National Council on Family Relations

Family Focus On...

Aging

Issue FF27

IN FOCUS:

Aging: Everybody's Doing It!

by Rona J. Karasik, PhD, Director, Gerontology Program, and Professor, Community Studies, St. Cloud State University, St. Cloud, Minnesota

It is almost impossible to escape the media blitz surrounding the not-so-new news that our population is aging. According to U.S. Census data, in 2002, 35.6 million persons (12.3 percent of the U.S. population) were age 65 and over. By 2030, the older population is expected to grow to 20 percent of the U.S. population—roughly 71.5 million persons age 65 and over.

Not surprisingly, most of the media coverage on aging has been negative—focusing on the problems posed by health care, social programs, retirement funding, and dwindling resources. While many of these concerns are valid, the coverage overlooks the positive aspects of an aging society. For instance, our population is aging because people are living longer and healthier lives. This is not a small fact to be ignored. Rather, all of us—researchers, policymakers, service-providers, and family members—need to understand that aging is a process, not a disease. We are all aging—but what does that really mean?

Much of the media attention focuses on the Baby Boomers, who were born between 1946 and 1964. Few from this cohort of 41 to 59-year-olds, however, consider themselves to be "old."

What is old age?

In reality, there is no single accepted definition of old age. Some point to the chronological age of 65—a political throwback from the late 1800s—to mark the onset of old age. Others break later life into subsets with colorful names such as *young-old* (ages 65-74), *old-old* (ages 75-84) and *oldest-old* (ages 85 and older).

Still others eschew chronological markers to focus on a person's appearance and abilities (functional age) or on the roles and expectations society places on persons based on their chronological and functional ages (sociogenic age). Each of these approaches to defining aging serves a purpose, but none provides a complete picture of the older population.

Defining aging is complex, in part, because it is not a single experience. Although often associated with gray hair, wrinkles, and a host of chronic diseases that may or may not be age-related, aging is also about how we view people (including ourselves), how we look and act, and how long we've lived.

As attested to by the wealth of anti-aging beauty products and corny (often callous) greeting cards, many of our expectations about aging are negative. There are, however, both positive and negative aspects to aging. Certainly, health concerns and the specter of being dismissed as less than valuable are alarming. On the other hand, how many of us would, if given the opportunity, go back to relive the challenges of our youth? Knowledge and hindsight can be powerful rewards.

Elders are capable

On the whole, older adults are a typically capable group. The vast majority live in the community and are self-sufficient. Many continue to work or take on volunteer opportunities. Over half of those 65 and over are married, and studies have repeatedly shown that many older adults report healthy, satisfying sex lives.

As for infirmity, the risk for chronic health problems does increase with age, and heart disease remains the number one killer of men and women in the United States. Many health conditions, however, are

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Human Development in the Genomic Revolution

by Thomas O. Blank, PhD, Professor and Kimberly A. Petrovic, MSN, RN, Doctoral Student in Aging and Adult Development, School of Family Studies, University of Connecticut

With the advances in genomics and proteomics, aging is bound to be different as we proceed through the 21st and into the 22nd century. Aging in the future will be more fulfilling and more complicated. Aging may become a process in which we are actively engaged and over which we exercise more control than is currently possible.

The identification and manipulation of genes, such as those responsible for cancer and dementia, may increase human longevity and favorably influence human development and aging. This may allow us to manage once deadly conditions as chronic diseases or to avoid them altogether. This will also, however, lead to a myriad of challenges and ethical issues.

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Cancer and aging

Over half of all persons diagnosed with cancer are elderly when diagnosed. The majority live for decades after diagnosis. Even those who are not old when diagnosed grow old as cancer survivors. Many family members become directly involved in caregiving for older persons who are dealing with cancer from diagnosis to end-stage care.

Cancer is also intimately related to family history. Medical researchers and clinicians have long suspected that the presence of specific genes may be at least partially responsible for the onset of cancer and its growth. As genes that influence likelihood of cancer are discovered, families will grapple with how to use this information for future generations.

Environmental factors, such as poor diet, lack of exercise, and cigarette smoking have been implicated as factors that contribute to the development of cancer. Society often takes steps to alter these environmental influences. But it's also possible that lifestyle alone does not cause cancer. Perhaps the presence of other genes contributes to the expression–or suppression–of cancer-causing genes.

As we learn more about various gene combinations, we will be able to alter our personal and interpersonal environments. As this occurs, family members will be even more directly involved in the prevention, treatment, and care of cancer survivors.

> The identification and manipulation of genes may increase human longevity.

Dementia and aging

Alzheimer's disease and other dementias are devastating in their impact on the individuals and their family members. But progress is being made toward the identification of genetic and environmental mechanisms that may trigger dementia.

Future identification and manipulation of genetic and environmental conditions that contribute to the onset of Alzheimer's could begin within the early weeks of pregnancy. Subsequently, prophylactic gene manipulation for this and other types of dementia could repair defective genes, thus improving the aging process for the individual.

Ethical questions and challenges

Bioinformatics, genomics, proteomics, and genetic engineering will continue to provide researchers with opportunities to study the influence of genes. The potential for identification and manipulation of genes in utero will be refined and greatly extended, thereby influencing and altering the course of aging.

These are just a few of the ethical questions that arise from the development of such techniques:

- Once all genes can be tested, will they be? Should they be?
- Will everyone be "de-diseased" genetically as a matter of course? If so, what are the implications for individuals and for family life across the generations?
- Will these changes make aging "so 20th century," or will they simply make growing up and growing older more complex?
- Should we support the development of genetic research and engineering or should we be voices for caution?

With the development of genetic technology, scholars interested in aging and human development across the lifespan will need

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Why States Matter: State Variation in Elder Friendliness

by Jean Giles-Sims, PhD, Professor, Department of Sociology; and Charles Lockhart, PhD, Professor, Department of Political Science, Texas Christian University

The United States is an aging society in which various advocacy groups are concerned about meeting the needs of elderly persons. States matter, in part, because they increasingly develop, fund, and control a broad range of public opportunities and services for the elderly. Nationwide, for instance, state Medicaid programs pay for two-thirds of nursing home residents. Yet states differ significantly in eligibility rules, benefits, and reimbursement rates. This variation presents the elderly and their families with widely different opportunities and constraints in their attempts to access necessary services.

Our research on "state elder friendliness" follows the example of Marc and Marque-Luisa Miringoff in comparing and ranking state political, economic, and social milieux. We have developed, operationalized, and validated a five-dimensional index of state elder friendliness. Developing reliable

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manageable with the help of diet, exercise, assistive devices, and modern medicine.

And while concerns about dependence and "senility" feed our fears about later life, less than 5 percent of persons 65 and over live in nursing homes—although the risk of institutionalization does go up modestly with age. Similarly, only about 5 to 6 percent of the older population has dementia (a diagnostic category—not a specific disease), although, again, the risk does increase some with advanced age.

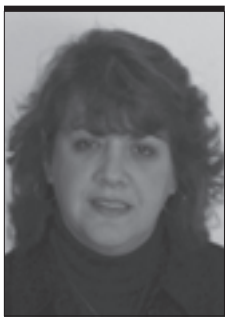
A heterogeneous group

So what are the realities of old age? This is a difficult question since older persons are a highly heterogeneous group. The way in which we age is affected by a variety of factors, including, but not limited to, gender, socioeconomic status, ethnicity, health, and social networks.

With regard to gender, for example, women have been found to live an average of six years longer than men. The life expectancy for men born in 2002 is 74.5 years, as compared to 79.9 years for women. Women's longer life expectancy may be seen as a double-edged sword, however, when combined with gendered societal expectations about things such as marriage.

For example, women 65 and over—who outnumber older men 141:100 – are much less likely to be married than older men. In fact, in 2002, U.S. Census data showed that 73 percent of older men and only 41 percent of older women were currently married. Conversely, older women were over four times as likely to be widowed as older men. Not surprisingly, older women are also much more likely to live alone than men, and are much more likely to experience poverty.

Socioeconomic status, similarly, has a multi-layered impact on how we age. Economics affects our ability to access quality health care beginning in the prenatal stage of life. Lack of good health care can lead to an increase in acute and chronic conditions requiring additional, often costly, care. This cycle is interwoven with our access to education and employment, which in turn affects the availability of health insurance, as well opportunities for retirement and leisure.



Rona J. Karasik, PhD

Rich and diverse relationships

Finally, how we age is also affected by our social networks. Despite the stereotype of elders as isolated and alone, many older persons maintain rich and diverse social relationships—which may include life partners, children, grandchildren, siblings, friends, and even elderly parents. Not surprisingly, the pleasures and challenges of these relationships tend to mirror those of younger persons: Who can I depend on? Who depends on me? What will the future bring?

These questions, at the heart of relationships, are also at the heart of the aging experience. Aging is a complex combination of biological, social, and psychological processes. No one can know for certain what the future will bring—but understanding the positive outcomes along with the not-so-positive possibilities can help us to prepare for our own aging, as well as the aging of our society.

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to be aware of and understand gene-environment interactions. In addition, we will need to create new models of aging that go beyond those with which we are familiar, including models which build upon developmental contextualism and other philosophical systems.

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The Older Americans Act: An Overview

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The three primary age-based or related policies in the United States are Social Security, Medicare, and the Older Americans Act. Most people know or have heard about Social Security and Medicare, although they may not understand the intricacies and debates surrounding these two programs. Both have been in the news and are often tied to election promises and rhetoric. The Older Americans Act, however, has received less public or political attention. This is ironic because the Act affects the daily lives of older adults, their families, and those who work with them and on their behalf.

What is it?

The Older Americans Act is a far-reaching policy. Like Medicare, this legislation was enacted in 1965 and acknowledges that age in and of itself may be a criteria for need. While Social Security and Medicare (at least currently) use age 65 as the beginning of retirement or old age, the Older Americans Act defines older adults as age 60 and older. The exception (and there is always an exception!) is Native Americans, who, under certain criteria can receive services or benefits starting at age 45.

> The Older Americans Act affects the daily lives of older adults, their families, and those who work with them.

During the 1980s, the Administration on Aging explored the feasibility of changing the age of eligibility for everyone to 70. This created quite a stir among practitioners who felt the change would be detrimental to elders in general. The proposed age change was also seen as especially harmful for elders of color whose overall life expectancy is less than that of their white counterparts. The issue was dropped and today the age remains at 60.

The preamble of the Older Americans Act maps out an ambitious course. In brief, it lists 10 service provision objectives for older adults:

1. An adequate income.
2. The best possible physical and mental health.
3. Suitable housing.
4. Full restorative services.
5. Opportunity for employment without age discrimination.
6. Retirement in health, honor and dignity.
7. Pursuit of meaningful dignity.
8. Efficient community services when needed.
9. Immediate benefit from proven research knowledge.
10. Freedom, independence, and the free exercise of individual initiative.

Equity and access

In theory it is difficult to argue with the Act's objectives. But the language is so vague and the funding so inadequate that achieving these objectives is not realistic. The vagueness of the language is both a plus and a minus. On the one hand, this vague language may allow localities to determine what is adequate and best for their constituency, but, on the other, it can also make the aging experience less equitable.

Because funding has not kept pace with either changing demographics or the economy, elders in rural America often do not have access to the same scope or level of services as elders in urban and suburban United States. Rural service providers do not find it fiscally feasible to bring services to consumers. Instead, most services are set up for the consumer to come to a specified location. This means that even elders who live in urban and suburban areas may not have good access to needed services.

Programs and eligibility

Programs and services under the auspices of the Older Americans Act include congregate meals, home delivered meals, nutrition education, transportation, home repair, and employment, to name only a few. These programs and services can preserve the independence of many older adults at risk of institutionalization and allow them to stay in the community.

There is no income eligibility for programs (one exception being stipends for some employment services). But because funding is limited, priorities have been established to focus services on those at greatest risk of institutionalization. The priorities include individuals who are age 75 and older, live alone, are members of an ethnic minority, and have a low income. Certainly many elders fit all these criteria, and some who do not may also be at significant risk of institutionalization. But given the constraints of limited resources, the use of priorities is an attempt to focus on elders most in need of help.

The role of Area Agencies on Aging

The funding for the Older Americans Act works like this: Monies are appropriated through the Act to the Administration on Aging, which then allocates funds to the State Units on Aging. The State Units on Aging in turn allocate monies to the Area Agencies on Aging, which then contract with local entities or provide services directly. Every locality in the United States is served by an Area Agency on Aging. Some Agencies cover large urban areas,

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while others cover multiple counties and municipalities—particularly in rural areas.

Area Agencies on Aging provide advocacy, program monitoring, and in some localities, case management, referral, and direct-service programs. This often depends on municipal and state regulations.

Agencies are also required to have a 1-800 number and to be a "one-stop shop" where community members and service providers can find information about senior services.

Controversy and discussion

The Older Americans Act should be reauthorized every five years. Throughout its history, though, it has taken a backseat to higher profile policies like Social Security and Medicare. The Act is seldom debated in public, yet without it many elders currently in the community would be institutionalized.

The Act has also generated some controversy. Some question the efficacy of a policy that uses age as a primary determinant for need. Certainly nutrition, housing, and transportation are needs that know no age limit. Should we have a policy that pertains to only 13 percent of the population? This has been an on-going discussion between those that advocate for older adults, and those who advocate for children and other populations.

Phyllis A. Greenberg, PhD

But for now the programs and services mandated by the Older Americans Act are available, if limited in scope. For more information on the Act, and other age-related and based policies, visit: *www.geron.org*, a website with links to just about everything related to aging and older adults.

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and valid measures of state elder friendliness furthers our understanding of how macro-social conditions (state characteristics and programs) influence individual and family efforts to meet the needs of the elderly. These measures can enable future studies to augment personal correlates of aging well with salient contextual factors. This research offers family practitioners information essential to helping elderly persons make critical decisions. It can also help public policymakers and administrators design sound programs for the supporting the elderly.

The dimensions of elder friendliness

The five dimensions of state elder friendliness are: political organization and mobilization of the elderly, recreational lifestyle, modest socioeconomic milieu, health and acute medical care, and long-term care and Medicaid. Here we introduce each dimension and outline some basic findings.

Political organization and mobilization of the elderly: This dimension focuses on political efficacy among the elderly. We measure how well a state's elders are able to influence state public officials on common concerns such as minimizing employment discrimination against elders or maximizing tax preferences for them. Sharp cross-state variation on this dimension suggests that we treat features of the mostly highly efficacious states as models for other states.

Recreational lifestyle: The second dimension focuses mainly on the vibrant portion of the elderly population. Demographic and labor market changes have tempered the portrayal of life beyond age 65 as a time of relaxation and recreation, but significant numbers of elderly persons—who generally enjoy good health and secure financial positions—seek recreational lifestyles. Often, they move to states such as Arizona or Florida that offer lots of sunshine, relative warmth, and well-developed recreational facilities. Other elders cannot move from states, such as Iowa, that rank low on this dimension, but they still have recreational needs.

> What state is most ielder friendlyî? It all depends on oneís needs at the moment.

Modest socioeconomic milieu: This dimension rates states on the relative affordability of a safe environment. This is important because a significant portion of the elderly live on modest and relatively fixed incomes. In fact, according to AARP, slightly more than half of Americans 62 or older depend on Social Security for more than half of their incomes. Rural states dominate the top ranks on this dimension.

Health and acute medical care: This dimension assesses the quality of health, medical-care, and dying-related variables among a state's elderly population. Infants and the elderly suffer the highest rates of health problems and thus, the greatest need for medical care.

Long-term care and Medicaid: States often become responsible for providing assistance with aspects of daily living through long-term care. The U.S. General Accounting Office indicates that slightly more than half of the Americans who reach 65 will require some period of care in a nursing facility, and half of these persons will need extensive periods of service. Long-term care is quite expensive. Few residents of long-term care are covered by private insurance, and most eventually exhaust their personal resources and rely on Medicaid. Yet state Medicaid programs vary in their coverage of long-term care expenses.

