 to 21 of the surveys conducted between 1972 and 2004 (Danigelis et al. 2007).

Although Oberlin College emphasized undergraduate instruction, it recognized that an active program of scholarly engagement would enhance the instructional experience. Not only did the college have a generous sabbatical program but it also had a limited number of "research status awards" which, when combined with a one semester sabbatical, gave the recipient a full year off at full pay. I was fortunate enough to receive one of the research status awards and spent the 1975–1976 academic year at the Center for the Study of Aging and Human Development at Duke University. There I had the opportunity to spend a year in the company of George Maddox, George Myers, Erdman Palmore, Gerda Fillenbaum, Linda George, Dick Campbell, and others, to avail myself of the rich set of postdoctoral and other program activities of the Center, and to have access to data from the Duke Longitudinal Studies to use in conjunction with data from the Oberlin surveys (e.g., Cutler 1977). This extraordinary intellectual and networking opportunity more than compensated for the gerontological isolation I experienced at Oberlin.

Other developments during this period speak to the growing legitimacy of aging as a field of inquiry and have proven to have had a lasting and significant impact. In 1974, the National Institute on Aging was established as part of the National Institutes of Health. Under the visionary leadership of the founding director, Dr. Robert Butler, NIA from the outset proved to be receptive to and encouraging of sociological research on aging. In fact, the first and long-time director of the Behavioral and Social Research Program was Matilda White Riley, herself a sociologist and a vocal and effective proponent of the value of social and behavioral research.

And within sociology, of course, the Section on Aging was established in 1979. The culmination of efforts spearheaded by Harold Orbach and others gave an ASA organizational imprimatur to the growing interest among sociologists in the wide array of fascinating theoretical, methodological, and substantive issues surrounding late life and the life course.

The late 1970s and early 1980s also saw efforts to facilitate access to the aging research infrastructure. A noteworthy example was the establishment of the National Archive of Computerized Data on Aging (NACDA) as a unit of the University of Michigan's ICPSR. With funding from NIA,

NACDA has become the principal repository of easily accessible, thoroughly documented, and analytically ready aging-related data sets. Recognizing the value of ultimately making such data available to the wider research community, beginning in 2003 NIH has required investigators to detail plans for archiving and distributing data gathered with NIH funding.

My Vermont Years: 1984–2009

My move from Oberlin to the University of Vermont (UVM) in 1984 reflects still another indicator of the growing visibility and legitimacy of aging as a significant focus of social and behavioral education and research. Beginning in the 1970s with Title IV funding from the Administration on Aging (AoA), colleges and universities started developing centers, institutes, and programs on aging, as well as courses, minors, and certificate programs; master's degrees and even PhD programs in gerontology would eventually appear. UVM had an active but informal interest group (the Multidisciplinary Committee on Aging) and a smattering of courses on aging around the university, but no officially organized programs. In an effort to catalyze and coordinate aging-related activities on the UVM campus, an endowed chair was created, the Bishop Robert F. Joyce Distinguished University Professorship of Gerontology. According to Bell (1986), this was 1 of 29 endowed positions in gerontology and geriatrics in the mid-1980s, 80% of which had been created since 1980. In an effort to align my academic and curricular responsibilities with my major scholarly focus (aging), I applied for the position and became the first incumbent of the Joyce Professorship, holding the position until my retirement in 2009. Curricular and programmatic activities were proposed, approved, and initiated, and UVM joined the large and growing list of institutions of higher education that recognized the significance of aging as an area of study.

The move to Vermont not only provided me with a group of local colleagues who shared my interest in aging from a variety of disciplinary perspectives but it also provided me with the encouragement, support, and indeed the expectation to immerse myself in the burgeoning professional activities in aging and gerontology. If my entry into aging and gerontology in 1964 was on the "ground floor," the Vermont years beginning 2 decades later allowed me to be part of the explosive growth and maturation of the field from a variety of professional vantage points: as Chair of the Behavioral and Social Sciences Section of GSA (1987), as a member and chair of NIH's Human Development and Aging Study Section (1988–1992), as Editor of the *Journal of Gerontology: Social Sciences* (1989–1993), as Chair of ASA's Section on the Sociology of Aging (1994), and as President of GSA (1998).

A Last Look Back

If I think back to that gerontological awakening some 45 years ago in Professor Freedman's population course and reflect on the development of the field and on my involvement in it, two unmistakable achievements stand out. First, the sociological study of aging has come a long distance since Professor Reiss suggested that my dissertation topic needed to be more mainstream. The sociological study of aging and the life course has, indeed, become mainstream. Witness the occasion for this set of essays: the 30th anniversary of the establishment of the Section on Aging (and the Life Course) and the regular appearance of articles on aging and life course topics in the major sociological journals. Second, a research infrastructure that both supports and reflects the growth of the field of aging is now well established. Witness the public investment of financial resources in large-scale, multi-wave data collection efforts (e.g., Michigan's Health and Retirement Survey, Chicago's

National Social Life, Aging and Health Project, Duke's National Long Term Care Survey, etc.), and the theoretical and methodological advances that guide us in formulating the questions, interpreting the findings, and analyzing the data gathered by such studies. From these and the many other perspectives explored in this volume, the sociology of aging and the life course has come of age.

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Chapter 40
Long Time Coming, Not Here Yet: The Possibilities of the Social in Age and Life Course Studies

Dale Dannefer

The advance of scientific knowledge and understanding proceeds through a continuous dialectic of multiple intellectual tensions – between theory and research, and sometimes practice, and between multiple and often competing conceptual and methodological paradigms within and across disciplines. At its best, scientific work entails an ongoing discourse of discovery and interpretation guided by logic and evidence, and yet it is also a discourse that is shaped unavoidably by the biographical experience and social location of individual researchers. "Making science" is a human process, located in a specific sociohistorical space, within the broader everyday life processes through which society is continuously reconstituted. Thus, it is epistemically incumbent on the researcher to consider carefully the impact of her own life history and social location upon her work. The editors of this volume are to be especially thanked for inviting essays that encourage such reflexive work – combining a view of the field of aging and life course studies with autobiographical particularity, which is what I shall attempt in this essay.

Although I had the great benefit during the course of my graduate training of working and studying with Matilda White Riley (including taking her very first *Sociology of Age* course at Rutgers in the mid-1970s), I had no particular interest in the study of age while in graduate school. My doctoral research was informed by interests in the sociology of knowledge, culture, meaning, and identity in late modernity. My first real substantive connection with the study of age and the life course came as a result of empirical studies of those issues via intensive qualitative interviews with targeted groups of respondents as they revealed that meaning-making is a lifelong process that can only be apprehended as part of the actor's broader biographical experience or life narrative.

With that realization, I returned to the sociology of age and discovered the life course, as well as the fields of lifespan psychology and adult development, as I searched for frameworks and concepts that could help organize and offer insights for dealing with the rich and complex qualitative interview data I was amassing. These literatures – serving up terms and topics such as *life history, seasons, cohorts, stages and transitions, fallacies, age structures and allocation,* and *change vs. constancy* – represented several distinct paradigms and offered a provocative range of multiple and competing approaches to understanding human development and aging over the life course, often leavened by lively debate and a sense of discovery.

Nevertheless, what I found most striking in this array of approaches to aging and development over the life course was not their *differences* but two underlying *similarities* that characterized most of them, and that many had in common: (1) a predilection to envision the basic contours of aging primarily as an organismically grounded individual process and a corresponding lack of recognition of the magnitude of the importance of social forces to account for age-related patterns and outcomes

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and (2) a lack of attention to the role of institutionalized power relations in society in shaping both the life course and its study, inviting an implicit assumption of a generally benign relationship between social structures and dynamics and individual needs and aging.

Thus, rather than providing the framework I was seeking for my own research, what I found in this set of literatures was a cluster of theoretical assumptions and substantive assertions that themselves needed to be scrutinized and critically analyzed. As a consequence, I began to focus my scholarly work on the implications of social theory and sociological knowledge for aging and the life course (e.g., Dannefer 1984, 1987), and I have yet to finish the empirical studies that sent me to these literatures in the first place.

I begin with this account not for the sake of reviewing the past but because the field of aging and life course studies continues to be constrained by these same problems. The tendency toward life course reductionism, which leaves the explanatory potential of social forces unrecognized in studies of age, has consistently been – and remains – an enduring tension in the field of aging and life course studies. Moreover, even when the reach of social influence is more fully recognized (as in constructivist work), the systemic nature of social structures and processes in shaping of the life course is generally neglected. Taken together, these two problems represent what I have called a *functional-developmental symbiosis* that sustains, albeit often in disguised or subdued form, a "normal aging" view of the individual life course. The general problem is, of course, most readily visible in work that explicitly presents aging as a highly general or universal process (e.g., Gutmann 1987; Levinson 1994). However, on careful inspection it becomes clear that even many approaches that attempt to emphasize the role of social context continue to rely on a view of age does not venture far from a "normal aging" view of the individual, relying implicitly if not explicitly on an individualized and organismic view of change across the life course.

As I have suggested elsewhere (Dannefer 2011), the overall problem can be clarified by contrasting two fundamentally different intellectual postures – or *heuristic positions* – that provide alternative paradigmatic orientations to the subject matter and that are the basis for reacting to and interpreting findings. I call these the heuristic of *containment* and the heuristic of *openness*. Both of these heuristic positions recognize the challenges posed to the normal aging paradigm by cohort analysis, constructivist approaches, and related breakthroughs of the late twentieth century that demonstrated diversity in patterns of aging and the relevance of context in understanding such diversity. Where they differ is in their response to these developments. The *heuristic of containment* describes a defensive move on behalf of the "normal aging" paradigm – an intellectual predisposition to recognize and give credit to, but then promptly limit, the encroachments of external forces on the normal aging paradigm. The *heuristic of openness*, by contrast, describes a logic that imposes no preconceived limits on external influences and embraces the attendant complexities and challenges for measurement, analysis, and theorizing. Thus, openness implies a view that countenances the unrealized and even unrecognized possibilities for the future of the life course and of the social institutions that organize it. However, it also means that the task of the science of aging is much more daunting. If the tasks of science are to understand, bring order to, and make predictions about empirical phenomena, the heuristic of openness acknowledges that the phenomenon age and the life course are less predictable than the dominant heuristic of containment assumes them to be. And when a phenomenon is as rich, multivariate, and contingent as is human aging, it will not advance understanding to force it to conform to a paradigmatic framework selected *a priori* that, no matter how appealing, does not fit the nature of the phenomena under investigation. As Herbert Blumer (1969) frequently emphasized, the first task of science is to be true to its subject matter.

In this brief essay, I can only discuss a couple of examples of this persistent tension in aging and life course studies. I will describe one of its significant early manifestations in social science research, (cohort analysis), followed by a discussion of a contemporary instance (nursing home research and reform), which is one of several domains in which an opportunity currently exists to move beyond the heuristic of containment. This discussion will also require consideration of the special place of the life course as a social institution both in the past, and in contemplating future possibilities of this paradigmatic tension.

Cohort analysis may seem an unlikely target for this complaint. As is well known, cohort analysis was central to the successful challenge posed in the late 1960s and 1970s to the widespread assumption that cross-sectional age patterns could be equated with actual life course trajectories of aging. It demonstrated that aging is contingent on historical circumstance, and that how individuals mature and age will depend on the kind of world they experience. It posed a major challenge to a universalistic view of aging and was rightly seen as a threat by those who argued for a view of age as a transcultural, transhistorical process (Gutmann 1987; see also Dannefer and Perlmutter 1990).

By posing this challenge, cohort analysis opened a "Pandora's box" of logical possibilities, inviting consideration of other forms of external and social influence upon aging beyond those indexed by social change. However, as I have noted elsewhere, the implications of this opening were hardly embraced. Instead, a primary mode of response to cohort analysis encouraged a tendency to equate and conflate the scope of social influence with social change, assuming that social forces are mainly visible or of interest during periods of rapid change (Hagestad and Dannefer 2001). The paradigmatic form of cohort analysis probably remains the intercohort comparison of mean trajectories, so that each cohort itself is implicitly treated as having its own normally distributed pattern of aging. This is more than curious since it takes only a moment's thought to realize that if social influence creates change in patterns of aging, it may also be at least partly responsible for stability in patterns of aging and for the variation in age-related characteristics among the members of a cohort, as well as between cohorts.