Research and policy implications

We find that states exhibit sharp intra-unit and inter-unit variation on all five dimensions. States near the top of the rankings on one or more dimensions are apt to lie near the bottom of the rankings on other dimensions. No state appears among the top-ten or bottom-ten ranks on all five dimensions. Furthermore, the distance between leading and laggard states is substantial for each of the five dimensions.

At any given time, different states are apt to be more "friendly" to some segments of the elderly than to others. This means that, as individual elders age, the states that best suit their shifting situations and needs are apt to change. Thus, we do not attempt to combine states' scores on the five dimensions into a single overall measure.

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The Intergenerational Equity Debate Goes Global

by Steve Wisensale, PhD, Professor of Public Policy, School of Family Studies, University of Connecticut

In 1882, Anthony Trollope published *The Fixed Period*, a futuristic novel in which older citizens seemed to have outlived their usefulness and were viewed as burdens to society. The setting is Britannaula, a fictitious island where the younger citizens had adopted a "fixed period" law that required all citizens 67 or older be "deposited" in a special honorary college known as a "necropolis." Here, members were expected to spend one year in deep thought and peaceful reflection before being chloroformed and cremated.

Slightly more than a century later, a similar literary portrait was painted of the United States. In the 1985 novel, *Mega-traumas: America at the Year 2000,* the lead character pays a visit to the Oval Office to warn the President of the United States about an emerging problem: "Simply put, America's elderly have become an intolerable burden on the economic system and the younger generation's future. In the name of compassion for the elderly, we have handcuffed the young, mortgaged their future, and drastically limited their hopes and aspirations."

While *The Fixed Period* is the product of a professional writer, *Mega-traumas* is not. Its author, Richard Lamm, is the former Democratic governor of Colorado who in 1984 reportedly said that older persons "have a duty to die and get out of the way." In 1993, he was even more pointed in his commentary, asking, "Is it not only fair, but desirable, to have a different level of care for a 10-year-old than for someone who is 100?"

A class war in disguise?

Though 100 years apart, Trollope and Lamm had at least one thing in common: intergenerational equity, a concept that surfaced in political debates and among the popular media throughout the 1980s and 90s. Daniel Callahan's 1987 work, *Setting Limits,* argued that limited resources should prompt policymakers to consider a health care rationing program based on age. A year later Henry Fairliee authored a story on intergenerational equity in the *New Republic* that referred to the old as "greedy geezers." In a 1996 *New York Times Magazine* article, MIT economist Lester Thurow strongly suggested that generous entitlements for the elderly at the expense of the young will produce the ultimate backlash: the birth of a new revolutionary class.

From another perspective, however, the intergenerational equity debate can be viewed merely as a class war in disguise, designed to undermine the cross-class strengths of the old-age coalition and weaken the power of the elderly lobby. An elite group of conservative policymakers, academicians, think tanks, and business leaders have orchestrated the rhetoric of young versus old to create a public image of the elderly that justifies cuts in social spending and major reforms for Social Security. For example, just one day after winning his second term as president in 2004, George W. Bush announced that he would push for a major overhaul of Social Security in an effort "to ease the burden on our children and grandchildren."

The rhetoric of young versus old has been orchestrated to create a public image of the elderly that justifies cuts in social spending.

The graying of the globe

Meanwhile, intergenerational equity is gradually making its way onto the political agendas of nations throughout the world. Longer life expectancies, combined with lower fertility rates, have produced a demographic profile in which developed nations have about the same number of children under age 15 as they have adults over 55. Consequently, we are members of a global society that is the oldest in the history of the world and we are getting older. By 2030, most European nations will have elderly populations that constitute 25 percent of the total. In Japan, the elderly are expected to make up nearly 30 percent of the nation's population by 2030.

However, the problem does not end there. Individual nations are experiencing shifts in their particular age structures that, ultimately, will affect their respective dependency/support ratios. This ratio represents the number of people under age 15 and over age 64 who are dependent on those who usually participate in the work force (ages 15-64) and pay taxes to support the "too young" and the "too old." It is precisely at this intersection where questions concerning intergenerational equity are spawned. That is, how should resources be allocated across different age groups? And, who should pay how much, for what programs, to serve which populations within a given society?

A moral imperative, a societal goal

In 1999, the theme for the United Nations International Year of Older Persons was "Toward a Society for All Ages." Recognizing that the globe is graying rapidly and there is great potential for conflict between generations over limited resources, the United Nations adopted a plan of action designed to initiate and maintain a dialogue on this important issue. A key component of the action plan is anchored in two fundamental questions: First, is intergenerational equity morally justified? And second, is intergenerational equity something toward which a society should strive?

With respect to the first question, it can certainly be argued that intergenerational equity is always morally justified. The fair allocation of resources between and among various birth cohorts and age groups is not an easy task. Nevertheless, theoretical models do exist and should be explored further. For example, Norm Daniels has developed a framework from the work of philosopher John Rawls that could, in principle, justify age-based allocation or denial of resources according to an equitable distribution procedure over an entire lifespan.

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Couples and Retirement: Not Just a Matter of Money

by Maximiliane E. Szinovacz, PhD, Sue Falkner Scribner Distinguished Professor of Geriatrics, Glennan Center for Geriatrics and Gerontology, Eastern Virginia Medical School

Researchers have typically treated the retirement transition and its outcomes as an individual transition, and retirement planners have focused on the financial aspects of this transition. But increasing longevity means that widowhood is delayed until older ages so that many individuals face retirement while still married. Furthermore, the rise in the labor force participation of women means that many couples facing retirement are dual-earners.

These demographic changes imply that retirement transitions need to be seen from a couple perspective: Both partners will have to negotiate when each partner should retire, and partners will have to adapt not only to their own retirement but also to the retirement of their husband or wife. Recent research, including our own analyses based on data from the University of Michigan's Health and Retirement Survey (HRS), provides some insights into the couple context of retirement transitions.

The retirement transition

With the abolishment of mandatory retirement, the decision to retire now rests foremost on individuals' ability and willingness to continue employment in later life. Although not all retirement transitions are voluntary (for example, job displacement or illness may force people into retirement), this policy change has enhanced employees' control over the retirement transition and widened the range of factors impinging on retirement decisions. Among these factors are characteristics of spouses and the marital relationship.

There is quite consistent evidence that couples favor joint retirement. But this can be difficult, or even impossible, due to circumstances such as illness or the job displacement of one spouse. Joint retirement can also be hampered by benefit eligibility regulations (both Social Security and pensions). For example, eligibility for full Social Security benefits currently is set at age 65 (it will increase to age 67 over the next decades). Because husbands are typically older than their wives, spouses often do not reach full eligibility at the same time.

> Spouses in happy marriages are more eager to retire and tend to retire earlier.

To overcome this hurdle, some couples decide to retire separately, while others still retire within a relatively short time period but not at the exact time of full eligibility. Husbands may delay retirement somewhat to enhance their wives' benefits, while wives tend to retire somewhat before reaching full benefits.

Although many couples agree on the timing of their retirement, this is not always the case. U.S. studies suggest that spouses exert mutual influence on each other's retirement, but that the husband's influence prevails. For example, older retired husbands who do not want their wives to remain in the labor force sometimes are successful in "pushing" their wives into retirement.

Other factors that influence retirement decisions include spouses' health and the quality of the marital relationship. One spouse's illness can lead to early retirement of the other, who then cares for the sick partner. Or the healthy spouse may be obliged to work longer to support the household and pay the medical expenses.

There is also evidence that retirement decisions depend on the quality of the marital relationship. Spouses in happy marriages are more eager to retire and thus tend to retire earlier. Partners in less satisfactory relationships tend to delay retirement.

Adjustment to retirement

Generally, research documents considerable stability of marital quality during the retirement transition. Nevertheless, retirement has been shown to influence relationships both positively and negatively. Whether retirement enhances or hinders marital satisfaction and the well-being of individual spouses depends at least partially on the couple's retirement timing decisions, on each spouse's characteristics, and on both partners' adjustment to retirement.

As far as spouses' retirement timing is concerned, traditional gender ideology favors retirement of the wife either earlier or at the same time as the husband. Such retirement transitions are in line with the husband's traditional role as primary provider. Studies confirm this trend: Couples in which wives continue employment after the husband's retirement tend to report more post-retirement adjustment problems (for example, in terms of their own emotional well-being or of their marital happiness). Couples in which wives retire earlier or at the same time as their husbands report fewer adjustment problems.

But the relationship between marital satisfaction and retirement timing may be contingent on the couple's gender role ideology and on the pre-retirement quality of their relationship. In addition, the wife's emotional health may suffer if she is forced to retire because of her husband's illness.

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Concerning the second question, intergenerational equity is definitely a goal towards which any society should strive. To paraphrase Harry Moody, it should be viewed as more than a code word that is employed during political campaigns. Instead, it should serve as a means to keep the debate going, to keep the dialogue responsible, and to remind us of our basic societal principles so that we can make wise decisions for ourselves and for the greater good.

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Academic Women and Retirement

by Norma A. Winston, PhD, Professor of Sociology, University of Tampa; and Jo Barnes, PhD, Senior Lecturer, Department of Societies and Cultures, University of Waikato, New Zealand

Retirement from the labor force, once largely a male phenomenon, is becoming increasingly common among women. The findings reported here come from a study of retired academic women.

We interviewed a sub-sample of 10 women who had retired from academia in the United States and New Zealand. Four women were married, four were single, and two were divorced. The American academics had been retired for an average of six years, and their average age at retirement was 65. For the New Zealanders, the averages were a little lower: an average retirement of three years and an average age of 63.

Only three women had planned to retire at the age they did. For the others, retirement was triggered by unanticipated events, such as university "buyouts," burnout, or a spouse's decision to retire.

Attitudes toward retirement

All gave positive responses to the question, "How has retirement been for you?" One respondent said: *It's such a joy to think that I don't have to worry about Monday morning. The weekend is every day ... and you can do whatever you want whenever you want to do it!*

Surprisingly, there were no differences between those who had freely chosen their time of retirement and those who had retired due to unanticipated events. One respondent whose contract had been bought out evaluated her retirement on a scale of 1-10 as a "10." She went on to say that her schedule filled up very fast in retirement—a sentiment echoed by almost everyone. She was just as busy as when she was working. But there was a difference: *...my schedule has a lot more flexibility to it and I can pick and choose pretty much what I like to do.*

> The women felt no loss of status in retirement.

Financial preparation and planning

The interviewees in both countries had accumulated sufficient financial resources to provide them with a good standard of living by paying into retirement funds. Some had additional savings and investments, and in all cases, their homes were paid for. All the respondents, excepting one, had enough money to travel.

The women had done remarkably little planning. Just one woman presented a clearly planned scenario. She and her husband intended to complete the writing they had not been able to do while employed full-time, in addition to taking up other interests.

Retirement activities

Nine of the 10 women continued working in academia. Their activities included full- to part-time teaching, research and writing, consulting, and administrative work. Several women also remained socially connected with members of their former departments.

Four women served on boards, commissions, or associations, and another

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Some wives also reported lowered emotional well-being if "pushed" into retirement by already retired husbands.

Other research shows that some couples profit from retirement. This is often attributed to the couple's increased opportunities for joint endeavors. In addition, less spillover of work-related stress often means a more relaxed atmosphere at home.

Problems encountered after retirement center around issues of propinquity and expectation. Some wives complained about the husband being underfoot ("I married him for better and for worse but not for lunch"), while husbands found their wives' household routines lacking. Couples with high expectations about joint leisure after retirement also may be disappointed if their expectations cannot be met.

Implications for policy, practice, and research

Retirement policies have tended to focus on the individual. They are thus often at odds with the needs of couples and families. Options that would allow more choice in retirement decisions and accommodate spouses' preferences could ease the retirement transition for many couples.

For example, some European countries allow individuals to purchase credits toward benefits, an option that may help couples retire jointly without loss of critical benefits. Similarly, work policies and programs that reduce the stress of caring for a sick spouse while continuing to work could help people remain employed and maximize their retirement benefits. Creating such options would boost retirees' emotional well-being and potentially reduce the cost of treating mental and physical problems associated with stress.

Practitioners who do pre-retirement counseling would be well advised to discuss marital issues as well as finances. When a couple's retirement plan optimizes financial benefits but conflicts with the preferences of one spouse, couples should try to find a compromise solution that balances both. This approach is likely to have better long-term consequences for the couple than a plan based solely on financial considerations.

Similarly, benefits of continued employment to the individual or couple should be weighted carefully against costs of role stress. Even in old age, spouses who are strongly attached to their work role may benefit more from stress-reducing work programs than from an unwanted retirement transition.

Researchers need to pay greater attention to the complexities of retirement transitions and the linkages among life spheres. A life-course approach that maps linkages among work, family, and other salient roles over the life span will be best suited to advance our knowledge on retirement and other major life course transitions.

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Rekindling Romance: Seniors Who Find Lost Loves

by Nancy Kalish, PhD, Professor of Psychology, California State University, Sacramento

Rekindling romance has become trendy since the creation of websites to find old classmates, people search engines, and even television shows that reunite guests on the air.

I have been researching rekindled romances since 1993 (full disclosure: I am the Relationship Expert at Reunion.com). This research was, and still is, the only empirical research conducted on people who have reunited with lost lovers after many years apart. The results clearly indicate that contacting a lost love should never be taken lightly.

In my 2004 survey of 1300 adults, randomly selected by the Syracuse University StudyResponse.com program, 30 percent of the participants ages 18 to 92—none of whom had ever tried a lost love reunion—indicated that they would reunite with their first loves if they could. Of the married participants, 18 percent said they would reunite if their first loves appeared.

All 50 states are represented, along with 38 additional countries. Data from the first 1001 participants are included in *Lost & Found Lovers,* published in 1997. Since then, the study has grown to 2500 participants, ages 18 to 95, who have tried lost-love reunions after a separation of at least five years, with the longest separation being 75 years. A control group comprises 1300 adults who have never tried reunions.

The lost love participants were recruited through paid newspaper ads, public service announcements, print and broadcast media interviews, Internet forums (AOL, CompuServe, and later, my own website), word of mouth, and posters, among other methods. There were no significant differences in geographic regions or in how the participants learned about the research.

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volunteered in the community. Two, both of whom had retired early, worked outside of academia to supplement their income.

In addition, these retired academics engaged in a number of other activities. Nine of the 10 reported spending more time with family members since their retirement and six spent more time with friends. Four were caring for ill family members. Seven women spent time reading for pleasure. Five of the interviewees gardened, five did some regular physical activity, such as walking or working out at the gym, and five traveled. Three were taking classes for personal fulfillment.

Adjustment

All of the interviewees reported feeling well adjusted to retirement. But they did say they missed the loss of authority they had in the classroom and the structure of the academic workday. They also missed being around young people. Some reported having difficulty "slowing down."

Contrary to what might be expected, the interviewees did not report feeling a loss of status in retirement. Their status, they said, was not linked to the title they had while they worked in academia. One woman spoke eloquently about the process of readjustment: *You have to let go of getting your sense of achievement through being an academic and structure something else in. This business of creating a structure in retirement–there's certainly no lack of fulfilling and interesting things to do. It's just working out which ones you want to do!*

Concerns

A universal concern—more about aging than retirement itself—was that of remaining in good health. Fifty percent of the interviewees actively promoted good health by maintaining a pattern of regular physical activity.

The lack of affordable health care was of concern to the Americans. They were very aware that one major illness could cripple them financially and leave them with insufficient resources for the rest of their days. In contrast, New Zealand has had a universal health care system since 1941. Consequently, the cost of health care was not an issue for the New Zealanders.