That is why in my work I began to focus on *intracohort variability* and on evidence that variability and inequality tend to increase with age, which seemed to me to demonstrate clearly the operation of life course processes of social stratification and exclusion, and cumulative dis/advantage (CDA). Nevertheless, reviewers of my first submitted paper on this topic (Dannefer 1987) criticized it for lack of attention to individual-level processes, suggesting that the psychosocial accentuation of personality or other individual characteristics could be the primary factor accounting for divergence with age (see also Clausen 1993:521). Despite such efforts at *containment* of the complications social forces, I regard the CDA perspective as one domain of scholarship in which the expansion of the sociological imagination is quite manifest (e.g., Crystal and Shea 2002; Dannefer 2003; Ferraro and Shippee 2009).

In contrast to the dominant "containment" approach, the *heuristic of openness* recognizes that the discovery of cohort differences represents only the beginning of the problem of specifying external effects on individual aging, not the sum total of it. Cohort differences thus appear as only one among many potential kinds of evidence showing that individuals "age differently" (Maddox 1987), due in substantial part to the nature of their daily life experience, and life experience is inevitably socially organized and regulated.

The same tension applies in the treatment of numerous other topics in social gerontology and related literatures (e.g., lifespan theory, activity theory, family solidarity theory, cumulative dis/advantage, gene-environment interaction), as I have discussed elsewhere. In the space remaining, I focus on a significant contemporary site of the tension between these two heuristics that has real-life relevance – the topic of long-term care research, reform, and culture change. To approach this problem it is important first, however, to introduce explicitly the second major analytical fulcrum of life course studies, which is a focus on the life course as a social institution.

A concept of the age and the life course as elements of social structure is clearly present in the initial formulations of Cain (1964) and Riley and associates (1972), but it was most systematically elaborated in the work of Martin Kohli (1986) and others in the 1980s, which revealed the significance of the life course as a social institution. The crucial importance of this perspective is that it makes explicit the power of age, not as an inherent feature of individual organisms but as having its own independent reality as a constructed, yet potent, feature of social order. Age is thus a property of social structure. Increasingly, age is relied upon in late modern societies as a central basis of social organization and reality construction.

Given the recency of this historical development (e.g., Chudacoff 1989; Kett 1977), its taken-for-grantedness is remarkable. It reflects a *naturalization* of age, as there is a widespread popular,

professional, and academic assumption that the "three boxes of life" (school, work, and retirement) and the observed empirical trajectories of development and aging represent the "normal" human life course to which the age-graded institutions of school, work, and retirement serve as *accommodations* (Dannefer 2008), meeting the age-graded needs of the normal life course. The acceptance of these institutional forms as a response to human needs and of positive benefit to human interests reflects the heuristic of containment. So unrealistic and destructive is the logic of containment when applied to institutions (and not just individuals) that it prompted Matilda Riley (among whose best friends were counted the leading functionalists Parsons and Merton) to declare the three boxes of life a reflection of "society's failure to provide meaningful roles" in the subtitle of her book *Age and Structural Lag* (Riley et al. 1994).

Institutions of long-term care that are associated with advancing age – assisted living and especially nursing homes – can be thought of as a "fourth box." This fourth box is officially defined as a further accommodation to the normal life course to some imagined final life stage of social and existential, as well as physical withdrawal and decrepitude, a legitimate and professionally and scientifically sanctioned form of the systematic social exclusion of elders. The resilience of this widely accepted exclusionary practice is a reflection of the depth and resilience of ageism in late modernity. It is noteworthy that it ordman nursing home life appears as a shock to frontline caregivers in the United States, who are themselves from traditional societies (e.g., West Africa or the Caribbean), in whose eyes the circumstances faced by elders appear cruel and barbaric abandonment. Their culturally grounded perspectives on aging involve hope and expectation of more for elders, in terms of quality of life and social engagement, than does the ageist culture of late modernity.

Why, then, have the devastating and well-founded critiques of the prototypic institutional forms of long-term care – as warehouses that require the "elderly" to adjust to the logic of a total institution (Boyd 1994; Vladeck 1980), as regimes that impose "helplessness, boredom, and loneliness" (Thomas 1996) and "depersonalization" and "infantilization" (Kayser-Jones 1990) upon their residents – come mainly from practitioners and professionals working in the field and not from social and behavioral scientists?

Over the past 15 years, a national movement to promote a fundamental *culture change* of rehumanization of long-term and other elder care (Fagan 2003) and to resist ageism more generally (Barkan 1995; Thomas 2004) has grown rapidly, with goals squarely in line with the intellectual concerns of established developmental theory (e.g., Deci and Ryan 1985) and progressive social gerontology. It is a movement that sees its mission precisely as combatting an especially insidious manifestation of what Matilda Riley called structural lag.

Long-term care institutions that have sought to apply the vision of this movement to change their structures and practices to be more responsive to elder residents have had some, if limited, success (Dannefer and Stein 2000; Kane et al. 2007; Weiner and Ronch 2003). In virtually every case, the critical analysis of both the contradictions of institutional practices and their adverse effects on human development and human potential came from the field and from critical practitioners while the published discourse of social and behavioral scientists on nursing homes largely contented itself to consider topics such as incontinence, caregiver burden, decontextualized recreational "therapies," regulatory change, and a host of other topics that largely left the medical-model structure of the traditional nursing home unquestioned and therefore legitimated.

Why has the cutting edge of analysis of institutional structures and practices – and hence the call for reform – come, with few exceptions, not from social gerontology but from imaginative frontline leaders who have derived their own critiques of ageist assumptions about the diminishing lives of elders from the manifest human contradictions and destructiveness with which the empirical reality of everyday life confronted them? These are legitimate questions for social and behavioral scientists to ponder. Such unquestioned acceptance of the status quo is, of course, a reflection of the power of the heuristic of containment.

In the opening paragraph of this essay, I emphasized the importance of scientific reflexivity. When considering the current movement of long-term care reform, one obvious, overarching question is, "*Where were we?*" Where were social and behavioral scientists in analyzing the damage done by institutions and considering the possibilities for change, instead of largely accepting their basic form? I suggest that, overall, the problem can be diagnosed as a lack of development of the heuristic of openness and a reliance on the logic of containment.

In the reflexive moment, these considerations raise yet other questions. Culture change and other reform initiatives have highlighted and sought to change some adverse aspects of the treatment of elders, but they represent only a few halting steps in making institutions more responsive and in nurturing late-life development. What arenas of needed change are not yet visible? What additional frontiers remain to be explored that hold possibilities for upgrading expectations and opportunities for improvements in engagement, quality of life, and further personal development for frail and impaired elders (see Baker 2007; Siders et al. 2006)?

This brief essay cannot, of course, even enumerate the array of other questions about the tensions of long-term care reform that confront us as scholars – questions of balancing stability and change and viable aspects of existing structures with possibly risky reforms; questions of co-optation of rhetoric and trappings of reform to make unwarranted claims of transformational success; and of sustaining celebrated and publicized change initiatives after the researchers and media crews have left.

To identify and pursue the promising questions, it is clear that a rigorous and imaginative advance in considering the maximal possibilities for elders is needed. As reformer Barry Barkan (1995) puts it, "If someone has only 3% of their functioning left, we try to make it 5%." In my view, the potential contributions of the social and behavioral sciences to understanding the realities and untapped possibilities of aging will be meaningfully advanced to the extent that we adopt a similar posture that reflects an underlying heuristic of openness.

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Chapter 41
Looking Back: My Half Century as a Sociologist of Aging and Society

Anne Foner

The 1960s do not seem to have been a propitious time to embark on a major project exploring social aspects of aging in the United States. In those days, when the baby boom cohorts were about to come of age, public attention was on young people rejecting traditional ways and in apparent revolt against those over 30 – not on aging, which was generally thought of primarily as growing old. Yet it was at that time that Matilda White Riley received a major grant from the Ford Foundation and the Russell Sage Foundation to pull together, evaluate, and analyze social science knowledge about the middle and later years. It was then, in the initial stages of the project, that I was invited to join in what turned out to be a lifelong career studying age and aging and a decades long association, collaboration, and friendship with Matilda Riley, one of the leading scholars in the field.

The sociology of age and aging as a field of study was relatively undeveloped in the 1960s, although there were important foundations. At the theoretical level, as early as 1928, Karl Mannheim ([1928] 1952) had written about the problem of generations; in the 1940s Ralph Linton (1942), Talcott Parsons (1942), and Pitirim Sorokin ([1947] 1969) had analyzed age as an element in the social structure, and in the 1960s Leonard Cain (1964) focused on the life course and social structure, and Norman Ryder (1965) called attention to successive cohorts and social change. But there was no broad conceptual scheme tying these important strands together. On a substantive level there was a substantial body of interdisciplinary research and a treasure trove of data, much of it collected by government bodies such as the US Bureau of the Census. But often these were focused on particular research objectives. At the institutional level, the field was not a specialty in many sociology departments. And the Section on Aging and the Life Course (earlier, Section on the Sociology of Aging) had yet to be established in the American Sociological Association.

In setting about tackling some of these gaps and to carry out the mission of codifying and analyzing existing knowledge about age and aging as social phenomena, Matilda Riley recruited a group of scholars, many of whose main interest had been in other fields. Matilda Riley herself had made her mark as a methodologist and had done major substantive research on social communication and adolescent–parent relationships. At the time, I was relatively new to sociology and my interests were in theory, class, and social conflict. Whatever our particular previous interests, the small group of us who did the initial spade work for what ended up as the three-volume *Aging and Society* came to the project with fresh eyes, not tied to any specific approach to understanding this key topic. On a personal level, I was returning to complete graduate study and looking ahead to entering the workforce after a hiatus devoted to family obligations – part of an early wave of women "returnees" in their 30s and 40s. Thus, in our own lives, as we broke with previous traditions about the appropriate roles for women, we exemplified an important principle: that life course patterns are subject to change.

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The first volume of *Aging and Society: An Inventory of Research Findings* (Riley and Foner 1968) involved more than collecting and organizing the existing literature on aging. It also entailed evaluating the research. In the process, the volume set forth a preliminary conceptual scheme for understanding age as an element in social structure and social change as both a process that proceeds from birth to death and a process that itself changes as each new cohort proceeds through a unique segment of history.

This scheme was further elaborated in *Aging and Society vol. 3*, *A Sociology of Age Stratification* (Riley et al. 1972), whose subtitle captured key aspects of the approach. Indeed, the term "age stratification" became synonymous with the conceptual scheme being proposed. Although heretofore the focus of much scholarly work in the field had been on the individual, the age stratification perspective also called attention to the age structure, which consists of society-wide age strata – for example, the youth, middle-aged, and older strata – existing apart from the particular individual incumbents, with rules and roles governing opportunities, attitudes, and behavior of strata "members." (Later the term "age stratification" was dropped and the approach relabeled the "Aging and Society Paradigm" in order to capture the broad range of issues not clearly suggested by the earlier title.)

Given my interest in social structure and social stratification, my own early efforts at developing the broad age stratification conceptual scheme were directed at further exploring age as a basis of social stratification. How good an analogy to social stratification in general and class structure in particular was the age stratification approach? Was there a theoretical payoff to pursuing this idea?

First, there was the issue of social inequality, a fundamental feature of social stratification. I noted that age inequalities are pervasive and they are built into the social structure. Access to social roles that are unequally rewarded with wealth, power, and prestige is governed by age criteria that persist beyond the incumbency of given individuals – in short, constituting a system of structured social inequality based on age.

Of course, age-based structures of inequality differ from class systems and other forms of social inequality in important ways, including the dynamisms of individual aging over the life course and the succession of cohorts through different periods of history. I sought to pursue the implications of both the similarities with and the differences between class- and age-based systems of inequality by addressing questions fundamental to analysis of class but often neglected in the study of age: How do advantaged or disadvantaged positions influence individual behavior and attitudes? To what extent does common social location lead to within-group solidarity and awareness? Or to conflict or interdependence with other strata?

In looking into these issues I noted that there were some parallels with class patterns and some intriguing differences. Much like class patterns in modern American society, studies conducted in the 1960s and 1970s showed that there were, for example, age differences in political and social attitudes, life style, organizational attachments, and subjective reactions to their economic status, family situation, and life in general. But as compared to class patterns, fewer of these age differences could be clearly attributed to social location in the age-based stratification system. For example, despite many deprivations, older people were more likely than those younger than they to report satisfaction with their jobs, their marriages, and life in general. To understand such apparently anomalous reactions, various hypotheses pointed to the role of dynamic age-related processes. The aging process itself, as people experience and deal with successive changes over their lifetimes, can lead older people to accommodate to new changes they undergo. Moreover, the cohorts under study may not have had high expectations for their lives in the later years because these expectations were influenced by the social environment in which they spent their formative years, an environment with lower life expectancy, poorer health, and greater economic risks for the older population than existed in the 1960s and 1970s.