The role of continuity

The academic women studied reported a very positive experience with retirement. What accounts for this is unclear. Noteworthy, however, is the role of continuity: During the first three years after retirement these women transitioned gradually from academic work to a pattern of social and recreational activities. The continuation of some academic associations may act as a bridge between full-time academic work and the state of full retirement.

Norma A. Winston, PhD

Jo Barnes, PhD

We find it interesting that the women expressed no concern about the loss of academic status. Perhaps the reason is that a woman's daily life is filled with multitasking. It may be, therefore, that academic women see their status as deriving from the combination of roles they play, which attenuates the loss of their academic role.

The findings, albeit based upon a very limited sample, indicate that adequate financial preparation, continued contact with academia, a pattern of interaction with others, and a repertoire of activities all contribute to the quality of the retirement experience for academic women.

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Long-lasting relationships

In recruiting participants, I did not specify how long ago participants' reunions had taken place (that is, whether they were recently reunited or had reunited 50 years ago at the time of the survey). Thus it was possible to see if couples who reunited years ago had maintained long-lasting relationships: they had. The overall divorce rate for this population was 1.5 percent.

A majority of participants (55 percent) chose to reunite with someone they loved when they were 17 or younger—their first love. And another 29 percent chose a former sweetheart from late adolescence (ages 18 to 22), very often their first love. Some individuals reported "returning" to people they considered lost loves from when they were 8, 9, or 10 years old. Senior participants, especially, reunited with "puppy loves." These reunions were not statistically different from reunions of first loves from high school or college years: they had the same high success rate.

The most frequent reason for the breakup of the initial romance was "Parents Disapproved" (25 percent). Other frequent reasons included, "We Were Too Young" (11 percent), "Moved Away/Went into the Military" (11 percent), "Left to Attend School" (7 percent), and "Began Dating Someone Else" (13 percent). The reasons the young romances broke up were primarily situational. Years later, during the rekindled romance, the original roadblocks were gone.

Another reason for the high success rate of the rekindled romance was shared roots. These people grew up together during their formative years, went to school together, shared a peer group, and were often close to their first love's family. Together they discovered, and invented, their identities and what love meant to them. Descriptions of the rekindled romances invariably include "comfortable" and "familiar."

Successful senior reunions

Thirty-seven percent of the participants were in their 40s and 50s when they reunited with their lost loves, 10 percent reconnected between the ages of 60 and 70, and 4 percent were in their 80s or 90s. Longevity, of course, is a factor in the decreasing percentages.

Although the number of reunions decreases with age, the "success" of these reunions increases. In their written comments, senior citizens attributed their success to their maturity: improved communication skills, a new-found ability not to "sweat the small stuff," and knowing exactly how they wanted to spend their later years. They also commented that now they lacked the tolerance for arguments, so they avoided arguing. These factors have also been cited in research on relationships of seniors with their spouses and their old friends.

More younger people reported sexual involvement as teenagers. But sexual involvement did not influence a couple's choice to reunite: 46 percent had not been sexually involved with each other during their teen years, and 48 percent had been. Further, being sexual together as teens neither increases nor diminishes the adult couple's chance of success in the reunion.

Contacting a lost love should never be taken lightly.

The couples' first love had endured through their many years apart and, in the case of widows and widowers, often through very happy intervening marriages. These reunited couples believe they are soul mates and many believe that a Higher Power brought them back together. One man in his 70s wrote: *Where we end up after death, only God knows. But we will surely be together.*

Risks and stumbling blocks

The high success rate for rekindled romances suggests that older adults who are lonely or reluctant to date strangers should consider pursuing an old flame. However, seniors should be warned that there are risks and stumbling blocks.

During the 12 years of this project, which corresponded with the growth of the Internet, the number of participants who found each other online skyrocketed. By 2000, the Internet accounted for nearly two-thirds of the new participants – and 80 percent of these are extramarital affairs!

Seniors are no exception. Most of the extramarital affairs start with innocent e-mail. Usually the adult who initiates the correspondence is divorced or widowed but then finds that the lost love is married. Neither of them is planning to become involved in an affair.

But the correspondence escalates quickly –71 percent of participants report obsessive thoughts and compulsive behaviors. E-mail messages often lead to telephone calls, and the urgency of the calls leads to the first meeting, which usually begins an affair.

Because they were brought up at a time when premarital and extramarital sex was especially stigmatized, members of the World War II generation who were involved in affairs were ashamed and guilt-ridden. A minister (one of seven clergy men and women participating in the project) wrote:

I have spent the last 45 years of my career in the Church trying to lessen people's pain. So it brings me great sadness to think that I will cause pain to my innocent wife and children. But this love for my first love can no longer be denied.

Reaction of adult children

Adult children are often unsupportive of these new romances. When the parent is widowed, children see the old flame as an interloper. This is true of many second marriages, of course, but rekindled romances bring special concerns: the old flame preceded the other parent. Even middle-aged children feel uncomfortable with that, as if the parent is telling them, "This is the person I should have married." In fact, some parents do say this to their children, leaving them to wonder, "So I shouldn't have been born?"

In addition, middle-aged children are often protective. They may believe that the lost love is coming back to their parent to take their inheritance away. Or, they worry that their parent does not know this person anymore: after all, 50 years may have passed. Children may worry that the parent is senile, or at the very least, chasing a fantasy.

To make matters worse, these romances proceed very rapidly. Elder lost lovers feel they have wasted many years without each other, that they have little time left, and that they do not want to wait. They marry within months—or days—of reuniting. No wonder their middle-aged children are worried.

When these elders go into therapy, often at the insistence of their families, therapists usually have no more insight into rekindled romance than the grown children. Rekindled romances have a different history and a different pace, follow different rules, and

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A Comparison of Cohabiting Relationships Among Older and Younger Adults

by Valarie King, PhD, Associate Professor of Sociology; and Mindy E. Scott, MA, Doctoral Candidate, Department of Sociology, The Pennsylvania State University

Although cohabitation is more prevalent among younger adults, it is increasing among older adults. While the cohabitation rate among unmarried persons under 40 years old almost doubled between 1980 and 1990, the rate among those 60 and older tripled during the same period. Using data from the 2000 Census, we found that over 1.2 million persons age 50 and older were cohabiting.

An unstudied phenomenon

Research has largely ignored the role of cohabitation among older adults. It has been suggested that older couples develop greater maturity, patience, and appreciation for life. It has also been suggested that the relationships older couples may also be more stable than younger couples because they are less likely to be dealing with stressful responsibilities such as raising young children or dealing with peak career demands.

On the other hand, as people age, they are more likely to have experienced divorce, widowhood, or the breakup of prior cohabiting relationships. Prior cohabitation is negatively associated with the quality and stability of subsequent unions. Furthermore, individuals with prior marital experiences have fewer plans to marry their cohabiting partner, another factor negatively associated with relationship quality among cohabitors.

The experience of cohabitation is also influenced by cohort membership. Older adults grew up in an era where cohabitation was rare and viewed as deviant. They are, therefore, significantly less likely to cohabit or to approve of cohabitation. Opportunities for cohabitation are also more restricted among older adults because of fewer available partners for older women.

> Older cohabitors are more likely to view their relationship as an alternative to marriage.

Possible reasons for cohabitation

Some reasons for cohabiting—such as sharing living expenses—may be equally attractive to old and young. And like younger people who wish to remain independent, many older widowed and divorced women report that they are unwilling to give up their new-found independence. For these women, cohabitation may provide intimacy without the demands associated with a traditional marriage.

On the other hand, older people probably do not choose cohabitation because it requires less sexual faithfulness. They came of age in a very different sexual climate before the sexual revolution of the 1960s, and they appear to take dating relationships seriously, with monogamous, *steady* relationships as the norm.

And since older cohabitors are less likely to report marriage plans, it is likely that they do not view cohabitation as a way to test compatibility before marriage.

Older adults may also cohabit for reasons that have little relevance for younger people. For example, concerns about inheritance and the views of adult children appear to factor prominently in some older adults' decisions to cohabit or remarry. The financial advantages of cohabitation with regard to taxes, Social Security, and pensions may also be important, although the evidence is largely anecdotal or derived from small convenience samples.

A look at empirical data

In our study, we began with the hypothesis that, compared to younger adults, older adults (a) have higher levels of relationship quality and stability, (b) are less likely to have plans to marry, and (c) differ in their reported reasons to cohabit. Our model took into account gender, race, education, duration of the current union, presence of children in the household, and prior marital and cohabiting experiences.

Using a broad set of relationship measures, we focused explicitly on age patterns in cohabiting relationships. We also examined the influence of marriage plans on the association between age and relationship quality. Finally, we examined whether the associations between age and our measures of the cohabiting relationship were moderated by the respondents' gender.

We used data from both waves of the National Survey of Families and Households (NSFH). To maximize the number of older persons in our sample, we pooled cohabitors from each wave of the NSFH, for a total sample of 966 respondents.

To identify distinguishing characteristics of older cohabitors, we examined the relationship between age and variables such as relationship quality, relationship

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have better outcomes than average romances. These are loves that were interrupted. It would benefit therapists to learn more about this phenomenon. The number of reunions is growing, and there will be more lost love clients in the future.

Nancy Kalish, PhD

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Health, Sexual Minority Oppression, and Aging Across the Life Course

by Robin M. Mathy, MA, MSW, LGSW, MSt, MSc, MEd(c), University of Cambridge, University of Oxford, and University of Minnesota, Twin Cities

Same-sex marriage is one of the most contested issues of our time. At the same time, the scientific debate between the essentialists ("born that way") and the constructionists ("learn or choose to be that way") is at least as old as Modernism. But the jury is still out. It may take another millennium before we can determine the specific factors and iterative processes that lead to same-sex attraction, behavior, or associated identities.

However, the adverse consequences of the oppression of homosexuality are clear. Studies of sexual orientation and suicidal behavior show a strong relation between homosexuality and self-reported suicide attempts among adolescents and young adults. But almost all studies of sexual orientation and completed suicide have failed to find a relation between the two. Moreover, it should be noted that the vast majority of gay, lesbian, and bisexual individuals do not attempt or even think about suicide.

Although we know a great deal about sexual orientation and suicidal behavior among youth and young adults, studies of this topic among individuals in middle and later adulthood are scarce. In one of the few studies that have been done, developmental psychologist Tony D'Augelli found no relationship between sexual orientation and suicide attempts by older adults.

My own research indicates that the relationship between homosexuality and suicide attempts does not appear to extend beyond young adulthood. This is perplexing and points to the need for further studies of middle-aged and older adults.

Changing contexts

As a social worker trained to pay close attention to human ecology, I argue that studies of sexual orientation and suicidal behavior must be specific to social contexts. Social oppression and the stigma of homosexuality have varied according to the time and place in which gay, lesbian, and bisexual individuals have lived and experienced same-sex attractions and behavior.

The 1948 publication of Kinsey's *Sexual Behavior in the Human Male* awoke the public to the reality that homosexuality is far more prevalent than previously thought. In part due to the groundbreaking work of Evelyn Hooker and other researchers, the American Psychiatric Association was compelled in 1973 to remove homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders*.

> Sexual minorities have much to teach us about health, social oppression, and aging.

Hypothetically, individuals who reached adolescence prior to 1948 experienced more oppression than those who became reproductively mature between 1949 and 1973. Similarly, we might expect those who reached adolescence after 1973 to have experienced somewhat less oppression.

Individuals who reached adolescence in 1948 (about age 12) are now aged 69 or older. Those who reached adolescence in 1973 are approximately aged 40 or older. These two groups correspond roughly to later adulthood and middle adulthood, respectively.

Needed: Research on older cohorts

Little is known about suicidal ideations or behavior and mental health service utilization among middle and later adulthood cohorts of GLB-identified individuals relative to heterosexuals or peers in younger cohorts. This may be important precisely because most sexual minorities who are now in middle and later adulthood did not have access to GLB-affirmative therapeutic interventions to help them cope with stress-related disorders as they developed their identities.

Further, age is an essential and often neglected aspect of cultural competence even among experts in multiculturalism. To better provide culturally competent services to sexual minorities across the lifespan, further research is needed to understand the extent to which individuals' mental health histories vary by age cohort.

Controlling for the influences of sex, sexual orientation, and age cohorts, we might expect a significant decrease in gay, lesbian, and bisexual-affirmative barriers to health and mental health care following the removal of homosexuality from the *DSM* in 1973. Arguably, individuals now in middle and older adulthood may have been affected adversely by a social system that once deemed them *de facto* mentally ill.

Conversely, it is possible that the additional stress of coming to grips with a stigmatized identity at a relatively young age led to increased resilience in middle and later adulthood. If so, we might expect to find that the prevalence of risk-taking and self-injurious behaviors does not vary by sexual orientation in later life. To answer this question, it will be necessary to carefully take participants' histories to determine whether these behaviors vary by age group and age cohort after controlling for the age(s) at which they occurred.

Health of transsexuals

It is also important to understand the life course of transgender individuals. Transsexuals, both female-to-male and male-to-female, have better surgical options than they did in 1952 when Christine Jorgensen had surgical sex reassignment or in 1976 when Renee Richards underwent surgery.

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stability, plans to marry, and reasons to cohabit. We then used a series of regression models to test how the nature and quality of cohabiting relationships differ for older and younger cohabitors.

Characteristics of older cohabitors

We found that older cohabitors differed from younger cohabitors in significant and expected ways:

- The larger percentage of the oldest cohabitors was male.
- Older cohabitors were currently in relationships of longer duration and they were more likely to have experienced the dissolution of a marriage.
- Cohabitors in their 30s and 40s were the most likely to have prior cohabitation experiences, followed by somewhat lower levels among cohabitors aged 50 and older, with the lowest levels among cohabitors under 30.
- The oldest cohabitors were least likely to have children living in the household.
- Older and younger cohabitors did not differ by race or levels of education.

Older cohabitors reported higher quality relationships than younger cohabitors on most dimensions. The oldest cohabitors, 50 and over, reported higher levels of fairness, spent more time alone with their partner, had fewer disagreements, and were the least likely to argue heatedly or violently.

The oldest cohabitors were also less likely to report thinking that their relationship might be in trouble. And they were less likely to have plans to marry their partner.

Men were more likely than women to regard their relationship as fair. They were less likely to report heated arguments or that they thought their relationship was in trouble during the previous year. There were no gender differences in plans to marry or reasons for cohabitation.

We found few differences between older and younger cohabitors when it came to their reasons for cohabiting. The biggest difference was the older couples tended not to view cohabitation as a way to test compatibility before marriage.

Our results suggest that older cohabitors are more likely to view their relationship as an alternative to marriage, whereas younger cohabitors are more likely to view their relationship as a prelude to it. We found that relationships of older cohabitors are not as adversely affected by not having marriage plans as those of younger cohabitors.

Unanswered questions

Future research may explain exactly why older cohabitors are more likely to view their relationships as an alternative to marriage. For example, do prior dissolution experiences make older adults less trusting of marriage? Perhaps older adults feel less pressure to marry or see fewer benefits in it. Do taxes, financial benefits, or concerns about inheritance play a significant role?

Valarie King, PhD

It must also be recognized that cohabitation may be serving as an alternative to singlehood for some older adults, not necessarily an alternative to marriage. Again, we know little about the role that cohabitation plays vis-à-vis either marriage or singlehood in the lives of older adults.

Although we found little evidence that reasons for cohabiting vary greatly by age, we believe that it is premature to conclude that older couples cohabit for the same reasons as younger couples. Certainly some reasons would resonate equally well among cohabitors of all ages (for example, sharing living expenses), but we suspect that there are other reasons that would be more important for older cohabitors such as the views of adult children and questions of inheritance—but these were not asked about in the survey.

The differences we find between younger and older adults likely are related to a combination of effects that result from both the effects of aging and from cohort differences, although we are unable to distinguish between them in our study.

To the extent that these differences result from aging, they portend how cohabitation experiences may be for tomorrow's older cohabitors. To the extent that these differences reflect cohort differences, they may be unique to today's older adults.