Given the undoubted influence of such dynamic processes on the behavior and attitudes of older people in this period, I suggested that future cohorts of older people might not react in similar ways.

It is an open question whether subsequent cohorts of older people socialized in their youth to have relatively high expectations for their future lives will be likely to accept setbacks in old age with the equanimity that appeared to characterize the elderly born in the early twentieth century – surely a question for scholars to revisit in future times of economic troubles.

Going beyond age patterns in individual reactions to their age status a fundamental question for sociologists is the impact of social location on group life. Age as a basis of within group cohesion and intergroup relations was an issue that was particularly highlighted in the United States of the 1960s and 1970s by the collective actions of the post-World War II baby-boom cohorts. Taking off from the specific age-based struggles in those years I sought to look at the general issue of age conflicts and age solidarity (e.g., Foner 1974).

Several factors, I argued, encouraged a sense of common fate among age peers. At any one period they are likely to have many similar roles and share the satisfactions and pains of current life tasks. As they grow up and grow older they face the problems of making major role transitions at the same stages of their lives. Because they were born at the same time, they move together through and are influenced by the events of a particular slice of history. In addition, especially in highly complex and developed societies like the United States, various structural factors reinforce a sense of *we-ness*: age grading in schools, mass media programming organized to appeal to different age groups, a host of age-graded voluntary associations, age-segregated residences for many young people in their college years, and increasing numbers of retirement communities for the old.

Whether or not people of similar age do develop a degree of cohesiveness and sense of common interests has implications for relations with other strata. With the student rebellion in the 1960s and 1970s receiving much public attention at the time I was beginning to write about these issues, I wanted to explore conditions that might lead to societal-wide age conflicts.

As I noted in several essays (e.g., Foner 1974), various factors appear to trigger cleavages among the age strata. Power, status, and material inequalities endemic within age systems can motivate the disadvantaged to oppose existing arrangements. In addition, members of successive cohorts whose collective histories differ widely are likely to have divergent values and world views, life styles, and cultural tastes. When they feel they are without the institutionalized power to impose their views, the powerless – often the young – can feel impelled to challenge other age groups in order to assert their "rights."

In fact, tensions between the young, the middle-aged, and the old *are* fairly common, but these tend to play out within particular institutional spheres such as the family and the work place, and the issues at stake differ from institution to institution. Societal-wide conflicts such as the youth rebellion of the 1970s have been less frequent; when they have occurred, they have typically been initiated by the young, over "ideal" issues such as war and peace, justice for all, and social morals. I argued that such ideal issues are less susceptible to conflict-reducing mechanisms than material issues dividing age strata. In the first place, economic issues often activate class interests that create divisions within age strata and supersede age-based interests. In addition, material issues are more subject to compromise than so many struggles over ideal "all or nothing" issues. Futhermore because of the inevitability of aging, young people's discontent with their relatively poor economic status can be allayed as they look forward to future gains.

As I write in the first decade of the twenty-first century, these general principles may soon be tested. The United States is in the midst of a deep economic recession, and class divisions appear to have come to the fore as public policies are debated about how to deal with the economic crisis. At the same time, however, there is talk of coming age-based struggles among the young, middle-aged, and old over shoring up or diluting public entitlement programs such as Social Security for those 65 and over. Such predictions are not new; they were made in the 1980s, another period when the solvency of old age programs in the United States was of public concern. At that time, age-based clashes did not erupt; indeed, there were coalitions of organizations with constituents crossing age lines to save, not weaken, *Social Security* as a social program. As for the coming years, whether or

not age conflicts over age-based entitlement programs do break out across the society, the underlying issues – understanding the nature of group life and intergroup relationships among age strata – will continue to be of fundamental importance to sociologists.

My discussion of age stratum cohesiveness or interstrata conflict suggests that the age stratification analogy has had relevance for understanding key aspects of age structures. Nevertheless, exploring the applicability of the stratification paradigm points to other important themes, not clearly derived from the stratification analogy, that await in-depth analyses. In my own work I considered some of these other themes such as life course transitions, age-related aspects of the family and political life, and changing age structures.

Life course transitions, stages when individuals give up familiar roles and take on new ones, punctuate the aging process in all societies. According to long-held views, such transitions have been seen as particularly likely to be troubled in modern societies such as the United States, in contrast to smoother transitions in less complex and less developed societies. In several articles on life course transitions (e.g., Foner and Kertzer 1978), David Kertzer (an anthropologist) and I showed that these ideas did not hold up in a particular case, a comparison of life course transitions in the United States with those in 21 African age-set societies, a group of preliterate, small-scale societies where age is a major organizing principle. Despite the vastly different societal contexts, in both settings, transitions were associated with tensions for the individual. At the same time, in both contexts there were mechanisms – although particular to each environment – that served to ease some of these difficulties. We also found that as both individuals and societies adapted to transitional problems and to social and environmental transformations, the transition processes themselves were subject to change.

Turning from these general conclusions to a specific and major life course transition – retirement – Karen Schwab and I examined the retirement process in the contemporary United States, dealing with issues on the individual level as well as societal-wide problems associated with retirement (Foner and Schwab 1981). Our analysis was consistent with the general principles noted above: that the retirement process involves an interplay between the individual and the society and that this interplay is likely to put a new face on the process and provide new challenges in the future.

The theme of social change also runs through much of my other work. For example, my articles dealing with intergenerational relations in the family noted the continuing vitality of intergenerational connections. They also discussed the ways these relationships have changed historically, as when independent living among older people became the norm. In writing about age-related aspects of political life, I took note of the influence of succeeding cohorts on political events. As each new cohort experiences and deals with a unique economic, social, and political environment, its members often react with a new "take" on political affairs and help to influence new political alignments in the society.

More generally, I suggested that age structures are subject to change both from forces outside the age systems – such as the creation of a national old age pension program that helped provide the means for older people to establish new patterns of residential independence – and forces intrinsic to the age system – such as new norms reflecting values and world views introduced by succeeding cohorts. In addition, I proposed that there was frequently a tension between the structure of the age system and the continual flow of new cohorts into that system. For if the existing norms governing an age system are not appropriate for oncoming cohorts of different size or composition, there is often a push for change in these norms.

In short, while we may not be able to predict the exact nature of change in age systems, transformations are inevitable. This leads to a few final words about future work in the field. For students of age and aging as social phenomena there will be opportunities to reexamine "old" issues under changed circumstances as well as discover new developments for a research agenda. While our studies must deal with the particulars at hand, our full understanding of age and aging will be enhanced as scholars try to extract and articulate the general principles underlying these analyses. And in so doing they will be contributing also to sociological theory in general.

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Chapter 42
As Time Goes By: Gerontological and Life Course Musings

Linda K. George

When I was a senior in high school, everyone in my class was asked to submit his or her aspiration, to be printed under our pictures in the year book. While my classmates were submitting such aspirations as "work for a tire company," "be a beautician," and "drive a truck," I submitted the ambition "to be happy." Mrs. Ludwig, the English teacher supervising the year book, said that my aspiration was "unsuitable" and told me to come up with an acceptable alternative. But I was not to be dissuaded and this can be verified by looking at the 1965 Highland High School year book where, under my smiling picture, are the words "to be happy." I had no inkling then that I would spend about equal portions of my life course being happy and studying happiness.

During both undergraduate and graduate school, one topic of lively intellectual debate revolved around questions of whether older adults are typically satisfied with their lives and, if so, what life circumstances underlie happiness in later life. Disengagement theory (Cumming and Henry 1961) was well-established and posited that the key to a comfortable old age was to give up the roles that had structured life earlier in adulthood and to live in a smaller, less demanding world. By the time that I was in graduate school, disengagement theory was under attack on multiple fronts. George Maddox, who was one of my primary graduate school mentors, used longitudinal data from the Duke University Normal Aging Study to demonstrate that the strongest predictors of life satisfaction in later life were such high levels of social activities as spending informal time with others and participating in organizations (Maddox and Douglas 1974). Research by my undergraduate mentor, Robert Atchley, generally supported the conclusion that high levels of social engagement were the foundations of life satisfaction in later life. Atchley added the proviso, however, that the activities that promoted well-being in later life were those that reinforced pre-existing identities and emotional commitments – a perspective that he labeled continuity theory (Atchley 1989). By the mid-1970s, ground-breaking empirical data based on a representative sample of American adults documented that not only were the vast majority of older adults satisfied with their lives, they were more satisfied with their lives than young and middle-aged adults (Campbell et al. 1976).

These debates had repercussions for the field of aging far beyond specific questions about the extent to which later life is satisfying versus dissatisfying or happy versus unhappy. Before these debates, a "crisis orientation" characterized the field – a sense that older adults were a semi-invisible minority group who were systematically, if perhaps inadvertently, barred from the rewards due to them in an affluent society. And on purely objective grounds, a case could be made for that perspective. During the 1960s and first half of the 1970s, older adults were more likely to live in poverty, lack access to medical care, have disabling illnesses, and report being socially isolated than young and middle-aged adults. Research on life satisfaction among older adults did not challenge these

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objective facts, but it did challenge – indeed, debunk – the notion that these deprivations severely compromised perceptions of life quality.

The objective life conditions of old age began to improve substantially by the end of the 1970s. Legislation was passed that guaranteed cost-of-living adjustments to Social Security benefits. The first cohorts in which large proportions of members had private pensions – and most were defined-benefit pensions – transitioned into later life. As a result of these changes, within a decade the elderly moved from being the most likely age group to live in poverty to being the least likely to do so. Though initiated in the 1960s, it was not until a decade later that Medicare's contributions to promoting the health and well-being of older citizens became visible. Improved medical technology also disproportionately benefited older adults. It was in the mid to late 1970s that CT scans first allowed physicians to distinguish between strokes caused by blockages and those caused by bleeding in the brain – a critical distinction because one required thinning the blood and the other required clotting it. At this time, a variety of interventions, including bypass surgery, stents, and pacemakers also became routine weapons against cardiovascular disease, the largest cause of death for older adults. In addition to improvements in income security and medical care, new cohorts entered late life better off in education, health, wealth, and social resources than their predecessors.

As a result of all these changes, the crisis orientation that had been the foundation of aging theory and research in the social and behavioral sciences became difficult to justify. Indeed, by the 1980s, public discourse included references to older adults as "greedy geezers," and inaccurate but nonetheless fervent predictions of large-scale intergenerational battles in which economically strapped young and middle-aged adults revolted against older adults who spent their time in luxurious leisure were rampant. Although the "greedy geezer" image was obviously inaccurate, it was clear that traditional stereotypes of older adults as poor, needy, and disabled were too. But I believed then – and still do – that the aging field lost much of its vigor, integration, and sense of purpose once it was clear that most older adults are not "underdogs."

Beginning in the late 1970s, subjective well-being (SWB) became the "umbrella term" used to denote positive orientations toward life (i.e., life satisfaction, happiness, and morale). A prominent theme that characterized research on SWB from the late 1970s through the end of the century involved questions about the extent to which SWB rests on objective life conditions. As would be expected, strong and significant relationships between objective life conditions – including education, income, being married, friendships, and health – and SWB were observed. The surprising finding, however, was that objective life conditions explained less than half the variation in SWB. That is, mismatches between objective indicators of life quality and subjective assessments of life quality were exceedingly common. Many individuals who were relatively deprived of the objectively good things in life reported high levels of SWB and, conversely, many people who seemed on objective grounds to be advantaged reported low SWB. My contribution to this body of research was to demonstrate that the relationships between objective life conditions and SWB were smaller for older adults than they were for young and middle-aged adults (George et al. 1985). In short, older adults were less dependent on health, wealth, and social relationships for happiness and life satisfaction than were their younger counterparts.

A second, and related, theme of research on SWB at this time was the search for explanations that could account for the frequent mismatches between individuals' levels of objective resources and their SWB. The primary theory that emerged to account for these mismatches was *aspiration theory*. The basic tenet of aspiration theory is that people report that their lives are satisfying and of high quality when the discrepancy between their aspirations and their achievements is small. Conversely, when the discrepancy between individuals' aspirations and achievements is large, they view their lives as less rewarding and satisfying. Thus, we would expect financially advantaged, healthy, socially connected persons to be unhappy or dissatisfied when they aspire to even higher levels of the "good things" in life. And relatively disadvantaged persons should report high levels of SWB if their aspirations are met.

Aspiration theory received strong support in multiple studies. I was able to show that older adults (1) had, on average, smaller discrepancies between their aspirations and achievements than young and middle-aged adults, (2) had generally lower aspirations than young and middle-aged adults, (3) but were not advantaged, relative to their younger counterparts, on objective resources. Indeed, older adults reported the lowest levels of education and, especially, health. With regard to marital status (i.e., being married) and income, older adults scored approximately equal to young adults and significantly lower than middle-aged adults (George 1992).

Although it received less attention, *equity theory* also appears to partially explain mismatches between objective life conditions and SWB, especially for older adults. In brief, equity theory posits that individuals will be satisfied with the rewards that they receive if they perceive that the distribution of rewards is fair. I was able to show that the perceived fairness by which economic rewards (income and wealth) are distributed was a significant predictor of SWB for older adults but was non-significant for young and middle-aged adults (George 1992).

Social comparisons also help explain the high levels of SWB among older adults, many of whom are not socially or economically advantaged. The basic tenet of *social comparison theory* is that we evaluate our own qualities and status by comparing ourselves to relevant others. In general, *upward comparisons*, in which we compare ourselves to those who are more advantaged than we are, generate relatively low levels of satisfaction. In contrast, *downward comparisons*, in which we compare ourselves to those who are less advantaged, promote a sense of satisfaction. A number of researchers reported that most older adults use downward comparisons, thus promoting SWB.

I interpreted the support of these theories as demonstrating the power of social–psychological processes to produce either the sense that life is satisfying or feelings of dissatisfaction – and these processes are at least as strong as objective life conditions. These findings also suggest that the capacity of older adults to establish aspirations that are closely linked to their achievements, to perceive the distribution of societal resources as fair, and to compare themselves to those who are less advantaged are tremendously adaptive, permitting them to sustain a sense of SWB despite loss of resources and age-related limits on their ability to increase their achievements.

The publication of *Children of the Great Depression* by Glen Elder in 1974 introduced the life course perspective and opened a new era of theory and research on aging. As described there, as well as in subsequent writings by Elder and others, the life course perspective rests on four primary propositions. First, and probably most important, the life course perspective rests on the assumption that lives unfold over time – that to understand the present, one must understand the past. Consequently, a requisite for life course research is longitudinal data covering long periods of time. Second, the life course perspective focuses on the intersection of history and personal biography – that is, the ways that historical conditions shape life course trajectories, providing unique opportunities for and constraints upon human actors. Third, the life course perspective pays attention to human agency – to the consequences of individual decisions. Social determinism certainly is not ignored by life course researchers, but it is balanced by a focus on human agency. Fourth, and finally, the life course perspective focuses on linked lives – on ways an individual's life course is intertwined with those of others.

I believe that the life course perspective energized aging research in a way that we had not seen since the demise of the crisis orientation. It provided a paradigm that is broadly applicable, regardless of the specific outcomes of interest. It is as applicable, for example, to health outcomes as to economic outcomes. The life course perspective also focuses on heterogeneity and recognizes the myriad of pathways that can lead to the same (or different) outcomes. Failure to acknowledge and investigate heterogeneity was perhaps the fatal flaw of the crisis orientation. By promoting images of older adults as poor, sick, and socially isolated, the crisis orientation failed to recognize the heterogeneity of late life – heterogeneity that recent theories, such as cumulative advantage theory, and research results demonstrate to be greater in late life than at earlier ages. When, as a result of social change, the crisis orientation described fewer and fewer older adults, it was certain to be reputed.

There are still, of course, older adults who are poor, sick, and/or socially isolated. The life course perspective, however, highlights the fact that this is just one of the many destinations observed in later life.

Empirically applying the life course perspective is methodologically demanding. Longitudinal data are required that span large proportions of the life course. Although the number and quality of data sources suitable to life course analysis have grown exponentially in the last decade or so, a number of topics have not been examined from a life course perspective because of lack of sufficient data. SWB is one such topic. A few studies have predicted SWB in late life using information collected at earlier points in time. None of these, however, have addressed fundamental issues about SWB across the life course, including the dynamics of SWB over time. I hypothesize, for example, that one common trajectory of SWB – probably the most common one – is increasing SWB as individuals move from young adulthood to middle-age to later life. Cross-sectional studies suggest this kind of aging effect, but they inevitably confound age changes with cohort differences. I also hypothesize that aspirations in multiple life domains – health, income, and amount of social contact – decline from middle-aged to late life. Again, this hypothesis is supported by cross-sectional research findings, but it is unclear whether this pattern is observed over time as individuals age.

Beyond the methodological issues involved in distinguishing between age changes and cohort differences, there are logical reasons for suspecting that cohort differences account for at least part of the age differences observed in cross-sectional data. Because succeeding cohorts have consistently entered old age (as it is conventionally defined) in better health, and with more education, wealth, and social resources than their predecessors, it is possible that these "resource-rich" cohorts will be less willing – or have less need – to lower their aspirations. Rather than not declining at all, however, it is likely that these cohorts will reduce their aspirations at later ages than earlier cohorts.

It is also possible that the Baby Boomers will behave differently from earlier cohorts. Although research evidence is scant and inconsistent, public discourse and the popular media claim that Baby Boomers will be more active and have higher expectations for their later years than earlier cohorts. If this proves to be true, it is possible that we also will observe a decline in SWB among Baby Boomers as they reach their late 70s and beyond, as age-related losses inevitably occur.

I believe that life course research requires multiple observations of the *same* individuals over long periods of time – in other words, true panel data. Although we lack suitable panel data for life course studies of SWB, some authors have used repeated cross-sectional data to approximate the "natural histories" of cohorts. Such analyses are very useful for understanding the "average" behavior of a cohort. They cannot, however, reveal the heterogeneous ways that lives unfold over time. Nonetheless a recent study of SWB in the US adult population, based on repeated cross sections over more than 30 years, provides a rich description of the average effects of age and cohort on SWB.

Yang (2008) used data from the General Social Survey to perform an age-period-cohort (APC) analysis of happiness among representative samples of US adults from 1972 to 2004. Yang also used a new methodology for APC analysis. Using this analytic technique, age effects are estimated with cohort effects statistically controlled and vice-versa. Yang observed age effects over the 32 years of data that mirrored those reported in cross-sectional studies: increasing happiness over the life course. There were significant cohort effects as well, with the Baby Boomers reporting lower levels of happiness at all ages than the cohorts that precede and follow them.

SWB also is now accepted by social indicators researchers as a valid indicator of the extent to which societies meet the needs of their members (Veenhoven 2009). Researchers in that field recognize that there are subjective as well as objective bases for individuals' reports of SWB and that these reports reflect comparisons to both absolute and relative standards of what constitutes the "good life." Although I continue to await the long-term panel study that will permit examination of the multiple trajectories of SWB over the life course, there is ample evidence that older adults in the USA are highly satisfied with the quality of their lives.

And what about my youthful ambition to be happy? Well, overall I am. I've had some pretty tough obstacles to get past, but so do we all. I also seem to be taking the path that research suggests. As I approach the conventional definition of late life, I am more satisfied than I can remember being at any other time of my life. With regard to aspirations, I'm not sure whether they have declined or simply become largely irrelevant. I just don't spend any time these days comparing my professional accomplishments or personal life to other people's or to some abstract notion of what constitutes "making it." I still have goals, of course, but they tend to be short-term goals about things such as finishing a paper, shampooing my carpet, or weeding my garden. I'm almost ready to believe that these really are "golden years."

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Chapter 43
Studying Age Across Borders

Gunhild O. Hagestad

Life Travels

When I was approached about writing this piece, there was talk of a "senior in the field." My first reaction was, "A senior? *Me*?" There are two bases for my puzzlement. The first is an experience many of us share: problems with accepting and internalizing such labels as "old, elderly, senior." A few years ago, I was in a long security line at an airport. People were tense, worried about missing their flights. A security officer was trying to speed up things and loudly announced, "The shoes coming through on the belt belong to the elderly woman." I looked around, but saw no older woman! I would like to believe that today I would respond differently. But reality is that it takes a while to live with such labels. We are not ready to become *geronts*, presumably the objects of gerontology. I return to that topic below.

A quite different side to my reaction was that I do not see myself as a senior in the field. I do not feel like a giant on whose shoulders others can stand, to paraphrase Robert Merton a bit. One key reason for this feeling is that I have been fortunate enough to know true giants, trailblazers in the study of age and aging. Some of them are no longer among us, but their work is very much alive. The list shows how fortunate I have been: Paul Baltes, Leonard Cain, Henning Friis, Bill Henry, Peter Laslett, Powell Lawton, Ursula Lehr, George Maddox, Bernice Neugarten, Michel Philibert, Matilda Riley, Leopold Rosenmayr, Irv Rosow, Warner Schaie, Ethel Shanas, Gordon Streib, and Hans Thomae. As the reader will notice, the list includes primarily psychologists, some sociologists, a philosopher (Philibert) and a historian/journalist (Laslett).

Among the people I mentioned, I worked most closely with Bernice Neugarten. She hired me in 1972 when she was head of the University of Chicago's Committee on Human Development. After studying sociology at the University of Oslo and the University of Minnesota, this was my first regular academic job.

As a student in Norway, I was interested in social change, but I also discovered George Herbert Mead! In the Twin Cities, I had several professors with a strong "symbolic interaction" perspective, among them Arnold Rose. As part of my doctoral work at the University of Minnesota, I did a minor in philosophy. Courses on pragmatism helped further my understanding of Mead and his circle. Thus, I got extensive discussion of *meaning*, its social production and reproduction. Since my minor was in the philosophy of science, I also became acquainted with two powerful scholars, May Brodbeck and Herbert Feigl. Both had spent a good deal of time pondering the issue of *levels* and units of analysis in science.

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My graduate courses did not teach me much about age and aging. After arriving at the University of Chicago, I had a pretty steep learning curve and was very pleased when a chapter on Age and the Life Course, coauthored with Bernice, appeared in the 1976 edition of *Handbook of Aging and the Social Sciences.* There was a lot to cover because so much had happened from the mid-1960s to the mid-1970s. A major, comparative study of aging in three industrial societies appeared in 1968. The international group of authors, led by Ethel Shanas, stated quite clearly that social *integration versus segregation* was the key issue facing the sociology of aging. Between 1968 and 1972, Matilda Riley and her colleagues published landmark volumes on *Aging and Society,* summarizing existing knowledge and presenting a model of age stratification. Age was here linked to social differentiation and the division of labor. The 1970s also marked the start of Glen Elder's groundbreaking work on the life course. By 1980, it was clearly time for ASA to have a section on aging. But it took until the late 1990s to add the life course to the name!

One scholar who, in my view, has not been given enough attention within sociological discussions of age is Leonard Cain. His 1964 chapter on life course and social structure in the *Handbook of Modern Sociology* was a pioneering overview of issues which have continued to challenge students of life course and age stratification. Already in 1959 he wrote a state-of-the-art article on the sociology of aging, covering work from several countries. Here, he made the somewhat prophetic statement that "ameliorative gerontology" might overpower theoretical sociology!

What was Bernice's disciplinary anchor? Throughout her professional life, she belonged to APA as well as ASA. Her research topics spanned from personality to age norms to policies for aging societies. For her doctoral work at the University of Chicago, her adviser was Lloyd Warner, famous for his work on inequality, but also a student of age classes and age sets. My impression was, however, that although she had worked closely with a scholar focused on social systems, Bernice anchored much of her thinking in individuals and their personal experiences. Towards the end of her career, she would often comment on presentations by asking, "Where is *the person* here?" There were times when I wanted to pose a corresponding question: "Where is *the society* here?"