Adapted with permission from King, Valarie and Mindy E. Scott. 2005. A Comparison of Cohabiting Relationships Among Older and Younger Adults. Journal of Marriage and Family, 67, 271-285.

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But surgical sex reassignment is one end of the transgender continuum. About 1 in 500 people identify as transgender rather than male or female. Thus, of the U.S. population of nearly 300 million people, about 60,000 are transgender individuals. Many take exogenous hormones to maintain an appearance that conforms to their gender identity. But we know little about the effects of long-term use of these hormones in this population.

These questions will become increasingly important as the general population ages. Individuals with gay, lesbian, bisexual, and transgender identities will—like other aging persons—have greater contract with the health care system.

Sexual minorities have much to teach us about health, social oppression, and aging across the life course. Whether or not we resolve the issues of same-sex marriage and the source of homosexuality, our humility and humanity requires us to ensure, if not demand, that the health and mental health needs of all are met with respect, dignity, and equality. If we cannot eliminate oppression, we must at least commit ourselves to providing the resources needed to study and eliminate its sequelae across the life course.

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HIV/AIDS and Older Adults

by Sharon M. Ballard, PhD, CFLE, CFCS, Assistant Professor, Child Development & Family Relations, East Carolina University

HIV/AIDS in older adults is a topic that has received little attention. This is disconcerting considering since people over age 50 account for 11 percent of persons diagnosed with AIDS, and almost 3 percent of these are over age 60. By contrast, only 2 percent of AIDS cases are individuals less than 20 years of age.

The number of new AIDS cases is increasing among midlife and older adults. Many individuals who are infected and diagnosed with HIV in middle age are more likely to survive into older age since research has shifted from finding a cure to prolonging life and enhancing its quality.

Transmission among older adults

Sexual activity, injection drug use, and contaminated blood products are the primary modes of HIV transmission among adults over age 50 and over. For many older adults—more so than for other age groups—the mode of transmission is unknown.

Overall, according to the Centers for Disease Control (CDC), the most common mode of transmission reported for older adults is sexual activity. Compared to homosexual transmission, heterosexual transmission has increased greatly, with the highest rate of heterosexual HIV transmission occurring in people over 50. However, men having sex with men is still the most prevalent mode of transmission for older adults. The use of injection drugs, both recreational drugs and medical drugs such as insulin, appears to be an increasing risk factor among older persons, both directly through contaminated needles and indirectly through sexual transmission.

Despite common perceptions, according to the CDC, only 2.2 percent of individuals age 50 and over with AIDS have received HIV-contaminated blood products. Blood supplies have been screened for HIV since 1985, but older people infected with HIV through blood transfusions before then may have continued to infect others.

Behavioral risk factors

Research has found that approximately 10 percent of older heterosexual Americans are at risk for HIV infection. Identified risk factors include multiple sexual partners, blood transfusions, hemophilia, injection drug use, and having an at-risk sexual partner. Compared to younger at-risk individuals, older heterosexual at-risk adults are less likely to use a condom during sex and less likely to have been tested for HIV antibodies. Barriers to condom use among older populations include lack of knowledge about transmission, lack of ability to see themselves as susceptible, association of condoms with birth control, and cultural factors.

People over age 50 account for 11 percent of persons diagnosed with AIDS.

African American men, men who have sex with other men, and older women are particularly at risk for HIV transmission. Post-menopausal women are vulnerable because of a decrease in immune system functioning, decreased vaginal lubrication, and thinning of the vaginal wall. These vaginal changes may increase the likelihood of a tear or an abrasion during sexual intercourse, leading to a greater risk of transmission. Denied risk and inadequate knowledge of condoms further exacerbate the risk among older women.

Diagnosis

It has been suggested that the actual number of older persons living with HIV/AIDS is higher than current estimates because of misdiagnosis, late-stage diagnosis, or no diagnosis at all. For older adults, there are two main barriers to diagnosis of HIV infection or AIDS. The first is the failure of health care professionals to recognize that older adults are at risk. Myths abound regarding sexuality and aging, including the belief that older adults do not engage in sexual intercourse. However, research clearly shows that older adults are interested in and active in a variety of sexual behaviors. In addition, many health care professionals don't see older adults as likely candidates for IV drug use.

The second barrier to diagnosis is that both doctors and older adults associate many symptoms of AIDS (for example, weight loss or fatigue) with other conditions common to aging. At the onset of the HIV epidemic, AIDS in older adults was deemed the "great imitator," because AIDS-related dementia often was misdiagnosed as Alzheimer's disease.

An additional barrier to diagnosis may be the stigma associated with the behavior responsible for infection. This may be especially true for older gay men who refuse to be tested, particularly those who have remained "closeted" and for whom a diagnosis would threaten their career, marriage, and family.

Older adults infected with HIV progress to AIDS more rapidly and have a shorter survival time than younger adults. Among older patients, the denial of risk, delayed diagnosis, attribution of symptoms to the aging process, reduced access to HIV-related health care, and a greater incidence of non-HIV-related comorbidity contribute to a poor prognosis after diagnosis.

Older adults as caregivers

In addition to being infected themselves, older adults are often called upon to care a person with AIDS. Approximately one-third of Americans with AIDS depend on older adults for care and support. Older adults may be the primary caregivers for partners, spouses, siblings, or adult children. They also may find themselves in a secondary caregiving role in which they provide care for friends, neighbors, or co-residents. Possible secrecy surrounding the illness, fear of becoming infected, the need to come to terms with their child's homosexual orientation, and the eventual off-time loss of an adult child can all add additional stress for the older caregiver.

Many older adults who care for their adult children also experience unplanned parenthood when they become the primary caregivers for their grandchildren. As many as one quarter of these grandchildren may also be infected. For these grandparents, AIDS can mean the serious illness or loss of both their child and grandchild.

Knowledge levels

Most empirical research on HIV/AIDS and older adults has measured knowledge levels. Across studies, the most consistent

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Great-Grandparents, Grandparents, and Adult Grandchildren in the 21st Century

by Nancy W. Sheehan, PhD, Associate Professor; and Kimberly Petrovic, MSN, RN, Doctoral Student in Aging and Adult Development, School of Family Studies, University of Connecticut

We are aging, not only as individuals but also as extensions of families. These days, many of us are aging as a collective of three-, four- and even five-generation families. Increased longevity, decreased mortality, and changes in fertility rates have transformed the structure and function of intergenerational families. But the impact of these and other well-documented demographic changes on the relationships between and among great-grandparents, grandparents, and adult grandchildren is not well understood.

What is understood, however, is that an unprecedented number of older adults in the United States are grandparents, and many have at least one adult grandchild. And 40 percent of grandparents are great-grandparents!

Families have expanded vertically as more generations survive, with fewer family members in each generation. Some scholars have used to term "bean pole families" to describe this phenomenon.

This expanded intergenerational family structure offers grandparents, great-grandparents, grandchildren, and great-grandchildren increased opportunities for interaction. Some scholars speculate that because these relationships will last longer, they will become increasingly important.

The relationship between grandparents and their adult grandchildren will likely form the basis for a new "stage" of the family life cycle—one that is not well understood.

The need for new theories

Neither the popular media nor scholarly researchers have really explored the intricacies of these intergenerational family relationships. By and large, studies focus either on intergenerational solidarity or on the intergenerational developmental "stake." The intergenerational solidarity theory has typically relied on on a narrow set of dimensions to describe the relationship (for example, affection, proximity, and support).

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finding is the inverse relationship between age and knowledge: as age increases, HIV/AIDS-related knowledge decreases. In other words, older people tend to be less knowledgeable about HIV/AIDS than younger people.

Even when there is a basic awareness of HIV/AIDS, older adults often lack a comprehensive understanding of the disease. Blood transfusions and casual contact (for example, thinking that you can get HIV from kissing an infected person) tend to be particularly confusing topics for older adults.

Implications for family life education

HIV prevention has been a popular topic for teenagers and young adults, but efforts have been limited for older populations. An extensive literature search yielded a handful of HIV prevention programs targeted at older adults, and many of these have not been empirically evaluated for effectiveness. Programs that have been evaluated tend to show an increase in knowledge levels.

This review of literature and existing programs indicates several content areas that should be included in HIV/AIDS programming for older adults:

- Basic facts, including myths surrounding HIV/AIDS.
- Perceived risk.
- Modes of transmission (particularly clarifying the risk related to blood transfusions).
- HIV antibody tests.
- Prevention skills, such as condom use.
- Communication skills needed to talk about sexuality and HIV/AIDS with healthcare providers, friends, or family members.

It may also be helpful to emphasize that everyone needs to know about HIV/AIDS in today's society. Increased knowledge of HIV/AIDS is important for the peers, children, and grandchildren for whom older adults may serve as educators and role models.

A multi-method approach may be effective in distributing information. But more materials, such as posters and brochures that include information for older adults, need to be developed. Because older adults may have difficulty talking about sexual issues in a group setting, one-on-one learning in a health care setting may be more effective. Family life educators can be important sources of information for health professionals, the AIDS community, and senior service professionals as well as older adults themselves.

Sharon M. Ballard, PhD, CFLE, CFCS

There is a great need for further research on HIV/AIDS and older adults. More resources must be devoted to primary prevention and intervention for this population, including educational resources and programming that is relationship-sensitive and age-sensitive.

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Young Adult Grandchildren's Perceptions of Their Grandparents

by Benjamin Schlesinger, PhD, Professor Emeritus, Faculty of Social Work, University of Toronto; and Rachel Aber Schlesinger, EdD, Associate Professor/Senior Scholar, York University

To learn about how young adults perceived their grandparents, we studied 92 undergraduate students at York University in metropolitan Toronto. The students ranged in age from 18 to 30 years. Eighty-seven of the 92 students were women (94.5 percent). Only 5 were men (5.5 percent).

Eighty-three students were single; 9 were either married or living with a partner. Within the group, the following ethnic backgrounds were represented by five or more students: Chinese, English-Canadian, Greek, Italian, Jewish, and Polish.

We asked the students to fill out a questionnaire. Several questions asked for demographic data related to the students and their grandparents. The remaining questions attempted to elicit information about the roles grandparents played in the lives of the adult grandchildren, and what activities the grandchildren did with the grandparents. The responses give us a sense of how these young adults perceived their grandparents.

Students were asked to describe:

- Their favorite grandmother.
- Their favorite grandfather.
- The most important roles a grandparent can play in the life of an adult grandchild.
- How their grandparents helped or supported them.

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GREAT-GRANDPARENTS *continued from page F15*

As a result, research has yet to explore the full range of dimensions that constitute the evolving conflict-solidarity model.

In addition, researchers who use an oversimplified version of solidarity theory fail to capture the dialectical tensions underlying the dimensions of intergenerational solidarity, such as intimacy and distance (affectual solidarity) or dependence and autonomy (functional solidarity). Although it's unclear whether the concept of intergenerational ambivalence is a new way of viewing intergenerational family relationships or merely an extension of existing theory, one thing is clear: researchers have yet to explore how ambivalence functions in this relationship.

Symbolic interaction theory has the potential to describe the various roles and meanings associated with being a great-grandparent, grandparent, or adult grandchild. Erikson's psychosocial theory of development has been applied to the generativity that grandparents may (or may not) experience. Theories of kin-keeping and kin-selection have allowed us to examine grandparent lineage and its effect on closeness in the grandparent-adult grandchild relationship.

But new theories are needed that look specifically at how the emergence of "beanpole families" alters the nature of family roles and relationships. Finally, from a developmental perspective, recent life span theories may provide insight into how great-grandparents and grandparents view relationships with their adult grandchildren. Selectivity, optimization, and compensation ("SOC") and socioemotional selectivity are two notable examples of recent theories that have the potential to explore the relationship from the perspective of great-grandparents and grandparents.

The need for new methodologies

Quite often intergenerational relationships are examined from a single viewpoint. Grandparents are asked to describe a favorite grandchild, or adult grandchildren are asked to describe a relationship with their closest grandparent.

Most grandparents now have at least one adult grandchild.

As a result, research says very little about either the congruence between grandparents' and adult grandchildren's perceptions or the grandparent-grandchild system within the entire family system. Instead, we know about only a very narrow, highly selective sub-set of all relationships that grandparents may have with all their grandchildren (for example, the favorite grandchild). Since continuity and change are essential aspects of all family relationships, researchers need to develop methodologies for capturing how intergenerational families evolve in response to both micro and macro events.

Finally, as age roles increasingly blur so that adult grandchildren, grandparents, and even great-grandparents potentially share many adulthood roles and experiences, researchers need to explore these changing relationships.

Nancy W. Sheehan, PhD

Aging Successfully Together

Unlike any other time in history, adult family members of extremes in age are sharing the life cycle. This phenomenon presents opportunities for personal and interpersonal growth, changes in the definitions of meaning and vitality throughout the lifespan, and new perspectives on the roles of great-grandparents, grandparents, and adult grandchildren. Along with opportunities for conflict, intergenerational relationships present family members with the chance to enrich the lives of one another, thereby contributing to successful aging.

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Structural Factors Related to Grandchild and Grandparent Co-Residence in 2000

by Twyla J. Hill, PhD, Associate Professor of Sociology, Wichita State University

In 2000, over 4.5 million of American children (6.3 percent) were living in a grandparent-headed household. Most studies of grandparent/grandchild co-residence are qualitative and done from a micro perspective. This project uses a macro perspective to see if structural conditions are related to co-residence. Social change, state motivations and capabilities, and social problems are considered as possible factors. State-level data such as divorce rates, nonmarital birth rates, and poverty rates are used to assess relationships between structural factors and the proportion of children residing in grandparent-headed households.

This study combines data from publicly available sources. The Census Bureau publishes state rates of co-residence, divorce, teen and nonmarital pregnancy, poverty, and employment of parents of young children. The Department of Justice publishes crime, drug use, and alcohol arrest rates. Specifics of methodology are available from the author.

Social change

Many sociologists argue that changes such as rising divorce rates have increased the importance of grandparents. As marriages have become focused on emotional intimacy and more prone to disruption, extended family members have tended to become reserve sources of financial and emotional support. When the middle generation divorces, grandparents are often expected to step in. One might expect, therefore, that states with higher divorce rates would have more grandchildren living with grandparents.

But state divorce rates were not strongly related to grandparent-grandchild co-residence in 2000. One possible explanation is that, like marriage, grandparenthood is also affected by the social emphasis on sentiment and autonomy. If this is true, rising divorce rates could also signal less willingness on the part of grandmothers and grandfathers to take in children.

Some researchers argue that rising levels of employment of mothers of young children mean increased reliance on aid from the older generation. But one might also expect that a mother's employment would allow her to maintain her own residence and rely on grandparents for day care, rather than full-time "parenting." If this is true, states with higher rates of employment of mothers of young children should have lower rates of co-residence.

Structural conditions are related to grandparent-grandchild co-residence.

Unfortunately, the only available statistic is the percentage of families with children under 6 with all parents in the family in the labor force, which is not an exact measure of mothers who are employed. But as predicted, this variable is negatively related to percent of children living in their grandparents' homes.

State motivations and capabilities

The third model examines government capacities and motives. For example, grandparents are increasingly being used as foster care providers. Although this phenomenon is partially a response to activism on the part of "family preservationists," it is also due to an increase in children who need foster care, which is also increasing in cost.

But low-income grandparents may need public aid to care for grandchildren. States with a political culture of social aid are more likely to make resources available than states without such a tradition. And because states with more resources tend to be more liberal, these states also should provide more support for grandparents who are "fostering" grandchildren. This, in turn, would mean more co-residence.

Public administrators may also want to increase their areas of control by expanding social programs to cover grandparent/grandchild co-residence: this argument predicts that states with more state employees relative to the general population will have more co-residence. In addition, urban states tend to be more liberal in starting social programs than states that are predominantly rural. Therefore, states with higher percentages of urban residents should also have higher proportions of children living in their grandparents' homes.