In the villa that houses Human Development, there were many intense scholarly discussions. Nearly always, someone would suggest that we try to move up a notch in the level of abstraction: "What is the bigger question here?" A thoughtful, widely traveled colleague, anthropologist Robert Le Vine, always placed the meanings of age in a broad comparative context. As Ralph Linton did in the 1940s, Bob also reminded us that men and women have different life scripts. He also stressed the degree of individualism/collectivism in different societies. So did another anthropologist who came to visit from the University of Illinois: David Plath. He used Japan as his main basis of comparison and in the process gave us new insights on lives in our own society. His beautifully written book *Long Engagements* deserves to be a classic. Another person who came to visit, offering important *diachronic* comparisons, was historian Tamara Hareven, who later spent considerable time in Japan. She highlighted the need to consider time dimensions on three levels: individual, family, and history. Glen Elder spent time in Human Development when he was trying to finish "the book," juggling lots of information about individual development, family, and historical context. *Children of the Great Depression* appeared in 1974. To me, the greatest contribution of that classic volume will always be its powerful illustrations of how levels matter and must be taken into account. Within the context of a national economic crisis, the financial stability or instability of *families* made the difference in determining future lives of children and youth. The lesson is that the meso-level of family functions as a "lens" between history and individual lives. Consequently, cohort contrasts entail intracohort differentiation. In some cases, the lens intensifies effects of historical circumstances; in other cases, it deflates and minimizes historical impact.

Ever since I first heard Glen talk about his book, I have wondered about *personal meaning* and historical change. If people are "carriers" of marked cohort effects which show up when we follow them across time, are they themselves aware of it? Is it part of their life story? I kept going back to Karl Mannheim's essay on generations, in which he argued that true generational units have

generational awareness – a sense of their "location" that they have in common. But then there was a conversation, many years ago, with life course researcher Karl Ulrich Mayer, who has provided striking examples of how history left footprints in the lives of German cohorts. He also has authored articles on how states structure life course patterns, showing policy shifts change lives. When I raised the awareness issue with him, Uli responded, "Gunhild, that is for psychologists to ponder; *we* are sociologists!"

Differences between psychological and sociological eyes; micro- versus macro views also marked ongoing discussions in my next place of work, the Department of Individual and Family Studies at Pennsylvania State University. I joined the interdisciplinary faculty in the late 1970s. Again, I was privileged to be around scholars who helped define the field of aging research: Paul Baltes, John Nesselroade and K. Warner Schaie, a significant triumvirate in laying conceptual and methodological foundations for the study of adulthood from a life span perspective. Paul was head of the department. He later became the director of the Max Planck Institute for Human Development in Berlin. We shared the experience of being "bi-continental," which has both positive and negative aspects. While belonging in two places represents a strength, it also raises issues of marginality. I believe we both experienced being seen as quite European when in the United States and quite American when in Europe. For me personally, it has always been difficult to understand and accept that many of my American colleagues do not seem to be familiar with relevant and important European research, even though it is readily available in English.

As is well-known, Warner Schaie was among the first to seriously address the age-period-cohort conundrum in the study of development. It might be the lenses of a sociologist again, but I detected a shift in his thinking over the years. As a psychologist, he initially seemed to think of cohort effects as bothersome "noise" messing up our understanding of "pure development," especially in the cognitive domain. Over the years, he admitted that the noise might actually be the most interesting thing to focus on!

After nearly a decade at Penn state, I moved back to the Chicago area, taking a position in a program founded by Bernice: Human Development and Social Policy at Northwestern University. At that time, I became truly bicontinental, dividing my year between Northwestern and the Institute for Social Research in Oslo. For a sociologist, a focus on connections between structural conditions and lives offered exciting possibilities, but most of my colleagues were psychologists. My main conversation partner was Fay Cook, who was deeply engaged in issues related to aging, posing research questions about political debates and policy issues. She later served as president of the Gerontological Society of America.

My life was profoundly changed by a cancer diagnosis in 1993. The illness put me totally "out of commission" for a year and a half, an experience I have described as *falling out of time*. Because long-term effects of treatment and a systemic infection greatly reduced my work capacity for nearly a decade, I decided to take early retirement in 2004. Since then, new medical intervention increased my energy and optimism, allowing me to go back to research and writing, as well as some teaching. I have collaborated with colleagues in the United States and a number of other countries. There have also been some intense, interesting meetings organized by the United Nations. The biggest marker for my "second chance" was an invitation to deliver a keynote address for the UN International Year of Older Persons. I was asked to reflect on the theme of the year: *Towards a Society for All Ages*. Work on the speech rekindled my interest in issues of age segregation. I was reminded of how I read the 1968 book by Shanas and her coauthors with excitement and optimism. Thinking about it 30 years later made me discouraged, but collaboration with Peter Uhlenberg has helped me move further in my thinking about age segregation and integration in some papers we have written together. Very few sociologists have actually addressed these issues. There was a major work by Irv Rosow, published in 1967, which did not get the attention it deserved. Was he too gerontological for the sociologists and too sociological for the gerontologists? Why do we have so few contemporary scholars who use aging as a domain for raising core sociological questions? Has the study of

aging helped make sociology wiser? Or is "ameliorative gerontology" still a risk, as Cain saw it 50 years ago? I must admit that when I read GSA journals, there is very little that tickles my sociological imagination!

In a speech delivered in early 1994, Bernice said, "I am greatly tempted to predict that the field of gerontology is going to disappear over the next couple of decades." Why did she make this prediction? And why does it seem that it was false? She argued that we have come to realize that aging is a lifelong process and lives are indivisible. Furthermore, as she put it, "need without age must override age without need" in policies and programs. Quite different age groups, she argued, have similar needs. Recently, this latter argument has been voiced by several of us, for instance in pointing to communalities between our youngest and our oldest.

A realistic view of current political debates and social planning could easily make us pessimistic. Across countries, there seems to be a hegemonic paradigm for discussing old age, one emphasizing dependency, needs, and burden. Recently, I had a strong impression of ruling paradigms when I participated in a working conference funded by the EU. Although my subgroup had been asked to discuss old people as care providers, it was nearly impossible to get people in the group to think of examples of old people providing care, to consider care other than physical care, or to admit that care provision is not always a source of stress. I came away with a strong discomfort about how research position, clout, and funding may require buying into – and thereby reproducing – a construction of aging that we know to be fundamentally flawed. I keep coming back to French sociologist Pierre Bordieu's reminder: We must never forget that we are engaged in a battle over common sense!

Now I am back to the point where I started, the *geronts*. As I get older, I am increasingly struck by how much "othering" is going on, even in scholarly discussions. It is both comical and sad to see a group of gerontologists, all well over 60, *talk about them* – the old. We talk as if we concur with Mary Pipher, who calls old age "a different country," a place where *we* do not reside. Would we make more progress if we said *we* and *us?*

I have tried to briefly sketch how thinking about age has been a part of my academic life across phases of my adulthood, starting as a mother in her 30s, through my middle years, to my current life as an older person and a grandmother of two rapidly developing grandchildren (who really want me to finish this piece so that I can join them on a long hike and even some bouldering!). Over those years, I have had extremely rich opportunities for learning. What is my hope for the future? That the study of age and aging can cross borders – across national research communities, across levels of human contexts, and across life phases.

For members of my own generation of sociologists, I wish a rich dialogue about our own aging, our own understanding of networks across age boundaries, in different cultures and in contrasting policy contexts.

Chapter 44
Living the Gendered Life Course in Time and Space

Phyllis Moen

I have always been interested in the life course, with age performing as a social marker related to the time and timing of events. My father's tales about the Great Depression were stories about the way historical and biographical events shape life chances and life quality depending on when they occur. (In his mid-20s, he had worked for years to save money to go to college and lost it all. But he then found a sense of purpose as a soldier in the Second World War.) My own life too has been a study of transitions and timing in context. I was widowed at age 32 and recoiled in horror when 70- or 80-something women would come up and hug me and say they were widows, too. I knew our age difference made me not "like them" but couldn't really formulate that notion until as a graduate student I read work by Bernice Neugarten. I never met Bernice, but her insights into time and timing norms became a key theme in my own work.

Going back to school as a young widow in the 1970s underscored this lesson. I was only 32, but life experience (two daughters and a husband who had passed away from cancer) made me feel out of sync with fellow graduate students even though the age difference was not as large as I felt it to be. Graduate school in the 1970s also brought the historical period, and especially the Women's Movement, into sharp relief. I was refused a credit card – and asked why. Specifically, I asked was it because I was a single parent? A woman? A widow? A graduate student? They gave me the credit card.

I learned about the life course as a subject of study when graduate students in the Family Development Center at the University of Minnesota read *Children of the Great Depression*. I was so impressed by the book that I lobbied to have Glen Elder invited to come give a talk. I picked him up at the airport but didn't recognize him as the person I came to meet. I told him that he was much younger than I had expected. This was in 1977 or 1978. He asked why. Was it because of his name, "Elder"? I said no, it was because he seemed so young to have written such an important book.

I drove Glen in my pickup to Reuben Hill's house for a party and got lost. This turned out to be great because I used the time to talk to and learn from him. I think he must have thought I was a bit of a crazy driver in my (late) husband's pickup and with no knowledge of Minneapolis streets. I was fortunate enough to share time with Glen at Cornell University in 1979. Even though he was my colleague then, I still sat in on his graduate classes, still learned much from him, and have continued to learn from his work.

Another Cornell colleague, Robin M. Williams, Jr. and my "first" graduate student, Donna Dempster-McClain, led me to the sociology of aging, but quite unwittingly. Donna was taking a class from Robin, where he mentioned a never-studied survey he had undertaken many years back, in 1956, on women's roles in Elmira, New York (less than an hour from Ithaca, where Cornell is

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located). Donna was intent on recapturing and doing something with Robin's data, as a now historical investigation of women's lives before the Women's Movement. Somehow, we got it into our heads that we would find these women and reinterview them 30 years later.

At first we couldn't get funding because people thought we would never find these women. Then our team (Donna, I, Dikkie Schoggen, and Melanie Miller) set out to prove them wrong. Melanie Miller was a young graduate student, and looked like someone's granddaughter or daughter as she knocked on doors in Elmira, asking about women who had lived there 30 years earlier. Neighbors helped. The town's historical records helped. Trips to view gravestones in the cemetery helped. (Remember there was no internet then, this was all done laboriously.) But we *found* them – all but two.

We wrote and received funding for a proposal to reinterview these women who were young mothers in the middle of the 1950s and their (now adult) daughters. Reading and working with the 1956 data had kept us thinking about them as they were in their twenties and thirties. When we went to interview the mothers, we found, to our amazement, that they were old – 30 years older than when interviewed the first time. And that is how I got interested in aging. But I always thought of them (and other older people I have studied) as young adults who have grown older.

In fact, I wasn't interested in old people. I was interested in how these Elmira women's lives played out over a 30-year period. And I continue in thinking of older people as people who have grown older, not as a separate category of "elders," the "aged," or the "young-old" or the "old old." This put me at odds with what was much of gerontology in the 1980s and 1990s. But it contributed to my interest in the sociology of age and the life course. And I am happy to report that gerontology has changed to become more "life coursey" over the years.

On the other side of the spectrum were my colleagues in human development (I had a joint appointment in human development and in sociology at Cornell), who saw "age" as going from zero to six, or at most to eighteen. I had a hard time getting students interested in what I was increasingly interested in – adults at all ages and stages. It helped that I studied women, since most women were mothers and, hence, were "mothering" some child at some point in their life course. I was ecstatic when Karl Pillemer and Elaine Wethington came to Cornell. We started the Cornell Gerontology Institute as a Roybal Center, and studied the second half of the life course in earnest.

Matilda White Riley was another pivotal force in my education in aging and the life course. Her ideas about structural lag permeated all of my work. But it was also her personality that touched my life. Watching her as the head of the ASA section on Aging and the Life Course, as a senior scientist at the NIH, was a wonderful chance to see age integration as she studied and lived it. My own enthusiasm for the research process – and belief in the importance of this topic – was reinforced by Matilda. The significance of what we do was also a lesson learned from Linda George over the years. And Martin Kohli's inspired work on the institutionalization of the lock-step life course into a tripartite of first education, then a lifetime of continuous, full-time paid work, then punctuated by continuous leisure in retirement, became key to my own thinking, since it so obviously excluded women's diverse and very contingent experiences.

Urie Bronfenbrenner always said that "we are the people in our lives." I couldn't agree more. Urie was another moving force in shaping my intellectual thinking, as he began to incorporate time and the life course into his ecology of human development approach, and I, influenced by him, attended ever more to the multilayered ecological contexts of lives.

I have been fortunate that my own biographical and intellectual journey has occurred in tandem with the development of the aging and life course field. Glen Elder has been a prime actor in moving the life course to center stage in the study of lives, highlighting historical events as potential turning points and introducing such important concepts as "linked lives" and "life course dynamics" in the

form of interlocking transitions and trajectories. Bernice Neugarten played a key role in specifying the normative temporal contexts of behavior and decision-making, with her focus on being "on" or "off" time in one's actions. (I, for example, got married at age 18, which was "on" time in the South in the early 1960s, but appallingly early from the vantage point of contemporary norms.) And Matilda Riley along with Martin Kohli supplied the policy contexts of the life course, even as Linda George contributed important insights in role theory and subjective meaning throughout the life course, and Urie Bronfenbrenner emphasized the developing individual embedded in multiple ecologies.

Where will the field move in the future? This is an exciting time to study aging and the life course, given the striking demographic changes, medical and technological advances, labor market, and economic dislocations converging to shape lives in new and unexpected ways. Suddenly age and the life course are high on both research and policy agendas, as the boomers move into their 50s and 60s and nations recognize the mismatch (structural lag) between existing policies and practices and emergent realities of an aging workforce, an aging society, a growing retired force – all overlaid by disparities along the fault lines of gender, race and ethnicity, occupation, and education.

Married women's movement into the workforce was the "story" of the last half of the twentieth century, bringing into sharp relief the need to study women's as well as men's life course paths. The "story" of the first half of twenty-first century will be the aging of the population and what it means for the care of infirm family members and assistance to the next generation, the (very probably multiple) retirement passages of men, women, and couples and the restructuring of retirement as we know it, and the health and well-being of adults in the second half of the life course. This is further problematizing the taken-for-granted lock-step (what I call the career and retirement mystiques), institutionalized based on the experiences of middle-class or unionized blue-collar male breadwinners with full-time homemaking wives in the middle of the last century and perpetuating a gendered life course.

The challenge for scholars is nothing less than to capture contemporary patterns of lives as they play out in distinctive ways over time and in multilayered contexts. We don't know, for example, whether the existing evidence on retirement (based on prior cohorts) applies to those now confronting this status passage and doing so on a moving platform of risk and change. As I write this, I am spending a month as a visiting professor at the Social Science Research Institute (WZB) in Berlin, which points to the importance of comparative cross-cultural analysis. By documenting a range of patterned experiences and expectations and their impacts, scholars can illuminate the complexity and the varieties of the contemporary life course, including the importance of cultural and regulatory contexts.

Moving to the University of Minnesota in 2003 after many years at Cornell opened up an opportunity to study (with Erin Kelly) actual changes taking place in the way work is accomplished in organizations, underscoring the importance of the normative clockworks of work (and retirement) as taken-for-granted, even invisible, forms of structural lag. Studying the links between policies and practices (and changes in them) and their impacts in shaping life courses is important future work. Another promising avenue of work is investigating time allocations by men and women at different points in their life course. By pursuing these and other fruitful research directions, scholars can also assist policymakers in the fashioning of structures conducive to multiple alternative pathways to gender and other forms of equality, as well as to optimal health and life quality at all ages and life stages.

Part XI
The Future of the Sociology of Aging

Chapter 45
Sociology of Aging in the Decade Ahead

Jacqueline L. Angel and Richard A. Settersten, Jr.

As the chapters of the *Handbook of Sociology of Aging* have shown, many remarkable and ground-breaking strides have been made in the field over the past 30 years. The histories and current state of scholarship in each of the topics represented in the handbook provide a solid foundation on which to build future research agendas. In this final chapter, we identify some of the most provocative or pressing topics that might be nurtured in the decade ahead and how sociology can play a role in understanding them.

We have chosen some because they have great social import and others because they show great promise for advancing theories, methods, and data. We begin with issues that seem relatively universal in their potential or their challenge, widely shared by people and governments around the world. These include the need for physical care and housing, issues related to financial support and inheritance, and the new reality of diverse family forms and networks. As the chapter progresses, we touch on other important issues that apply to more specific groups of individuals, families, or cohorts. Of course, the topics we cover throughout the chapter represent only a limited number of many possibilities and, for each, our comments are necessarily brief. It is our aim to simply turn attention to them. In addition, the significance of some of these topics may not now be immediately apparent but seem certain to emerge in the future.

Who Will Care For Older People and How

The physical environment and conditions of life affect the pace at which individuals and populations age. These are, of course, profoundly affected by social factors (e.g., social class, behaviors, and networks) and require social institutions to address them. But in developing and highly developed societies alike, it is within the context of families that the care of needy family members is negotiated, and it is here that commitments to providing care, especially at home, will be sorely tested in the coming years.

The challenges of family life and care in the later years raises difficult but important questions about the expectations and responsibilities of siblings, children, grandchildren, and other relationships in a "post-traditional" society. The concept of a post-traditional world refers to a new social order, one in which rapid social change and modernization have left people with more choices and

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fewer constraints on their lives – but also with more risks, as the choices they make are perceived to be of their own making and there are fewer safety nets to protect them. Unlike traditional societies, in which values, practices, and social institutions more heavily structure opportunities and decisions, post-traditional societies lack well-established social norms and rules for expectations and obligations and, consequently, place greater emphasis on individual action and choices.

The freedoms of a post-traditional society have in part created the extraordinary breadth in family forms that exists today. But we know little about what the strengths and vulnerabilities of these family forms means for the aging of their members, or what normative expectations and obligations their members have for giving and receiving care. Traditional definitions of family, especially the two-parent nuclear family, have become outdated in the face of a wide variety of family or family-like forms and relationships. This variety is driven by many factors, including multiple divorces and remarriages across generations, multi-partner fertility and nonmarital fertility, nontraditional partnerships, the co-survival of multiple generations over many decades, and the presence of four and even five generations at any single moment in family life. The growing physical distance from immediate family members also creates role ambiguities about filial obligations and consequently strains support systems. Together, these and other changes might lead us to envision societies that are relatively kinless, for lack of a better phrase, characterized by fragmented or superficial family ties and limited or uncertain support to family members in the face of poor health, economic distress, and other needs. Of course, we might equally envision that the kin and kin-like relationships that are actively chosen and voluntarily nurtured within these very same conditions might be stronger and more meaningful than those in more traditional societies. Either way, it is unclear how these new or complex configurations of relationships are supposed to function or feel, and who is responsible to whom and for what.

Such role ambiguity, for example, may carry significant consequences for the quality of relationships as family members grow old. Who should provide care, or is expected to provide care, when family relationships are tenuous or fragile – and even when they are not? Curiously, we lack rigorous multi-method studies about how adult children and aging parents make decisions regarding health care, living arrangements, and financial management. Many factors clearly come into play in these decisions, including the number and gender of siblings, their history of relationships with one another and with their parents, work-related issues, other family demands, and so on. Systems theories are but one example of the sort of heuristic device that can help us understand decision-making processes in families.

For these reasons, it will become necessary to determine how informal mechanisms of support might be augmented (and in an extreme scenario, replaced) by formal sources designed to ease the potential dependency burden of care and to improve the quality of life for everyone involved. As of yet, however, the cost-effectiveness or sustainability of such programs, and their ability to keep infirm older persons out of nursing homes, has not been demonstrated. Rather than serving as a substitute for nursing home care, home health care evidently taps a large reservoir of otherwise unmet need in the community. Under current arrangements, many infirm older individuals who might seriously benefit from assistance in the community simply do without it.

As nursing home costs continue to rise, home-based programs seemingly hold even greater potential to support individuals with intermediate levels of need in the United States. Research should more carefully document this need, especially in determining the extent to which individual services reduce the risk of institutionalization. This will also permit better targeting of services to the very frail and vulnerable, as impaired older clients at risk of dependency show greatest potential for long-term care cost reductions. Research should also project the potential relative costs and benefits – social, economic, and human, and to families and society – of caring for older parents and populations with severe dementia and other serious chronic illnesses.

Providing care to an increasingly diverse older population presents an entirely different set of challenges. What does it now mean to grow old in the face of the dramatically shifting racial and

ethnic composition of a society? In the United States, for example, these population changes will have implications of great consequence for the nation as ethnic minorities, particularly Hispanics, and their children assume a greater role in the formal and informal labor market. Members of these groups are also among the most vulnerable in our population with respect to health outcomes and access to health care and insurance. Much remains to be learned about their health care needs as they age, the specific social contexts in which those needs are not met, and the potential role of families, the government, elder care organizations, and businesses in meeting them.

More broadly, it is important to design and evaluate new institutional arrangements and services that better take into account the needs of older people – a priority that has only been heightened by dramatic changes in the health care industry in the past 20 years. Consider, for example, the factors that influence when an older person and family caregiver come into contact with the acute and chronic health care system. These have far reaching implications for the outcomes of the encounter as well as for how satisfied patients and caregivers are with treatments and services. It is also vital to ascertain the role of the profession of medicine in treating – and creating – the health care problems of older people in different settings. What are the pathways of elder health care service use in ambulatory settings? How does acute care articulate with chronic caregiving systems? The more we know about how health care organizations affect the health and illness experiences of older adults, the better positioned we will be to improve the geriatric health workforce of tomorrow. More attempts, however, must be made to understand help-seeking processes for both formal and informal types of support.

Role Inversion and Parenting

Another interesting question at the intersection of sociology of aging and family life pertains to a sort of role inversion: children who, because of their special needs, are unable to live independent lives, and whose parents will not have the experience of fully launching them. This is a growing social challenge in part because medical care and technological advances have improved the infant and child survival rates of those who are medically fragile (e.g., infants who are extremely premature, very low birth weight, or drug-addicted) or developmentally disabled. The growing incidence and prevalence of attention, hyperactivity, and autism spectrum disorders among children has similarly created new challenges for parents. What is the experience of aging like for parents as they are responsible for children with intensive special needs for extended periods, and even their lifetimes? How do these provisions affect the social, psychological, and financial well-being of parents as they age? What is the fate of that child's aging?

These "role inversion" challenges do not only apply to a small slice of the population. Because the transition to adulthood is a more prolonged period today, parents across all social classes are providing much more support to their adult children, and for longer periods of time, than ever before. As a result, the "empty nest" today is one that comes later and remains open or cluttered as children make their way into adulthood and as the achievement of adulthood has become more elusive. This may bring serious "ripple effects" in the lives of aging parents, affecting their financial, emotional, and other resources at midlife and beyond, even prompting the need to revisit plans for retirement. Of course, new generations of parents produce new kinds of children, and there is evidence that parents and their young adult children are now closer and more connected today, even if they experience bumps as children forge new pathways into adulthood. One begins to wonder whether the greater investments that parents are now making in children from infancy well into their 30s will come with greater support when parents are old. Will these children feel stronger obligations to reciprocate support to aged parents? Will aged parents have stronger expectations that it be provided?

Social Sources and Consequences of Intergenerational Inequalities

The old-age dependency ratio, typically defined as the number of working-age people aged 15–64 relative to the population 65 and over, is beginning to present major challenges for governments in guaranteeing both the financial and health security of older people in the developed and developing world. In the United States, for example, there is a vastly unequal distribution of retirement income in old age among the baby boomers, yet few investigators have examined options for improving overall income adequacy in later life for vulnerable groups. What will reductions in, or the fading away of, pensions mean for people in the middle of their careers? How will working families with low incomes and few or no benefits afford to grow old? It will be crucial, therefore, to understand how old age policies and programs, especially social security, will impact intergenerational equity in the distribution of benefits – across generations in the family and across cohorts in society – as well as the financial well-being of future generations of workers and retirees. Similar challenges exist for many European nations and Japan.

Serious and controversial questions about intergenerational inequality demand closer scrutiny and the contributions of sociologists. The 1990s brought much attention to this topic, but gerontologists then largely dismissed charges that growing attention to the needs of the old would necessarily drive inequalities or fuel resentments from other age groups. But there is reason to believe that these heated debates will again emerge in future social and political conversation. For instance, to what extent will the future generation of workers receive a fair rate of return on their investment based on their lifetime contributions to the social security system? Cohorts of men who are now old were able to count on continuous work histories in well-paid and well-protected jobs, and cohorts of women were able to count on long-lived marriages – both of which are assumed in determining access to social security in the United States. How might more fragmented and unprotected work and marriage experiences today create serious risks in old age for future cohorts?