But in fact, states with more resources actually had lower levels of co-residence in 2000. Perhaps these states have provided aid for parents, reducing the need for co-residence.

On the other hand, states with higher levels of full-time public employees in proportion to the population are associated with higher proportions of co-residence. And states with more urban residents also have a higher proportion of children living in their grandparents' homes. Overall, it seems that states with a culture of social assistance do have more children in grandparent-headed households.

Social problems

Lastly, many researchers suggest that co-residence is driven by social problems that affect the middle generation's ability to parent. These problems include drug and alcohol abuse, teen pregnancy and single parenthood, incarceration, unemployment, and poverty in general. But most social problems are not confined to just one generation. This means states with higher nonmarital birth rates, higher poverty rates, and higher incarceration rates should also have higher rates of co-residence.

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Parenting Again: Grandparents Raising Grandchildren

by Kathy Zimmerman, BS, Provisional CFLE, Master's Student, George Fox University

Statistics show that 44 percent of grandparents spend at least 100 hours a year taking care of their grandchildren. Some grandparents baby-sit for the children while their parents work. But many children and their parents are living in the grandparents' home. Currently, there are approx 2.1 million children being raised solely by their grandparents.

Grandparent-headed households have increased 30 percent since 1990. According to the AARP, there are eight times more children in grandparent-headed households than in foster care. Grandparents raising grandchildren come from all ethnic backgrounds and socioeconomic levels, though many live at the poverty level.

A "lost generation"

Most grandparents come into this role by default because of their children's death, divorce, or mental illness. The increase in never-married mothers and the AIDS epidemic are also factors. But more than any other reason, grandparents are raising grandchildren because their own children have become irresponsible parents. These grandparents are parents of what is referred to as "the lost generation," people of childbearing age who are addicted to drugs or alcohol, are incarcerated, or have lost custody of their children due to neglect or abuse.

I know a number of grandparents who are raising their grandchildren. Their daughters were teenagers when they became pregnant. Though the girls wanted to keep their babies, they didn't want to give up their lifestyle. These grandparents are now parenting two generations at the same time. One of their biggest fears is that their daughters will become pregnant again.

According to Alma Johnson, who facilitates a group for grandparents raising grandchildren for the Urban League of Portland, "Grandparents often feel guilty about how their children turned out, and sometimes it is that guilt that motivates them to take the grandchildren."

The challenges of a new role

Adjusting to the role of caretaker and the life changes that occur when raising grandchildren is difficult. Grandparents wonder if they will be able to deal with the challenges of childrearing again and if they will be healthy enough in the years to come. Many of the complaints are similar: fatigue, guilt, and lack of emotional support. In many cases there is a financial drain. In addition, grandparents struggle with medical coverage and childcare (if they are still working). Even enrolling the children in school becomes an issue if grandparents do not have legal guardianship.

Johnson said that many grandparents meet the physical needs of the children but not their emotional needs. Children who come to live with grandparents, especially from abusive or addictive homes, bring a lot of emotional baggage and often have behavioral problems. It is not uncommon for children to feel resentment, anger, confusion, and grief. Children may idealize the parent, making the grandparents feel unappreciated and rejected.

"These kids need to be taught to deal with their feelings. It is important to break the cycles of abuse and addiction when the children are young so they don't repeat the pattern," Johnson said.

Need for support

The group I observed at the Urban League consisted of women only. All were caring for two or more children, ranging in age from babies to children in their late teens. These grandmothers come together one Tuesday a month. They indicated they did not socialize with each other outside of the group mostly because they were just too busy. They did enjoy getting together and knowing they were not alone. They shared what worked for them in various situations such as dealing with teething, sickness, childhood diseases, emotional outbursts, and school problems.

When I asked Johnson whether the grandfathers were supportive, she indicated that it is usually the grandmother who takes responsibility for the children. This is usually an area of contention for the grandparents as a couple.

School issues

I asked the women in the group, "How is your communication with the school?" One grandma said she thought she embarrassed her grandson. He was now in junior high, and she doubts that he has shared that he lives with his grandma. Because they have the same last name, it is not evident that she is the grandmother until she attends school conferences.

> Educators need to be sensitive to the needs of grandparents raising grandchildren.

Another grandma told me that a teacher once told the class that everyone should own a computer. This statement offended the grandmother, since she neither wanted nor could afford a computer. Like many older people, she found computers, the Internet, e-mail, voice mail, and other technological "advances" confusing and stressful.

Educators need to be sensitive to the needs of grandparents raising grandchildren. For example, since grandparents have not had children in the school system for many years, they may need help understanding policies and procedures. In addition, teachers should remember that the children are not responsible for their living situation.

It's also important to make grandparents aware of helpful resources. One such resource is "The Apple of Your Eye," a

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Three proxies are used for drug and alcohol abuse: the crime index, the alcohol arrest rate, and estimated proportion of drug users. The alcohol arrest rate and drug usage are not related to co-residence, however. But as predicted, crime, poverty, and incarceration rates are positively related to proportions of children living in their grandparents' homes in 2000.

The proportion of births to unmarried women has the strongest relationship with percent of children living in grandparent-headed households in this model.

Conclusions

In the combined regression model, the following variables have strong relationships with the percentage of children living in their grandparents' homes in 2000:

- The nonmarital birth rate, which seems to encourage co-residence.
- The percentage of full-time state employees relative to the general population, which appears to create a political culture of social aid that increases co-residence.
- The percentage of families with children under 6 with all parents in the family in the labor force, which discourages co-residence.

Twyla J. Hill, PhD

Because of the small number of cases, these findings should be interpreted with caution. This analysis does include all 50 states, however. Also, because this project uses state-level data, inferences about individuals cannot be made.

But the findings do show that structural conditions are related to grandparent-grandchild co-residence. The findings also remind us that these variables are reflections of social structure as well as individual characteristics.

This research was partially supported by a grant from the Wichita State University College of Liberal Arts and Sciences. The author gratefully acknowledges the research assistance of Edith Brown. Portions of this research were previously presented at the 2003 Annual Meeting of the Midwest Sociological Society, Chicago, IL. For more information, contact Twyla.Hill@wichita.edu.

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- How their grandparents influenced them.
- What they had learned from their grandparents that they might want to teach to their own children.

Description and roles

Grandmothers were described as accepting, caring and cheerful, courageous, generous, giving, spunky, strong, opinionated, outgoing, and patient.

Grandfathers were described as bold, caring, courageous, happy, helpful, having good taste in music, kind, loving, strict, supportive, and interested in athletics.

When asked about the most important roles grandparents can play in the life of an adult grandchild, the students replied:

- Can be like a second parent.
- Connection to the past.
- Moral support.
- Give advice on "grown up" problems.
- Guidance.
- Religious guide.
- Support grandchildren in decision about future.
- Role model.
- Mentor.
- Share experience.
- Teach life lessons.
- Friendship.
- Emotional support.

Help and influence

Students received various kinds of help from grandparents, including help with university fees, quality time and unconditional love, and emotional support.

Students also said their grandparents shared family history and helped them make decisions. One student noted that the grandmother had Alzheimer's disease,

Benjamin Schlesinger, PhD and Rachel Aber Schlesinger, EdD

but that the relationship with the grandfather was "strong" and "amazing."

Grandparents influenced the students by encouraging them to work hard, instilling moral and religious values, acting as role models, providing unconditional love, and helping them through hard times.

In answered to the question, "What have you learned from your grandparents that you might want to teach to your own children?" students replied:

- Conflict management.
- Full acceptance and support.
- The importance of family.
- Religious faith.
- The importance of cultural roots.
- Life is not as serious as you think.

Not all relationships were positive, however. Some students said their grandparents criticized them, did not like their friends or music, made demands on their time, or needed constant attention. Students also complained about overly religious, selfish, traditional, senile, nosy, quarrelsome, and alcoholic grandparents.

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15-minute video produced by the National Association of Elementary School Principals. It gives grandparents tips on educating their grandchildren. For more information, contact the National Association of Elementary School Principals at (703) 684-3345 or jmillion@naesp.org.

Kathy Zimmerman, BS

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Raising Grandchildren in a Multigenerational Household

by Eunice Warren, PhD, Assistant in Nursing, School of Nursing, Florida State University, Tallahassee

Six years ago I researched articles that focused on interactions between African American grandparents, grandchildren, and other household members or kin and came up with very little information. I found that research has focused little on the grandparent-grandchild interaction in general and even less on minorities, especially African Americans.

The focus of most research on grandparents and grandchildren has been on relationships, roles, and complex issues faced by grandparents who raise their grandchildren. African American grandparents have been raising their grandchildren for generations. Nevertheless, not much literature is found on the topic of interaction between grandparent, grandchild, and other household kin.

> Professionals who work with African American families should try to build on their strengths.

In 2000, I conducted an ethnographic study in a rural area of a North Florida community. Nineteen people from five family households participated. They ranged in age from 9 to 82 years old.

Strong kinship networks

The families had a strong sense of individuality and family identity. The strength of their kinship network was evident. The sharing of resources, advice, and support was an important part of this network. The families did not at any time mention the need for support services outside of their kinship network. Older kin gave advice to the younger generation. Family members provided economic assistance to each other. And the grandparents seemed content to be raising their grandchildren.

In only one of the households was a father involved in the lives of his children. Three grandparents indicated that the father of the grandchildren did not support the children. One grandparent said that the children's father did not want them. While the absence of the father created an unmet psychological need in the children, the grandparents and their kin did their best to meet the children's needs and help them become productive and responsible adults.

Roles and expectations

Being a grandparent comes with social roles and expectations. So does being a grandchild or child. Although role behaviors may be culturally prescribed, the cultural prescriptions are subject to change. The grandparents in these African American families molded their role to fit their lifestyle and parenting style.

One pattern of interaction noted throughout the participants' narratives was the grandparent's role as the one who pulled the family together. The roles of the other family members were diverse, and they were based on how each family's system was structured.

The grandchildren had to make role adjustments as well, and I observed some flexibility in their adaptation. From the narratives, many of the grandchildren spoke of being caretakers, comforters, and "being there" for their kin.

Family strengths

The study results revealed the following strengths:

- Intergenerational economic assistance.
- Intergenerational advise and counsel.
- Dedication of older generations raising grandchildren.
- Continuity of religious values.
- Strong family ties.
- Emotional support.
- Amicable resolution of conflicts.
- Family cohesiveness.
- Belief in the value of education.

Implications for programs and policy

Qualitative or ethnographic investigations of this kind allow for more in-depth communication with people about their lives, values, and beliefs. The findings of this study challenge family researchers and professionals such as schoolteachers, counselors, social workers, probation officers, and others who work with African American families to build on these strengths, even though it is sometimes easier to focus on the weaknesses of families.

This study also underlines the need for more accountability on the part of fathers. Policies and laws are needed that hold them financially accountable for their children.

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Eunice Warren, PhD

Perspectives on Aging

Old age is the most unexpected of all the things that happen to a man.
—Leon Trotsky, Russian revolutionary leader

It seems to me nowadays that the most important task for someone who is aging is to spread love and warmth wherever possible.
—Käthe Kollwitz, German sculptor and graphic artist

Every time I think that I'm getting old, and gradually going to the grave, something else happens.
—Lillian Carter, mother of President Jimmy Carter

Growing old is more like a bad habit which a busy man has no time to form.
—André Maurois, French writer

Resident Service Coordinators: Strengthening the Link Between Supportive Services and Senior Housing

by Nancy W. Sheehan, PhD, Associate Professor, School of Family Studies; and Mariana T. Guzzardo, MA, Doctoral Student, School of Family Studies, University of Connecticut

Resident service coordinators are essential to the successful integration of supportive services into senior housing. These services, which include case management, assessment, and coordination of community-based services, help residents age in place and postpone nursing home placement. Although policymakers are promoting the use of resident service coordinators as a strategy to limit public long-term care expenditures, the profession remains largely unknown.

A tremendous asset

The service coordinator's primary goal is to help frail residents remain as independent as possible. As a service coordinator in a subsidized housing complex explains: *[The resident service coordinator] is key to ... independent living, because you are able to connect residents with visiting nurses and services, and educate them on what is out there for them, to help them age in place.*

Elderly residents in age-segregated settings, such as subsidized housing, congregate housing, and assisted living facilities, are more vulnerable than their community-living peers because they are more likely to be single, live alone, have smaller support networks, and have more functional impairment.

Service coordinators are a tremendous help for people who live these settings. In addition to linking residents with services, many service coordinators help residents secure entitlements, mediate interpersonal conflicts, organize social activities, serve as advocates, and assist with relocation.

An unknown profession

At both the federal and state level, policymakers acknowledge that resident service coordinators are an important part of long-term care. Few studies, however, have explored this profession. Results from our recently completed study of resident service coordinators in Connecticut offer insight into their role and their concerns, and provide a snapshot of the complex, and often hidden, social problems within senior housing.

For this study, 63 service coordinators working in federal and state-subsidized senior housing and state congregate housing responded to a survey. The sample was overwhelmingly female, Caucasian, middle-aged, and college-educated. The majority reported working full-time for either housing authorities or housing management companies. They served an average of 152 residents. In addition, a few respondents were housing managers who had added service coordination responsibilities to their primary job.

> Resident service coordinators are an important element in residentsí supportive network.

Coordinators face challenges

A sub-set of 26 respondents participated in telephone interviews. These interviews highlighted major issues faced by resident service coordinators. For example, coordinators are often called on to mediate interpersonal disputes between residents, such as gossip or noise problems. Anne, a coordinator in federally subsidized housing, said that one of her major problems was "*the squabbles between residents, because it's very difficult to come to any decision on them.*"

Some service coordinators mentioned other kinds of conflicts, such disagreements with families about the ability of a resident to continue living independently or disputes with the property manager.

Most service coordinators said that residents suffering from mental health problems are especially difficult to deal with. A major challenge is the refusal of some residents to accept services or comply with treatment. Sherry, who works in state elderly housing, said that residents with substance abuse problems *...think they can do it themselves and so they don't accept [the counseling] services, and if they're not willing to make the change to help themselves, there's not a lot you can do.*

In addition, long waiting lists, a lack of in-home services, and the general dearth of appropriate and accessible mental health services make it tough for even willing residents to find the help they need.

Respondents also said that they didn't have the resources they needed to do their job. Susan, who works in congregate housing, expressed a common concern: *[We need] more money for socialization. I think [many coordinators] run into the same problem...because in order to get people to come out [and socialize], you do parties and you have entertainment come in, and you can't do it for free.* Others mentioned lacking basic office supplies such as a computer, Internet service, and a fax machine. And some said that they lacked adequate training for the job.

Confidentiality and self-determination

These interviews also raise concern about how service coordinators address residents' rights to confidentiality and self-determination. While respondents said that they made a conscious effort to uphold residents'

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Social Support Networks of Residents in Federally Subsidized Senior Housing

by Mariana T. Guzzardo, MA, Doctoral student in Human Development and Family Studies; and Thomas O. Blank, PhD, Professor, Human Development and Family Studies, and Director, Center on Aging and Human Development, University of Connecticut

Nearly two million persons age 62 and older live in federally subsidized housing. They are considered more at risk for institutional care than the rest of the population, because of factors such as older age, higher rate of disability, lower income, and greater likelihood of being single.

Supportive relationships are crucial for these residents who are trying to hold on to their autonomy while dealing with increasing frailty. Studies suggest that older adults who are embedded in supportive networks tend to enjoy better physical and mental health than those who do not maintain meaningful ties with others. Although age-concentrated housing can replace support that residents may no longer receive from the broader community, this doesn't always happen. In fact, studies have shown that residents in federally subsidized housing tend to be especially socially isolated and have fewer available family caregivers.