Sociologists of aging are well positioned to inform policymaking in an aging society, particularly in determining how inequalities in income and wealth are connected to age and cohort, gender, and race and ethnicity and in anticipating the consequences of alternative policy options on various groups. Consider, for example, the raising of the age-of-eligibility for retirement pensions and social security. What are the changing age norms for retirement in the United States and elsewhere? What are the various possibilities for strengthening economies to support aging societies? Who will be protected, weak, or fall through the cracks? How do retirement policies perpetuate privilege or further disadvantage women and members of other minority groups whose work lives cannot or will not match policy criteria? What conditions are necessary for generating broad public support for social security reform?

Thus far, we have focused on intergenerational issues across cohorts and on variability within cohorts. But we must also consider how social security retirement policies and programs affect the likelihood of intergenerational financial transfers within *families*. One of the most fascinating issues related to retirement security is the extent to which patterns of *inter vivos* ("between the living") gifts and bequests from older parents to adult children are connected to aging policies and programs. For example, is it the provision of social security and Medicare to old parents that makes it possible for parents to transfer wealth upon their death to their children? How is inheritance affected when the provisions of the government are made more generous or frugal? One window into these questions is cross-national: How do social security policies and programs affect intergenerational financial transfers in different national contexts? Most countries face the same problem of caring for a large retirement-age population, yet little is known about why welfare systems are different or how they result in meaningful differences in the well being of older people or the nation. What factors produce or explain the similarities and differences among countries in the developed or developing worlds?

Beyond *inter vivos* transfers and bequests, there is the grave problem of how individuals and employers will fund retirement plans, including defined contribution plans like 401(k)s. This is a crisis for municipal and state governments, let alone the federal government, which has made retirement fund commitments that far exceed what they could have ever realistically funded, especially to labor unions. This retirement tsunami raises crucial questions about who will pay for the oncoming wave of boomer retirement, especially early retirees from cohorts who have long life expectancies. What sort of structures should be in place for the old and the young, and for the poor?

This begs the question of what social consequences might result from these over-commitments when resources are limited. The aging of the baby boomer cohorts will increase competition for funding among the various recipient groups, and carry the potential for inter-cohort conflict, especially in times of significant economic retrenchment. Because of limited federal and state funding, the needs of impoverished women and children compete with those of the disabled and the elderly: Although the majority of enrollees in Medicaid are children, the majority of funding is spent on care for the disabled and the elderly. Almost half of long-term care is paid for by Medicaid. Medicaid long-term care for chronically ill elderly persons consumes about 17% of the average state budget, with spending estimated at $1.6 trillion dollars over the next two decades. The need for long-term care will only increase because longer lives mean that a large fraction of these cohorts will spend-down to Medicaid eligibility.

The new health care reform bill has clearly changed the health care financing landscape, but how it will directly affect Americans, and older Americans in particular, is as yet unknown. While it represents the only realistic means of covering any substantial fraction of the uninsured, there are numerous uncertainties about the specifics of the new program for younger and older Americans alike. It is unclear how health care coverage exchanges will work, and there is also the real possibility of repeal. As national health care expenditures grow toward 20% of GDP, cost controls are also inevitable. Medicare enrollment is anticipated to be the major force that drives public health care spending in the future fueled largely by a new prescription drug benefit and the rapid growth of the baby boomer population reaching retirement age. If Medicaid continues to pay less than other forms of insurance, providers may not participate unless they are forced. Still, Medicaid expenditures will increase as well.

Sources of Social Support

The stresses and strains of living with and caring for chronically ill people are well documented in the literature – whether the chronically physically ill, the severely and persistently mentally ill, or the infirmed. Arguably, the health consequences of extended life expectancy for older men and especially women will create difficult challenges for families and other societal institutions. The role of social support in preserving the physical and mental health of individuals who are old or very old, then, is clearly worth our attention.

Despite growing literature that documents the significance of social support for the overall well-being of the aged, there is relatively little good comparative data on how social support differentially enables some groups of people, including men and women, to better cope with the declines in resources (time, people, money, and power) that come with aging. The nature of relationships between parents and children has clearly changed as the result of shrinking family size, geographic mobility, and technological change – and yet we have so much to learn about how exactly those support systems have changed, and whether or how they have the capacity to provide emotional and instrumental support.

Studies of older minorities and immigrants suggest that there are reasons to suspect that cultural groups differ in the availability of social support, whether emotionally, financially, or otherwise.

How do culturally influenced differences in levels and types of social support affect the health of older minority group members? It is especially important to understand Latino cultures, which are large and rapidly growing segments of the aging population in the United States. Research indicates that Hispanics generally, and Mexican Americans particularly, benefit from aspects of their culture which are shown to be socially protective. This cultural protection operates primarily through strong family traditions and support systems.

Yet disparities in the health outcomes of different racial and ethnic groups also mean that aging itself is likely to be quite different for individuals and family members in specific groups. For example, despite a favorable mortality regime, the socioeconomic disadvantages among aging Mexican Americans and late-life immigrants point to a potentially high dependency burden placed on their families – a burden about which we know very little. For older African-Americans, multiple health vulnerabilities undermine attempts to age independently, and consequently may increase reliance on adult children and relatives who are ill equipped to provide adequate instrumental support because of other work and family obligations.

Emotionally supportive intimate relationships allow individuals to develop a strong self-identity that gives life meaning and purpose. Yet we have much to learn about how social environments influence the life satisfaction and morale of older people. The excessive focus on the individual factors that create vulnerability – vs. those in the social systems outside of individuals – has prompted research emphases that pay too much attention to depression per se rather than the social conditions that arise from or exacerbate it (e.g., role strain) or those that inhibit or diminish it (e.g., supportive relationships or services). Developing new research approaches to understand the protective role of social supports in late life is vitally important because social isolation, loneliness, and depression have been shown to increase the risk of death and physical or other mental illnesses. Other stressors, such as economic losses associated with the current "Great Recession," for instance, may also create new risks for older people who would otherwise not be at risk, or elevate levels of risk or distress for those who already are. A socially supportive network is crucial in helping older individuals cope with health challenges or economic losses.

The mental health benefits of social support suggest that it is not the number of people in one's social network that matters most, with more being better, but rather a step function in which the presence of at least one close confidant provides near total protection. While age-graded life events like widowhood or the death of an adult child punctuate the need for social support, they often come at a time when the social networks themselves are unraveling, often through the deaths of longstanding friends and peers. Social support is crucial in these situations and other harmful life events by preventing a severe stressful response and increasing the capacity to continue living.

Besides the clear practical benefits of social integration, the availability of relatives and friends with whom one interacts has a direct effect on mental health and morale as individuals grow older. Loneliness is a major health risk for the old and the socially isolated, and in particular for elders who lack English language proficiency. Studies frequently show that integration into a cohesive social network appears to protect individuals from many kinds of negative health outcomes. These findings, if replicated on ethnically-diverse populations, will bring us closer to demonstrating just how significant intimate relationships are in preserving healthful aging – or, likewise, to show just how significant their *absence* is in jeopardizing it.

There is also great need to develop a qualitatively-driven research agenda on how social environments support or fracture the potential to improve or protect health and quality of life for people and whole communities. Specifically, qualitative studies are needed to address the health consequences of the nature, degree, and quality of social support available to individuals across the multiple settings they inhabit. Detailed and highly textured analyses are also needed on the health consequences of emotional and social support provided at home and work. These settings, along with other nontraditional and emergent settings (e.g., internet cafes, social media sites, naturally occurring retirement communities, petting zoos), will provide fresh and valuable insights into contemporary contexts.

Social Dimensions and Determinants of Successful Aging

The field of life course studies has at its core two propositions for which there is an inherent tension: one emphasizing that the life course is the product of social forces (broadly construed as "social structure"), and the other emphasizing individual capacities and effort (broadly construed as "human agency"). A vital feature of an emphasis on aging is that people actively and regularly evaluate their behavior and make decisions about how to act in new situations depending on their past experiences. It also assumes that the choices people make – whether regarding education, occupation, marriage, and fertility or other major experiences – bring serious and enduring consequences for well-being in later life. Years of socialization and accumulated advantages and disadvantages equip individuals with a repertoire of social skills, liabilities, and resources that affect how they age and meet the realities of later life.

This theoretical point about the sociology of autonomy and aging underscores the complexity of the concept of successful aging. What does it mean to age well (as opposed to pathologically)? There has in the last two decades been an explosion of interest in "successful aging," which appears routinely in our lexicon. But what is this term or social label ultimately meant to capture? The literature suggests that it implies a certain amount of money, personal prestige and respect, and power that assures one can remain as independent and autonomous as possible. The social–psychological aspects of successful aging tend to overemphasize life satisfaction and happiness. But research must go beyond prescriptive definitions of successful aging toward an understanding of what the concept means for assuring the greatest personal autonomy and adequate security in old age. At the same time, the need for autonomy should not negate the need for social support – both are important parts of the human experience. The voices of sociologists are essential for broadening the lens of successful aging so that it is not as exclusively focused individuals and more often makes visible how particular aspects of particular social environments nurture or inhibit successful aging.

Changing Work and Leisure Roles

It is also important for sociologists to address how work-related experiences, roles, and expectations for them have changed in recent decades. New models of work and retirement have emerged as the manufacturing sector has given way to the emergence of the knowledge and service sector, as "lifetime" models of work have eroded, as the contract between employers and employees has weakened, and as employment has become more discontinuous. These changes have brought both new possibilities and new risks for aging.

At the broadest level, the meanings of "work" and "retirement" are being called into question and recreated in our postindustrial world. People with flexible work and ample resources are able to shift careers in midlife or reduce or step away from work in order to manage family obligations. Many retirees are seeking life-altering experiences and opportunities to reclaim old interests, beginning second careers, or volunteering. But what do "work" and "retirement" mean for the less fortunate among the old? And just as important, what is the fate of future cohorts, whose work lives will be more fragmented than those who are now moving into and through old age? What will work and retirement mean to them in their later years, how will they experience work and retirement, and how will our society in turn be affected?

We also know little about what work and retirement will mean to women, minorities, and immigrants in their later years, and how secure their experiences will be. For example, because of traditional gender roles and the gendered division of labor among couples, especially in pre-baby boom cohorts, women never or rarely worked, or did so only part time. The greater labor force commitment of women in the latter half of the twentieth century, coupled with the high degree of marital instability, however, mean that women are increasingly responsible for their own retirement security

and many are at risk of economic insecurity in old age. Are women's work trajectories likely to get longer and stronger in the years ahead – or will they continue to be more discontinuous then men's, regardless of the gains they have made, and at risk, especially in the face of shorter marriages?

Furthermore, there is broad public concern about whether retirement as we now know it will be possible or sustainable for future cohorts, whether because of their own diminishing resources, freedom from the three-box lockstep life, or the diminishing resources of the state and old age policies, especially as (or after) the boomers retire. The growing diversity of successive cohorts also means that disadvantages in the work opportunities for women, racial and ethnic minorities, and other groups will also diminish their retirement security and material and social well-being in old age.

Coping with Change in an External World

Late-life displacement is an emerging topic that encompasses aging at the nexus of social change and disorganization in the physical environment. For example, global climate change is an environmental threat and it, like hurricanes, earthquakes, and other natural disasters, poses a challenge for individuals, families, and the state in caring for older people. As keen observers of the social world, sociologists are especially equipped to shed light on how aging experiences are affected by a constantly and often rapidly changing social world.

To this end, we must reveal how particular cohorts, given their unique histories and position in life, might be differentially able to adjust to social change. In the event of a crisis, how might, say, being in a cohort that grew up in the Great Depression or wartime leave people more or less resilient in the face of hardships in late life? How might being old – that is, having lived a long life – leave people in stronger or weaker positions in weathering social change? Scant information is available on the resilience of special populations to late-life displacement due to political upheaval, economic depression, natural disaster, and the like, and how age interacts with other social statuses or roles to place people at greater or lesser risk (e.g., those who are old *and* poor, or old *and* a member of a minority group). Or is it "something else" that is instead the major factor?

We also have much to learn about how social institutions can be designed so that, when unexpected changes occur, older people are best prepared to handle those changes. Research on victims of natural disasters, for example, highlights the significance of research along these lines. There is a need for local studies that provide empirical verification of how nursing homes plan to carry out complex recovery efforts for elders in the wake of natural disasters. Researchers and government officials alike will find research like this useful as they recognize the daunting challenges linked to the mitigation of future hazards and unspeakable catastrophes.

Besides environmental disasters, late-life displacement includes disorganization brought about by economic decline, including the "Great Recession" that began in 2008. Economic downturns of this type can dramatically alter the realities of old age for many people and their families as they struggle with unemployment, face home foreclosures, and come to grips with lost savings and pensions, which shatter plans for retirement. The deficits worldwide are staggering.

As a result, governments in the developed world are wrestling with the plight of the unemployed, and especially the long-term jobless. In the United States, for example, political fears concerning the nation's financial health and growing budget deficit have dimmed hopes for extending unemployment insurance benefits. Will the productivity of the future labor force depend on continued and increased federal support to compensate for the new economic realities? Might employment programs to employ the unemployable, like those that existed during the Great Depression, be reconsidered today, and how might they capitalize on the skills and experiences of older workers? Finally, how will the current economic crisis affect the magnitude of public transfers, such as social security, or private transfers within families, for future generations?

In addressing issues like these, sociologists can begin to uncover the lifelong effects of economic decline and growth on an aging population and society and provide information to help determine how available resources can be allocated in a socially productive and responsible way.

Legacies of Immigration

Immigration and the income and health care needs of the older population will be among the most pressing and interrelated issues the United States will face in the near future. Historically, wars, natural disasters, political conflicts, and other major societal-level events have always displaced large numbers of people. But the need to respond to the needs of large numbers of refugees presents governments and civil society organizations with new and significant challenges. Of course, so much of the current political dialog is not about old immigrants, but about working-age adults, and often young parents and their children. There are, however, sizable numbers of immigrants now in their later years – and the experiences of being an old immigrant are surely different from being a young one, and conditioned by the age of the person at the point of immigration. To immigrate as an old person is different from being an old immigrant who arrived decades ago. The surges in the young immigrant population will also have effects on our society decades from now, as they grow older and eventually reach late life.

Other questions about immigration and aging also need to be addressed. For example, aging in another country a brings several health and social welfare challenges and opportunities issues for migrants in specific U.S. cities and those who return to specific foreign cities. This research could provide valuable information into how the migration process interacts with experiences in the labor market to affect general health and well-being. What impact does large-scale migration have on national and state-level health policies and health delivery systems on access to care in the United States and elsewhere? How is rapid population aging and migration in the United States and other developed nations affecting the structure of communities and even entire regions? In countries and states of high immigration and emigration, families, communities, schools, workplaces, and governments are being transformed. Transnational families are an important part of that process.

Late-Life Loss

While the experience of loss in later life would seem normative (e.g., widowhood for women), many aspects of loss are poorly understood. Aging into the eighth, ninth, and tenth decades of life brings with it the inevitable losses of spouses and partners, members of the extended family, and friends and neighbors. Although some of these losses may be normal and expected, and therefore may be prepared for, they are clearly not easy to live through. These aging-related losses often push the limits of human coping, adaptation, and resilience, and the normative physical and cognitive declines that come with aging may make that process more difficult.

Other losses in roles and social relationships are unexpected and even the result of an extended life span. For example, given the new certainties of a long life and the predictability of death in old age rather than earlier in life, it is natural for parents to expect to out-survive their children. But as both parents and children can now jointly survive into old age, the experience of the death of a child may become more likely. The process by which older parents cope with the loss of a child who is middle-aged or even older is not one that is acknowledged by physicians, policy makers, or family members. Understandably, stories of the loss of a child, regardless of how old that child is, portray family tragedy beyond comprehension and words. So, too, are painful stories of being the sole

survivor among siblings or longstanding friendship groups – what Bernice Neugarten once called the "costs of survivorship" in advanced old age. Yet research on the complexity and intensity of the emotions that accompany this kind of grieving in late life is missing in the literature. Sociologists have important work to do in conducting deeply textured research on how people make sense of and deal with the impact of the loss in life's final decades.

Moral and Ethical Dilemmas of the End of Life

We have much to learn about the moral dimensions of end-of-life care – for example, who should help and be helped in the end of life, how they should be helped, and who should pay. There is a need for studies to assess barriers to health care service use, especially those that stem directly from policies. An aging society simultaneously brings an increased need for hospital and home health care services, but also to find innovative ways to contain the growth in expenditures for the care of older people and maximize the use of less expensive community supports. These innovations must take into account a range of cultural differences, social trends, and moral issues, as well as changing economic realities.

In addition, research needs to examine the ethical considerations of competing costs for families and societies. When should one cease heroic life supports, and who makes that decision? Is it based on cost or on quality of life? The practical issues of curbing rising health care costs raises a serious moral dilemma related to the rationing of expensive life-saving interventions. How much should be spent on older people, given that public funding is a finite pie and given the sheer size of the baby boomer cohort? Who will win and lose in the game of support? What are the tradeoffs of supporting the old versus the young as the ratio of old-to-young increases? The complex family structures of baby boomers also seem likely to heighten questions of who is responsible for whose care, but few answers exist about the expectations and obligations attached to that responsibility. The ethical and moral dimensions of caregiving have been in large part glossed over, leaving a window of new opportunities wide open for fresh ideas to address the support systems of an aging society for generations to come.

These are just a few of the important topics we hope will be nurtured in the future. While they represent what seem like formidable challenges, to meet in the future, these and other advances will also be aided by some basic principles for guiding the generation and use of theories, questions, data, and methods. We now turn to these parting thoughts.

Basic Principles for Moving Forward

First, there is a natural synergy between aging and the life course, a point that was reinforced when the American Sociological Association's Section on Aging renamed itself in 1997 to the Section on Aging and the Life Course, as discussed in Chapter 1. Greater attention to the life course has yielded many new insights. Yet as attention to the life course has grown exponentially – and will continue to do so in the decade ahead – it is our hope that this will not compromise the scope and clarity of the sociology of *aging*. There are questions about aging that do not entail the life course, and many more questions about the life course that do not entail aging. Both are naturally treated in our work, but how we put the two together has tremendous implications for future scholarship. The life course perspective has grabbed hold of us, offered valuable insights, and transformed scholarship in our field. But it is important for researchers to consider what is gained and what is lost or put at risk in our understanding of the sociology of aging if too great an emphasis is placed on the life course.

In pursuing an understanding of "aging and the life course," does our field become too big and too broad to manage – a field of every possible age, and every possible transition, in every possible domain of life? As the life course perspective gains prominence in other subfields of sociology, these fields, too, begin to overlap with our own – indeed, the "life course" tag can be found with great regularity in the sociology of family, education, work, health, and criminology. What is it, then, that leaves our own subject matter distinct? Sociologists of aging must continue to wrestle with these difficult and critical questions in the years to come.

Second, and related, it is also important not to lose sight of the sociology of *age* (rather than aging), which was a central point of inquiry in the early years of our field. This scholarship, for example, examined how social roles and activities are allocated based on age, how age underlies the organization of social institutions, how age structures legal rights and responsibilities or is used to determine eligibility in social policies, how age is used to determine expectations of the self and others, or how it enters into social interactions. The salience of age in our scholarly lenses has diminished over time. This has occurred in tandem with what seems to be a growing *denial* of age – that age is something that can be defied or transcended – and an accompanying emphasis on *successful* aging among gerontologists and in our society. It is good that gerontology has, in the last few decades, seriously challenged the belief that old age is a dark period of irrecoverable physical and cognitive declines. Yet with the pervasive sense of optimism in aging research (and its emphases on successful, productive, and optimal development and on positive processes and outcomes), we must ask whether we do ourselves and old people a great disservice in the process. These emphases threaten to obscure from our scientific lenses the real underbellies of aging and old age that must be acknowledged if they are to be dealt with effectively. Here, we are thinking of even normative changes and vulnerabilities in physical health and cognition, and of the compression of illness and disease during the final years. When we deny the realities of aging and emphasize the differences among old people to the exclusion of the things they share, we jeopardize the political activities and policy agendas that serve elders' interests and needs.

Third, this demands that we renew attention to the things that people in a given life period have in common, alongside our investments in understanding difference. Sociological research on aging routinely references the high degree of variability among old people, consciousness about which has also been promoted by popular theories of cumulative advantage and disadvantage. But the field is in need of comprehensive empirical treatments of variability and examinations of its *social* sources and its *social* consequences. And because we now assume that variability is a key hallmark of old age, only rarely do we consider the things that old people have in common. This trend, coupled with more attention to the whole life course, make it increasingly important *and* difficult to clarify how old age is distinct from periods before it. When we lose sight of commonness, we lose sight of the things that make our subject matter distinct. To what extent are the challenges of old age simply those of earlier periods that are prolonged or revisited? To what extent does old age pose unique developmental challenges and opportunities? What are the markers that define entry into old age and movement through the "young-old," "old-old," and "oldest-old" periods so commonly cited in research on aging?

Fourth, it is important to reclaim attention to the macro phenomena that preoccupied sociological attention to age and aging in the early years. We are beginning to live in the top-heavy aging population that prompted so much reflection and concern, and drew attention to our field a few decades ago. It is important that scholars do not emphasize the individualization of aging so much that we lose sight of social structure – one of the very things that defines us as sociologists. We have an obligation as sociologists to keep social forces and factors front and center in our inquiry. It is especially important to keep in focus the implications of our aging society – and the demographic parameters that produce it (mortality, morbidity, and fertility) – *for* our society, families, and individuals.

The need to keep social factors in focus is also heightened by reductionist tendencies in science and the obsession with genomes and genetics. As we travel further out into social spaces and attempt to

take them into account, our empirical work becomes more difficult. Yet the tendency in individual-based disciplines, such as psychology or biology, to dismiss external forces as being too unwieldy to measure or as already represented in lower-order measures, means that we must, as sociologists, make them visible, which will also require advances in our measures and methods. This may be why biomarkers seem so attractive today, especially in the areas of abilities and health, for the further we drill down into biology and put our money on those factors, the more quickly we simplify the complexity posed by the social world. There is comfort lurking there, it seems, if only the right markers can be connected to the right outcomes. But these connections are rarely clear, and our theories do not get down that far or that specific to make meaningful connections. Worse still, in emphasizing what lies within individuals over what lies outside of them, we laud people for positive outcomes with little regard to the ways in which social environments bring them about, and we blame individuals for problems or failures that have little to do with their own actions and more to do with how their social worlds constrain their possibilities or squash them out. It is our responsibility as sociologists to show the way. New research focusing on the interplay of genetics, the social environment and aging creates a new opportunity to learn about the social implications of genetic research.

Fifth, it is important that our work become more anticipatory. Virtually everything that is known about aging is bound to cohorts born in the first few decades of the twentieth century. We do not know how much of our current knowledge base about aging will apply to future cohorts whose characteristics and experiences have been very different. Later cohorts have also grown up and older with different resources, expectations, and needs, and they have been subject to different constellations of government programs and policies, with different types and levels of support. We do not need to wait to see how they are different. These cohorts are the future of aging, which can be understood by getting more intimately acquainted with them and by *making history visible and tracing its legacy in their lives.* Understanding the middle aged is particularly important, for they are next in the queue and include boomers; understanding young people matters too, for their transition into adult life looks dramatically different from what we have seen before.

Sixth, we must remember that there are people behind the numbers, and that we must do more to bring the person back into research. As sociologists, we have an obligation to understand whole people, and to understand them in relation to the multiple social contexts in which they live. We also hope that in the face of increasingly specialized and fine-grained empirical work, we put more value to the task of integration, synthesis, reflection, and theoretical development. Both of these points speak to the need to develop more holistic views of people and knowledge, and to develop a science of greater meaning, for the people and things we study are rich and complex.

Finally, if we are to do right by our subject matter, we must do right by ourselves – to become more self-reflective and self-critical, to think more seriously about why we are drawn to our topics, to unearth the values that lie beneath our own work and the commitments of our profession, and to become more conscious of the things we are invested in promoting, accepting, or denying. One thing will not change: Most people who create expectations, conduct research, make policies, engage in practice related to old people and old age *are not themselves old*. We are outsiders to the very people and phenomena we hope to understand. Our values and assumptions affect what we do (or do not do) with and for old people. This predicament creates challenges for what we know, how we know it, and what we do with it. We hope that in the future we will have a stronger science of action, one that will permit us to more seriously wrestle with the moral or political imperatives we have to advocate for or intervene on behalf of the populations we study, and to feel compelled toward action and the improvement of the greater social good. In the *sociology* of aging, we must grapple with social problems, solutions, and interventions, for it is here that some of our most important contributions are to be found and realized.

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