The lives of five elderly residents living in federally subsidized housing in a small city in Connecticut give us a sense both of the social support needs of this population and their connection—or lack of connection—to family members.

Residents in federally subsidized housing tend to be socially isolated.

Sherry is a 75-year-old woman who has no family nearby. She lives with a roommate who, she says, has been her source of emotional support through her lapses in and out of depression. When asked if she receives social support from her neighbors, Sherry made it quite clear that she would not want to socialize with them because they pry into each other's affairs: *That's why I don't get in with the clubs, I don't eat with them, and I don't play bingo. The best thing to do when you live in a place like this is to stay out of everybody's business, and don't let them crawl into yours. Be very, very careful.*

Two Puerto Rican women also discussed the lack of socializing between neighbors. Neither woman speaks English, which can be a problem when trying to access services. Teresa, a 76-year-old married woman living with her husband, said that whenever she needs help from the visiting nurse or the housing management, she calls her daughter to translate. Teresa uses a wheel chair, so her husband is a major source of support for many activities of daily living, such as bathing, dressing, and toileting.

Maria, who is 74, said that a Hispanic homemaker who speaks Spanish provides both help and friendship. Maria connects with this woman because they share similar cultural backgrounds. In speaking about her problems with depression, she explained how the Resident Service Coordinator also helps her: *I came here very sick, I was*

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SERVICE COORDINATORS *continued from page 21*

right to confidentiality by not sharing information unnecessarily, the majority reported no formal policy regarding residents' private information.

Some service coordinators reported freely sharing information with housing managers. And some cited the tension between a resident's right to self-determination—for example, the right to refuse services—and his or her "best interest." Said one coordinator: *...my biggest conflict comes in [when I know] what is right for a resident and having the restraint to respect their choice even if they make a bad choice.*

Finally, while some service coordinators saw few limits to a resident's ability to age in place, others identified limits. These were related to either the capacity of the person—for example, dementia or increased proneness to falling—or the capacity of the housing—independent living is for people who can live on their own with minimal care.

Determining "scope of practice"

Resident service coordinators are subject to few regulations and only limited oversight. This situation raises serious concerns as more and more coordinators are employed in residential settings.

Gaining insight into the challenges and conflicts that resident services coordinators experience is an important first step toward defining their role. Next, long-term care policy experts, housing specialists, and social service professionals need to engage in dialogue and arrive at a consensus about the policies and procedures needed to govern service coordination in residential settings.

Nancy W. Sheehan, PhD

Mariana T. Guzzardo, MA

Resident service coordinators can be one of the most important elements in elderly residents' supportive network. Once their "scope of practice" is better defined, they will be more able to help elders age in place with dignity and autonomy.

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Ethical Dilemmas in Caregiving

by Carolyn S. Wilken, PhD, MPH, CFLE, Associate Professor and Extension Specialist, Gerontology, Family, Youth and Community Sciences, University of Florida

Ethics is a hot topic these days. Business people are charged with unethical business practices, political figures are caught in conflicts of interest, and the scientific and medical communities debate the ethical use of scientific breakthroughs. Quietly, in the midst of all the commentaries and debates about ethics, families struggle every day with their own ethical decisions and dilemmas as they provide care for older family members.

Ethical dilemmas

Ethics is broadly defined as the *standards of conduct that indicate how people ought to behave, based on values and principles society holds about what is right.* The study of applied ethics deals with how people make ethical choices and resolve ethical dilemmas in their daily lives.

Making ethical choices deals with the ability to distinguish *right* from *wrong.* The behaviors of some caregivers, such as abuse or neglect are easily recognized as *wrong.* Other behaviors such as caring and respect are clearly seen as *right.*

Of course, not all choices caregivers make are ethical. Some choices are simply a matter of preference, such as choosing between two similar nursing homes or between two equally qualified physicians.

The most difficult problem for caregivers occurs when they must choose between two options that are equally *right.* We would agree that caring for our disabled mother is *right.* We would also agree that taking care of our children is also *right.* As caregivers, our ethical dilemma comes when we must choose between caring for our mother and caring for our children. Both are important and both are ethically right. The question caregivers face is how to make a decision when faced with such a dilemma.

John's story

John is a long-distance caregiver for his mother, Sylvia, who has Alzheimer's disease. His sister lives near their mother and has been providing the day-to-day care. John and his wife have a young son and are soon expecting twins. Consider

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depressed. I felt lonely, I wouldn't talk to anyone, and I was without my family... Here, there are some [family members] but they are busy. Let's just say that I am alone. I worked with the RSC; he got someone to come every week that provided company. I was grateful because I needed the communication and the presence of someone here.

Robert, a 70-year-old, divorced man living alone, said that he did not need any formal services because his brother and sister help him with anything he needs. His lack of interest in formal services was surprising, because his only child had died in a freak fire in Robert's home only a few months before. He explained: *That part of it I don't worry about it. [The social workers] are busy enough as it is. I've been around long enough, watched them work, see them come and go, and I don't worry about it. That's why I have my brother and sister, if I call them they'll be here in a heartbeat. Just to sit down and keep company.* When asked about his neighbors, Robert said that he really didn't know them, and that he mostly enjoyed watching TV in his apartment.

On the other hand, Rita, a 70-year-old widow, was more concerned with getting out of the facility. She agreed that there was limited socializing among neighbors, and she said that she did not care to create relationships with them. As she explained: *There is an assumption that everyone has the same faith...but I find it strange. Because I've always lived among different faiths. I used to live...where there are so many different people and no one would think of saying something like "Oh, have you been to church?"* Instead of socializing in the facility, Rita takes art classes at a nearby university, visits the university library, and goes to a food co-op where she meets with friends.

Social support can also be a two-way street. Some elderly people in federally subsidized housing provide support as well as receiving it. For example, Rita is a foster grandparent in a local school, while Maria helps her children by taking care of her grandchildren. Providing support to others, through activities like grandparenting or volunteer work, has been shown to have positive effects on the well-being of elderly individuals, providing them with a greater sense of social embeddedness and self-validation.

This peek into the social support network of residents living in federally subsidized housing shows that:

Thomas O. Blank, PhD

- Social support among neighbors is limited.
- Social service and health care professionals provide friendship as well as assistance.
- Residents receive social support from family members and provide support to them in return, but this is often fairly limited.
- Non-English speakers may have a more difficult time requesting assistance because of the language barrier.

Because more people will be living in senior housing in coming years, it is important to learn more about their need for social support. Meeting this need will help offset social isolation and improve the quality of their lives.

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Caregiving Has Its Rewards

by Christine J. Jensen, PhD, Adjunct Assistant Professor of Psychology and Researcher, Center for Public Policy Research, College of William and Mary; and Michael Ferrari, PhD, Associate Professor of Individual and Family Studies, and Psychology, University of Delaware

Most of the clinical and empirical literature emphasizes *burden* as the primary experience of family members engaged in elder care. Repeatedly, there has been a tendency to view caregiving in an exclusively negative light.

A brief survey of published work reveals that for most of the past 20 years researchers have chronicled the numerous negative effects associated with elder care including financial strain and detriments to mental and physical health. It is no surprise then that the scales used to measure caregiver burden are abundant. However, they provide limited, if any, opportunity for caregivers to disclose positive aspects associated with their situation.

In sum, the risk is toward maintaining an overly biased view, one focused only on the burdens of elder care, without acknowledging potential benefits. In practice, this bias can set up negative expectations, self-fulfilling prophesies and limited conceptual treatments of caregiver adjustment and satisfaction.

Is it all so bleak?

With so little to look forward to, one wonders why future generations of caregivers would accept a caregiver role. Yet without those future generations of caregivers, who will meet the needs of a "Graying America"? The facts are undeniable; many of our long-term facilities are at, or near, capacity, and much of the elder care in the future will be delivered by family members, friends, and neighbors—not professionals.

In our studies of caregiving, we need to balance the experience of *burden*, which has been well documented, with the satisfactions of caregiving. At the same time, we must also be realistic about the need to support family members who will assume the caregiving role in the years ahead.

In general, it is not difficult to conceptualize how care *recipients* benefit from the care that they receive. Comprehending how caregivers might benefit appears less obvious. There is no doubt that elder care is a demanding responsibility and many studies document the sacrifices that spouses and adult children make when providing such care. Perhaps this is why the benefits of caregiving are seldom explored.

Indeed, the concept of caregiver satisfaction has only emerged in the literature during the past 10 years. This satisfaction has been referred to as *caregiver gain, uplifts, meaning,* and *well-being.* More recently, the concept of *positive aspects of caregiving (PAC)* has appeared, subsuming many aspects of satisfaction measured by researchers. One can only hope that this signals a dawning realization that caregivers *can and do* receive some satisfaction from their caregiver role.

Caregivers reported a wide variety of rewards.

Searching for the positive

In our research, we have begun to focus on caregivers' positive perceptions of their caregiving role. We have found that the challenges typically associated with elder care can provide possibilities for caregiver growth, a chance to discover and create meaning at a critical juncture in life, and an opportunity to experience new rewards.

Christine Jensen's dissertation, for example, involved in-person interviews of 100 caregivers, both spouses and adult children, from five states in the Mid-Atlantic region of the United States. Using a mixed-methods design, the study examined ways in which the relationship to the care receiver (spouse or adult child) and the type of impairment suffered by the care recipient (primarily physical or primarily cognitive) impacted perceptions of caregiver well-being and satisfaction.

Participants reported a wide variety of rewards including enjoying their ability to provide close personal care and emotional support. Furthermore, many reported that the family member receiving care demonstrated significant health improvements due to their attention to detail in care provision. Caregivers identified ways in which they were reciprocating for the care and support that the care recipient had given them in the past. Adult children also explained how their caregiving role taught their own children the importance of looking after the older generation.

Value of multiple roles and co-residence

Caregivers scored very low on a depression scale, even though the length of care, measured in months and hours per week, was well above reported national averages. Little indication of depression was present regardless of the caregiving relationship to the care recipient or the type of impairment involved. In addition, the more life roles an individual had, the lower their depression scores. In fact, performing "multiple roles" has been examined as both a buffer and a mediator of stressful outcomes. This study offered further evidence that multiple roles can indeed mediate the negative outcomes routinely found in elder care.

Although some researchers have found co-residence of caregiver and recipient to be significantly related to elevated depression scores, the findings from our work offered more support to the benefits of co-residency. When care recipients lived with the caregivers, caregivers were more likely to report their own health as "good" or "excellent" when compared to caregivers who lived in a separate residence from the recipient. There were also no differences in depression scores based on co-residency.

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ETHICAL DILEMMAS *continued from page F23*

some of the ethical dilemmas John faces as a caregiver:

Ethical Dilemma One. Early on, Sylvia began sending money to every solicitation she received in the mail. When John protested, Sylvia insisted that it was her money and she could do with it as she pleased. John also noticed that his mother had been leaving the doors unlocked. Late one night Sylvia's neighbors called to tell him that she had been seen walking down the street in her bathrobe.

Sylvia is adamant that she remain in her own home where she feels safe and comfortable. John knows that his mother may be in danger if she remains in her home. In a society that values independence, it is *right* for Sylvia to retain her independence. But it is also *right* for John to protect her to ensure her safety.

> Caregivers must sometimes choose between two options that are equally right.

Ethical Dilemma Two. John's sister, Susan, is angry because she feels that she is bearing more caregiving responsibility than John, who lives nearly 300 miles away. Susan insists that John come to relieve her one weekend a month. John's wife believes that his first responsibility is to her and their young son. It is *right* for John to support his sister in her role as caregiver, but it is also *right* for John to care for his own family.

Ethical Dilemma Three. As the disease progressed, Sylvia was placed in a long-term care facility well respected for its specialized Alzheimer's unit. Sylvia's home was sold to pay for her care, and her savings are now depleted. Susan wants John to assume the financial responsibility for Sylvia's care. John could provide the resources to do so but would have to take the money from his children's college fund. It is *right* for John to keep his mother in the best facility available, but it is also *right* for John to prepare for his children's education.

Josephson's model

In each dilemma described above, John must choose between two equally ethically right choices. The Josephson Model of Ethical Decision Making suggests a multi-stage process for resolving an ethical dilemma:

Stop to Clarify Goals. When faced with a dilemma, we are often tempted to make quick decisions. But usually there is time to stop and reflect on the dilemma. John must identify his goals—for his mother, his family, and himself. While these goals may sometimes be competing, his over-arching goal might be: "To provide for the welfare of all members of the family."

Determine the Facts. John begins by identifying key stakeholders: himself, his wife, their son, his sister, and his mother. All are affected and, when possible, must have a voice in the decision making process. Creating a list of the facts of the situation will help John be more objective about his decision.

Develop Options. Input from professionals, other family members, and people with caregiving experience may help John and his family see options they had never considered.

Consider Consequences. Once John has clarified his goals, the facts, and the possible options, he must determine the potential consequences of each option. Who will benefit, who will lose? What impact will each potential outcome have on John's mother and the rest of the family?

Choose. John must make a decision and act on it.

Monitor and Modify. Caregivers live in a state of flux as both the care receiver's needs and their own family responsibilities change over time. It's important to leave open the possibility for changing a decision as circumstances change. After making his decision, John can review the outcome and adapt accordingly.

Carolyn S. Wilken, PhD, MPH

Because caregiving takes place in the context of the family, resolving ethical dilemmas is particularly heart-wrenching for caregivers. Using an ethical decision-making strategy allows caregivers to make considered decisions that respect the interests of everyone involved.

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CAREGIVING REWARDS *continued from page F24*

Phases of caregiving

As family caregivers progress from the initial period of care, possibly following a crisis, a time of adjustment seems to ensue when additional resources and information are typically gathered. Some researchers have found that this adjustment phase can be followed by feelings of "burnout" as daily tasks become more consuming and exhaustive for caregivers.

But our research suggests that a rebound phase often follows "burnout." This rebound is characterized by a renewed commitment to provide quality intimate care for as long as the caregiver is able to do so. Not unexpectedly, periods of depression can occur and even fluctuate across caregiving phases.

Those individuals who were able to maintain feelings of satisfaction and well-being throughout the ups and downs, often proved the most interesting to study. But all caregivers who participated in this study reported many of the most positive and satisfying experiences associated with the phase of adjustment rebound.

Christine J. Jensen, PhD

This is good news for current and future caregivers. We hope that researchers will begin focusing on the development and maintenance of caregiver satisfaction. Greater understanding and appreciation of the benefits of caregiving will support current caregivers and encourage future generations to seek fulfillment from their own caregiving experiences.

Adapted with permission from Jensen, C.J., Ferrari, M., & Cavanaugh, J.C. (2004) Building on the benefits: Assessing satisfaction and well-being in elder care. Ageing Intl, 29; 88-100. For more information, contact cjjens@wm.edu.

Coming Home From the Hospital With a New Disability: Challenges for Elderly Spouses and Families

by Janet M. Liechty, MSW, LCSW-C, Doctoral Candidate, Department of Family Studies, University of Maryland, College Park

While we often imagine dealing with the gradual physical decline in older age, we rarely anticipate life with a disability. But many middle-aged and older people experience medical crises such as stroke, heart failure, advanced diabetes, or other diseases. These often result in physical or cognitive impairments that significantly alter one's activities, social and family roles, work and retirement plans, independence, and even identity. Such a life-altering health crisis affects not only the patient but also the entire family system.

Practical challenges

Hospital stays are increasingly short, and patients often are discharged with significant care needs. Practical challenges include: ensuring that the patient's basic needs for safety, food, hygiene, medical care, and equipment are met in the least restrictive environment possible; determining the physical accessibility of the home (for example, the number of steps, wheelchair access); securing needed rehabilitation through home health services or in a transitional facility; assessing time, abilities, and monetary resources of the spouse and the adult children; and learning about available federal, state, and community programs and services that could assist the patient and caregiver.

The adaptation of family routines, roles, and expectations to accommodate these practical challenges is a dynamic process of negotiation and psychosocial adjustment for everyone involved. Family members may help through direct physical care, regular phone contact, coordination of services, or by providing meals, transportation, or money to pay for needed services. The amount of time and care that adult family members can provide depends on their resources and on whether an illness or disability is acute or chronic.

Psychosocial challenges

Family roles and patterns of leadership, cohesion, conflict, and communication come to the fore as family members negotiate and puzzle out competing needs and resources within the larger family system. Is the patient able to acknowledge new limitations and accept help? To what extent do spouses give up their activities to care for or monitor the safety of their husband or wife? How do adult children equitably ensure the care of their parent, yet honor their own life goals, financial constraints, and prior work and family commitments?

In the wake of major physical and cognitive losses, it is normal for a person to feel angry, depressed, guilty, or anxious about the future. But if these feelings persist over time, they threaten the mental well-being of the individual and the entire family. Issues of identity and life purpose may arise when activities that gave life meaning and pleasure are no longer possible or when a person has been the one who gives help, not the one who needs help. On the other hand, the individual in crisis may, despite physical limitations, rise to the challenge as an emotional leader in the family and demonstrate unusual acceptance, humor, optimism, gratitude, self-determination, or equanimity in the face of change.

> A life-altering health crisis affects not only the patient but also the entire family system.

Family members who rearrange their lives to accommodate their loved one's new disabilities and care needs may experience role strain, work-family conflicts, and shifts in their own identity. Adult children or spouses who were dependent may have to become vital decision-makers. Spouses who never cooked or cleaned may have to take on these tasks. Equitable distribution of responsibilities among adult children becomes an important and sometimes sore issue. These changes are stressful, but also present opportunities for growth, deepened expressions of caring, and a new sense of meaning within families. Leaders may emerge within the family system and gain new respect. Areas of competence that were dismissed or invisible before the crisis may be highlighted. Old family conflicts may be exacerbated or set aside to address common concerns, as family roles and dynamics are reconfigured during and after a crisis.

Coping strategies

Get involved in care planning. Develop good working relations with the hospital discharge planning staff. Planning for discharge begins at admission. Provide staff with a list of names and phone numbers of all designated family contact persons, while being mindful of patient privacy issues.

Ask for help. Hospital discharge planning staff and your local Office on Aging can refer you to community resources available upon discharge, such as Meals on Wheels, visiting nurses, adult day care and recreation centers, home health aides, case management services, and nursing homes if necessary.

Hold family meetings. Keep family members informed. The more they know, the more likely they will be prepared to offer assistance, if needed. Hold family discussions (including the patient, if appropriate) about continuing care needs, resources and availability, rehabilitation options, and communication with the hospital.

Utilize social support. When families are dispersed, those who live near the patient often feel overwhelmed and alone. It's important for these family members to reach out to local networks (religious, community, neighborhood) for support. Help with meals, pet care, garden chores

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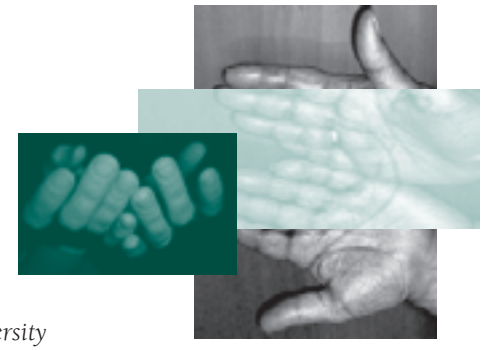
Couples Taking Care of Each Other: Does Ethnicity Matter?



by Marie-Luise Friedemann, PhD, RN, Professor, School of Nursing, Florida International University

Miami-Dade became a refuge for Cubans fleeing the revolution in the late 1950s. In a stream of immigrants that has not yet subsided, Cubans were joined by other population groups from troubled countries in Central and South America and the Caribbean. By 2000, the Hispanic segment grew to 57.3 percent of the total population. Since the early immigrants are now advanced in age and many younger immigrants have brought their aged parents to the area, Miami-Dade has some 172,000 minority elders, the largest percentage of minorities over the age of 65 in the U.S. This area, therefore, offers a unique opportunity to pioneer studies on aging and ethnicity.

Our survey study explores the caregiving arrangements of old couples and families of white non-Hispanic and Hispanic origin through extensive interviews. Some of our findings are startling.

Caregiving couples

We are surprised about the large number of couples in their 80s and 90s caring for each other, sometimes with assistance of the family, sometimes without. Often, we have difficulties pinpointing a caregiver, since both spouses have serious health conditions and complement each other: In one case, the husband needed help with moving about and the wife, with seeing things clearly.

> Miami-Dade has the largest percentage of minorities over the age of 65 in the U.S.

As expected, we find that most spouses across ethnic groups are strongly committed to caring for each other. They state that it is "a necessity," or a "responsibility." Caregivers describe their role differently, however. Some find it exhausting and are depressed or worried about their own health; others state they just have to do it or, better yet, they find enjoyment and rewards through their activities. Typical answers include both positive and negative aspects, such as the one expressed by a husband: *I love my wife and enjoy doing what I can for her, but I am totally exhausted. It is difficult because I need to be aware of all that is happening. I need to check on her frequently, even at night. I am always afraid that something will happen.*

Ethnic differences

A striking difference is that white couples worry about being a burden to their children. They are striving for optimal independence and help each other to maintain their daily routine. Many feel reassured to have helpful family members in case they might need them.

Generally, however, white relatives need to be asked for help and asking is often difficult. In contrast, in most Hispanic families, caregiving and the assignment of a person to be in charge is largely a family decision. Old Hispanic couples are less concerned about asking for help; decisions are made for them. Especially in poor families, financial factors influence decisions. We frequently encounter cases in which adult children have taken their parents into their home to boost their own income with the parents' social security payments. In one case, the person chosen to be caregiver and to move in with the elderly couple was a female relative who had been looking for a job unsuccessfully. Sometimes, these decisions are less than optimal, either because the caregivers are unhappy about their assigned role or the old couple has to be extremely careful not to be overly demanding.

Based on the literature about Hispanic families, we expected close family systems with members who all contribute to the care of elderly relatives. In reality, however, we find as many exceptions as cases that follow this stereotype. Many families we visit are needy and have at times serious social, psychological, and family problems. The support of older parents, therefore, constitutes severe stress.

Case study

Our interviewers reported that upon entering the modest apartment of the couple, they found the husband on the floor, unable to get up. His spouse had been desperately looking for help. The two interviewers were able to lift him off the floor and lower him into a chair. The man told them about his thyroid problem and

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like watering, transportation, or the laundry can make a world of difference to both patient and caregivers.

Seek counseling as needed. Be aware of the potential for caregiver strain after discharge. Learn about the resources available to caregivers. Consider using hospital or community-based support groups and counseling services.

Act now. Put your affairs in order and encourage your parents to do so, too. Complete and notarize a Living Will. Organize your files and make at least one family member aware of your financial situation. Secure a will and arrange for someone you trust to have Power of Attorney if you become incapacitated. Consider buying both life and long-term care insurance. If you're still working, purchase disability insurance for income-replacement. Finally, contribute freely to supportive networks of friends and family–they will bring you joy today and may be able to provide much needed support in the future.

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Integrating Recipients into Family Care Systems

by Whitney Brosi, PhD, Assistant Professor of Gerontology, Department of Human Development and Family Science, Oklahoma State University

In the field of family gerontology, few topics have received as much attention as family caregiving. Our colleagues have investigated this phenomenon relative to women and work, gendered expectations in families and society, financial implications, and health outcomes of caregivers. The primary focus has been on caregiver preparation and wellness.

The focus on caregivers has been appropriate, given that much of the initial caregiving research emphasized the experiences of those caring for loved ones with advanced dementia or Alzheimer's disease. In such cases, caregivers are responsible for intense, daily care as well as for decision-making. But in cases where care is not as intense, when care recipients are able to consider their options, what role should they play in decisions about care?

After the Crisis

Care arrangements are implemented both gradually and under urgent conditions. We are socialized as caregivers long before care is needed. In fact, many of us can identify caregivers-to-be in our own families. The selection process has been happening for decades. Then comes the moment care is needed: a midnight phone call to report a "bad fall" or a car accident. The gradual selection process has determined *who* needs to be called. By and large, however, the actual process of *how* to provide care has not been determined.

> Recipients find it empowering to play a role in their own care.

Because care arrangements are often made under urgent conditions, care recipients are rarely involved. In the moment, this is appropriate. But the question remains: How do care systems adjust as needs change? After all, care systems, like families, are dynamic. Furthermore, when adjustments are made to the care system, how is the recipient integrated into decisions?

Following the initial emergency, there are two common scenarios which emerge:

The roles of both caregiver and recipient, as created at the time of urgent need, remain the same. Because the intensity of need at the time of crisis is rarely maintained, two issues emerge. First, the caregiver maintains a level of involvement that may exceed the recipient's needs, unnecessarily depleting the caregiver's own emotional and physical resources. Secondly, the recipient feels isolated because his or her abilities are not acknowledged.

When care adjustments are made, recipients are uninvolved in decisions. Sometimes this happens because caregivers believe that making decisions will ease a recipient's stress. On the other hand, my research suggests that recipients play a role by deferring care decisions because either they believe "caregiver knows best" or they want to avoid being labeled as "difficult." But lack of involvement also isolates the recipient from important decisions and interactions, and can cause unnecessary strain on the caregiver.

Things to consider

In order to allow the care system to adapt, caregivers can:

Distinguish between negotiable and non-negotiable decisions. For example, if the recipient needs an in-home nurse three days a week, that is non-negotiable. But

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blamed his medications for frequent dizzy spells that caused him to lose his balance. This occurred about five times a week and each time, his wife had to call the neighbors and, on some occasions, the 911 rescue team.

After the official interview, the husband shared his history. He was born in Russia of Greek parents. His family then moved to Argentina and lived there for a long time. There he met his wife and got married and had six children. Eventually, when the economy in Argentina collapsed, the couple moved to Miami. Married for 50 years when we visited them, they were proud of their 12 grandchildren. The husband showed us photos of family members who had attended the couple's golden anniversary celebration. He also let us read some of the poems he had written for his wife over the years, and he claimed that he had been in love with her through all these years.

Nevertheless, the two were living on their own, in a precarious situation without extended family nearby. Their children worked and raised their own families. The children knew that their parents were financially secure, but they were not informed about the seriousness of their parents' health problems and the difficulties they experienced. Contrary to the cultural stereotypes, the couple did not ask for help or consider leaving their lovely home.

Challenges

People from Hispanic countries differ greatly. Even those who come from the same country may have diverse values, beliefs, and ways of living based on the background of their ancestors or their social class. The Hispanic couple described above had values typically held by elders of European descent. Understanding the needs and preferences for help and interventions of such elderly couples and their families can be difficult.

As professionals, we must understand culture as the process of adapting to changes in the environment while maintaining the core values and life patterns that are the very essence of a person. Caring for each other as a couple and within families directly reflects such values. No book can teach us about these values. To understand them, we must let the people tell us about their lives.

Many thanks to Lynn Seagrave, Luz Jimenez, Sandra Figueroa, and Peta Gaye Johnson, who collected data for this article. For more information, contact friedemm@fiu.edu.

Families of Frail Older Adults and Long-Term Care Decisions in Cairo, Egypt

by Michele A. Sinunu, MPH, Rollins School of Public Health, Emory University; Kathryn M. Yount, PhD, MHS, Assistant Professor, Departments of Global Health and Sociology, Emory University; and Nadia el-Afifi, MD, Director, Department of Geriatrics, Palestine Hospital, Heliopolis, Cairo

The Egyptian population is aging in a context of wider socioeconomic change, as well as changes in family structure and intergenerational support. Formal long-term care centers for frail older adults are emerging, despite cultural norms that stress family care of older relatives. This research explores factors that lead family caregivers to place their frail older relatives into a long-term care center in the Department of Geriatrics in Palestine Hospital in Cairo, Egypt. This department, which was established in 1994, is often filled to capacity.

An emerging social trend

Exploring the decision to use long-term care is important in understanding how families adapt their caregiving strategies to the changing circumstances of family life. Because few formal long-term care centers exist in Egypt, this study exposes an emerging social trend that has multiple implications for the allocation of public resources.

The project team conducted semi-structured qualitative interviews with 18 "case" caregivers who placed their frail older relatives into the Department of Geriatrics and 17 "control" caregivers who cared for their frail older relatives at home. We document important potential differences in the non-matched characteristics of cases and controls that may be associated with their strategies of elder care. We also document "old" and "new" ideals used by case caregivers to justify their reliance on formal long-term care.

Caregiver characteristics

The findings suggest that case and control caregivers differ in three important ways

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if the recipient wants this service provided on certain days of the week or at certain times of the day, this can be negotiated.

Discuss decisions with recipients when they return home. Perhaps the bathroom has been remodeled or the recipient's bedroom has been moved to the first floor. Explain why these decisions were made, who was involved, and how the recipient was considered even in his or her absence.

Ask recipients how they feel about the changes. Some decisions cannot be reversed, but recipients may have ideas about they could be more comfortable with the changes.

Integrate the recipient's wishes into the care plan whenever possible. Recipients often find it empowering to play a role in their own care, as long as their involvement is appropriate for their level of ability. This dynamic also proves helpful to everyone in the care system.

Additional research is needed to explore the recipient's role in care systems. First, it is critical for family members and researchers to remember that many recipients have also been caregivers. In my research, 100 percent of recipients had themselves provided between six and 19 years of assistance to elderly relatives. Experiencing the roles of both caregiver and recipient inevitably shapes the care system but research has yet to document how.

Whitney Brosi, PhD

It is also important to focus on the fact that recipients do more than passively receive care. They continue to hold valuable positions in our lives—not just as recipients but also as partners in the care system. Research must demonstrate how best to engage recipients and document the benefits of such involvement.

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When Older Parents Care for Adult Children...

Elderly parents often serve as the primary caregivers of adult children with developmental and intellectual disabilities. But as the parents grow older, they may become disabled themselves. If parents need to enter a nursing home or assisted-living facility, adult children living at home may be placed in a group home. And those who already live in a group setting may have no one to advocate for them, unless other family members choose to take on this responsibility.

Gerontological researchers, policymakers, and practitioners must keep in mind not only the needs of older individuals with disabilities, but also the needs of younger disabled people who depend on their elders for care and advocacy.

–Kimberly Petrovic, University of Connecticut

From a Distance: Experiences of Asian-Indian Caregivers Living in the United States

by Jyoti Savla, PhD, Data Manager, Georgia Centenarian Study, Gerontology Center, University of Georgia; and Adam Davey, PhD, Senior Research Scientist, Polisher Research Institute

Here and abroad, an increasing number of adult children leave their home communities in order to study, find an attractive job, accompany a partner, or experience another part of the world. Asian Indians form a large and rapidly growing segment of the American population, with nearly 1.9 million individuals reported in the U.S. Census 2000. As long as parents are able to provide for themselves, children may live far from their parents with no serious problems. But if their parents' health declines, adult children may suddenly face the challenges of caregiving. This dilemma is more daunting for migrant populations whose parents are thousands of miles away, often where services for the aged might not be readily available.

Aging research has tended to focus on caregiving that is contingent on residential propinquity, implying that parents who do not have children living close by are bereft of their children's support. This preoccupation with geographical proximity in the caregiving literature has resulted in sparse research on the relationships between aging parents and adult children who live far from each other. As a result, these caregiving relationships remain practically invisible. Some researchers have noted, however, that distant children still gave a great deal of help and support. Moreover, the difference in the extent of support by siblings diminished as geographical distance increased.

In Asian-Indian culture, the oldest son must care for his aging parents.

A cultural imperative

The issue of long-distance caregiving is especially unique for adult children who have migrated from eastern countries like India where filial obligation is an important norm. Asian-Indian culture stipulates that the oldest son must care for his aging parents.

There are explicit laws regarding the relationship between parents and their sons in the Vedas, the oldest Hindu scriptures. One of the verses reads *"Matri devo bhavah, Pitra devo bhavah"* (Mother and father are

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that may have affected their choice of formal and informal care:

- Almost all of the controls were the children or spouses of older relatives, compared to only two thirds of the cases. This difference is consistent with heightened expectations of care associated with children and spouses, especially wives.
- Controls had a larger number of siblings and more often lived close to these siblings. Siblings are an important source of support for the older adult and the primary caregiver.
- Cases reported that their older relatives had worse physical and mental health than the controls. Acute declines in health usually triggered the decision to place a frail older adult into long-term care. Additionally, case caregivers often expressed feeling under-skilled or otherwise unable to cope with the medical and other care needs of the frail older relative.

Families are adapting caregiving strategies to the changing circumstances of family life.

Justifying the use of long-term care

Another major finding from this analysis is the discovery of two distinct ways that case caregivers justified their decision to place their older relatives into long-term care. One group of cases stressed the need for relief from the burden of caregiving and placing a higher priority on personal needs. This need was not a repudiation or denial of the responsibility for elder care, but rather a reprioritizing of care within a broader array of responsibilities and social pressures.

The second group of cases held fast to existing ideals of family duty, but reinterpreted them to include institutionalization as a legitimate form of care. Both groups used adaptive strategies to meet the social and economic circumstances of daily life, and both felt they were meeting their familial obligations while acting in distinctly different ways from controls.

Michele A. Sinunu, MPH

As demographic, epidemiologic, and socioeconomic changes continue, an increasing percentage of families may adopt new combinations of care to support their frail older relatives. The findings from this study underscore the need for population-based research about strategies of caring for frail older relatives in this context.

This article is an extended abstract of a longer paper submitted for consideration to The Gerontologist under the title, "Informal and formal long-term care for frail older adults in Cairo, Egypt." For more information, contact masinunu@yahoo.com.

Patterns of Food Access and Food Insecurity Among Rural Elders

by Lois Wright Morton, PhD, Sociology; Kimberly Greder, PhD, CFLE, Human Development Family Studies; and Steven Garasky, PhD, Human Development Family Studies, Iowa State University

It is estimated that by 2030, persons age 65 and older will be 20 percent of the U.S. population, almost double the percentage in 2000. Older Americans are increasingly concentrated in rural areas as younger people move to metropolitan areas in search of employment. For example, in Iowa, North Dakota, and South Dakota, almost 15 percent of the population is 65 years or older, and in some counties 20 percent or more of the residents are 65 years and older.

Rural elders are concerned not only about food security, but also about having healthy food choices. Food insecurity in elders, defined as limited or uncertain availability of nutritionally adequate and safe foods, has been associated with poor nutrition and health outcomes. Food security and access to healthy foods mean that elders need sufficient income to purchase food, nearby grocery stores, the ability to get to a store, and the capability to cook and eat.

The consolidation of grocery stores over the past two decades has left many rural towns without grocery stores. In addition, due to a lack of public transportation, rural elders need a car and the ability to drive it, or relationships with other people who can take them to the grocery store.

Elders also get food from public programs, such as senior meal sites, emergency food kitchens, food stamps, and food pantries, and informal social support networks of family, friends, and neighbors.

Designing the study

To understand food access among rural elders, we sampled residents of two Iowa counties. We selected these counties because they met the following criteria:

- They were not adjacent to a metro area.
- They included towns with populations under 10,000.
- They had a higher than average elderly population (19 and 21 percent of residents were aged 65 and older).

In addition, per capita income for both counties in 2000 was below the state average of $26,431.

We randomly sampled households in these counties and sent a mail survey during the spring of 2004. A total of 1,272 mailed surveys resulted in a response rate of 62 percent or 793. We analyzed the responses of 334 respondents aged 60 years and older. The average age of these elders was 73 years. Their mean income ranged from $25,000 to $34,999.

Social support networks are important sources of food.

Food access

These elders report shopping for food on average at two different grocery stores. They are about 14 minutes away from their regular grocery store and most shop at a medium-sized store on a weekly basis. Less than half (43 percent) report shopping for groceries at stores outside their counties. Those who do, tend to shop at a SuperWalmart. Ninety-three percent drive their own car to the store. But 6 percent reported that it is difficult to get to the store.

Meals with family and friends (48 percent), the gardens of family and friends (34 percent), meat from farms of family and friends (13 percent), fish from family and friends or public water bodies (12 percent), and grocery items from family and friends (9 percent) are important sources of food. The personal garden is also a valuable food source. While we did not ask about preservation of food in this survey, focus group interviews among low-income elders suggest some do can and freeze garden produce.

Respondents seldom use food stamps or visit a food pantry. National samples of elderly below the poverty level show they are less likely compared to those in non-elderly households to use food stamps (12 versus 22 percent). This is also true of food pantry and emergency kitchens use. Community meal programs like senior center meals or meals on wheels are used by 10 percent of the respondents.

Weight and diet

Nearly half (44 percent) of the respondents have a body mass index in the overweight range (25-29.9). One-fourth (26 percent) is considered obese, with a body mass index of 30 or higher. This is higher than the percentages for all Iowa residents: According to the Behavioral Risk Factor Surveillance Survey (BRFSS) 38 percent of Iowans are overweight and 23 percent are obese.

Surveyed elders were asked how many servings of fruits, vegetables, meat or other protein, and dairy they consumed daily. We found that the majority of respondents are meeting recommended daily servings of milk (61 percent), protein (65 percent), and fruit (61 percent), but less than one-third (32 percent) consume the recommended servings of vegetables.

While 94 percent of our elderly sample is food secure as defined by the USDA, about 6 percent are food insecure and 2.1 percent are food insecure with hunger. A national representative sample of people aged 65 years and older reports similar findings.

Implications for further research

While the majority of rural elders surveyed are food secure and seem to have diets that meet many of the nutritional requirements for daily living, a significant number are not meeting all their dietary needs. Furthermore, many are experiencing weight problems that can exacerbate existing diseases and functionality.

Social support networks are important sources of food, as well as social relations. Thus, the older person who lacks local kin or friendships is at risk of a poorer diet. Social isolation in this context may result in a lack of transportation to grocery stores or community meal site in addition to loss of social support.

Finally, few of the rural elders in this study visited food pantries or used food stamps.

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equivalent to deities). These scriptures describe the filial service that is expected of sons. The eldest living male has the highest rank as well as responsibilities and obligations. In case of caregiving of the older parents, it is the eldest son and his wife who are obliged to play this role. Once married, the oldest son brings his wife to live with his parents, and she assists him in taking care of them.

Migration of an Indian adult child, especially the oldest son, dissolves this complex family system and prevents the fulfillment of filial obligations, creating dissonance between traditional values and modern reality.

Incongruent beliefs and behaviors

Researchers in the area of social cognition have observed apparently irreconcilable discrepancies and systematically explored the language of ambivalence that results when attitudes and behaviors do not correspond. Several researchers have studied intergenerational relationships in order to determine the extent to which older parents and their adult children "walked the walk" (behaved in accordance with their expressed beliefs) as opposed to simply "talking the talk" (behaving inconsistently with their expressed beliefs). Emigration to a foreign country results in the double bind of long-distance caregiving as well as the inability to follow the cultural norms, thus producing a natural sort of ambivalence.

A caregiving gap

In a recent attempt to explore the experiences of long-distance caregivers from India, we interviewed seven Asian Indian men living in the United States who were the oldest of their siblings and whose parents remained in India. All seven felt that they were unable to fulfill their role of an ideal son.

The emotions they expressed included worry, pain, depression, guilt, and helplessness. They tried to compensate their absence by calling their parents daily or by visiting them regularly, and yet they were not able to fill the "gap" or the "vacuum" because they were not "not being physically present."

Conflicting roles

Participants also described at length the ambivalence that they felt because of the opposing roles they were forced to play. On one hand, their cultural script defined a good son and his filial duties. On the other, their personal responsibilities toward their own spouse, children, jobs, and careers prevented them from fulfilling their duties to their parents. Said one participant: *Whenever there is that kind of discrepancy or that conflict between what your values are telling you...is the right thing to do and [what] logic is telling [you] ... that's when you run into this internal struggle.*

In describing the struggle between his "logical side" and his "emotional side," one participant said: *[The emotional side] was not strong enough to make me [stay in India]. But it was strong enough to make me feel guilty, when I did not do it.*

This imbalance in their personal scripts and their cultural scripts put the participants in a unique "dilemma" which made them feel "unfulfilled" and a "hypocritical." Interestingly, three participants had at least one other sibling living close to their parent in India. Yet all three felt they were not fulfilling their duty.

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A slightly different pattern emerged from the experience of one of the participants, who felt that his caregiving role had become more important after his brother's death. Perhaps this participant saw his role as the family breadwinner who gets more education and a better job, while his younger brother's role to take care of the parents, farm, and family home in India. This suggests that the cultural scripts may differ from family to family.

More research needed

Although immigrants from various countries have faced the dilemma of long-distance caregiving, most research on immigrants focuses on the process of adjustment to life in the United States, on the relationship between first-generation immigrants and their American-born children, or on the relationship between first-generation immigrant adult children and their aging parents.

The experience of the immigrant adult child with an aging parent in a far away country has been a neglected topic. Of the immigration literature reviewed, only two studies were found to have some focus on the topic of transnational long-distance caregivers.

While an adult child's decision to move away from family is shaped by many different factors, the conflict and ambivalence experienced by these individuals warrants greater attention. Future research needs to address caregiving in the light of cultural scripts and perceived roles for each child in the family—sons as well as daughters—and their partners.

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Further research is needed to understand whether this finding relates to aspects of the local community (the community does not have a food pantry or stores do not accept food stamps) or the individual (negative stigma attached to visiting a pantry or problems related to applying for food stamp benefits).

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Aging and Obesity

by Jaylie I. L. Beckenhauer, MA, CFCS, Lecturer, Department of Family and Consumer Sciences, Baylor University

Adults age 65 and over are the fastest growing segment of the population, not only in the United States, but globally. Obesity has reached almost epidemic proportions in America and is becoming a threat to other developing countries. These trends are related because normative patterns of aging include a greater tendency toward weight gain and obesity. Fortunately, older adults can avoid obesity through healthy lifestyle choices.

Physical changes favor obesity

The physical aging process promotes a tendency toward weight gain and limited exercise. Body composition shifts to make older people shorter and rounder. Vertebral compression results in loss of 1 to 2 centimeters in height per decade in the elderly. Fat-free mass, or muscle, tends to reduce with age and is replaced with adipose tissue. Fat mass also shifts from the limbs to the trunk area, increasing girth while decreasing strength in arms and legs.

Loss of physical sensations associated with eating also may contribute to weight gain. Decreased sense of smell and taste often makes food unappetizing to older people. Loss of teeth and use of dentures limit foods to those easiest to chew. Salivary gland production decreases with age, which often makes swallowing difficult and choking more likely. Comfort foods high in calories and low in vital nutrients are likely choices when eating is difficult and food is unappetizing.

Decrease in physical activity is a major contributor to obesity. Basal metabolism decreases with age so there is need for fewer calories. Higher caloric intake without increased exercise produces excess fat. Joint pain due to arthritis and the age-related loss of muscle mass known as sarcopenia significantly add to decreased exercise ability. Higher fat mass is associated with slower walking speeds and greater likelihood of disability. Low levels of physical activity are associated with loss of function and weight gain, forming a cycle of greater weight, less activity, and more weight gain.

Obesity is closely linked to other age-related health conditions: diabetes, cardiovascular disease, and osteoarthritis. Being obese doubles the likelihood of developing cardiovascular disease and triples the likelihood of developing diabetes—more than 80 percent of diabetics are overweight. Added weight significantly increases the stress to weight bearing joints and the pain associated with osteoarthritis. Every pound of body weight adds three to five pounds of pressure on each knee with each step. Decreased physical abilities, limited exercise, and progression through the life course all contribute to being overweight and to obesity.

Lifestyle changes play a role

Other factors associated with the normative aging process include changes in family life cycle, economic status, and lifestyle. Empty nest or loss of spouse may have an impact on food choices. It is often difficult to adjust cooking for one or two after cooking for a large family. There is a tendency to lean toward convenience foods that can be cooked quickly or to eat out more frequently rather than to invest in a home-cooked meal with high nutritional value and low calories. Retirement or death of spouse may mean less money to allocate for food. Meals high in carbohydrates and fat are often more economical than those made with lean meat, fresh fruits, and vegetables.

Aging may also mean a change in the type and location of housing. Some elders choose to downsize from a home to an apartment or move nearer to one of the children. Others choose retirement senior housing or assisted living. Changes in housing often mean changes in one's pattern of cooking and eating. Smaller kitchens with fewer tools might decrease a chef's desire to cook. Residents in group-living facilities rarely plan menus and must often adjust to unaccustomed foods and cooking styles. This can mean poor food choices high in calories, resulting in weight gain.

Small choices, big changes

Losing just 10 pounds can lower blood pressure by four points, lower bad LDL cholesterol by 20 points, raise good HDL cholesterol, and decrease pressure on the knees by 30 to 50 pounds. Blood sugar comes down immediately when people with adult-onset Type 2 diabetes start losing weight. Walking just a mile a day helps weight loss, and resistance exercise builds strength.

After age 70, however, weight loss should be monitored carefully because it could prove more detrimental than obesity. Some studies indicate that waist circumference is a better indicator of obesity in the elderly than body mass index (BMI) because it takes into account the redistribution of body fat to the abdomen.

> The loss of just 10 pounds can lead to dramatic physical improvements.

Adjustments make cooking for one or two easier. Buy a cookbook specializing in meals for one. Halve recipes before cooking. Prepare a whole recipe and freeze individual portions for quick meals later. Choose liquid food supplements, including diabetic formulas, for between meal snacks. When cooking on a budget, pair grains, such as cornbread, with legumes, such as beans, for a complete protein. Use canned fruits and vegetables as lower-priced alternatives to fresh produce.

Eating out can be more nutritious when one plans ahead. Most restaurants have menus with low-fat and low-carbohydrate choices. Many also supply nutritional analyses upon request. Salads with grilled chicken offer fewer calories than a chicken salad sandwich. A single hamburger is less dangerous without the fries and large coke included in the combo meal. Guides for healthy restaurant meals are available. Healthy and nutritious choices become easier with practice.

Group-living facilities can adjust menus to make meals more palatable and healthier for residents. Administrators and menu planners need to understand that meals for *all* older adults should contain less sugar, salt, and fat and include a variety of low carbohydrate and sugar-free choices. Carrying an herb shaker or salt substitute to the table will add flavor for ailing taste buds.

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The Role of Racial Diversity in Successful Aging

by Jeanne Slizyk, JD, MA, PhD. and MPH Student, Department of Sociology and Public Health, University of Florida

This article explores racial diversity in successful aging using qualitative life stories of four individuals between 71 and 80 years of age. "Sam" and "Tom" are African American men who live in nursing homes. "Hazel," an African American woman, and "Joe," a white man, are both still living at home.

Same cohort, difference experiences

All four were children during the Great Depression, came of age during World War II and the Civil Rights Era, and were all in their 70s when America experienced the events of September 11, 2001. But they encountered diverse life experiences within their families, social networks, and work environments, and were affected by racial, gender, community and institutional influences.

Sam, Tom, and Hazel grew up under legal segregation in the South. Bob grew up under de facto segregation in the North, but spent most of the last 50 years in the South. Legal segregation in the South, as well as continuing de facto segregation today, has greatly affected the life opportunities, longevity, health, and social environments of older African Americans. But the study of discrimination as it directly affects health is still in its infancy. And there is little research on how racism and segregation affects successful aging and well-being.

The experience of these elders indicates that successful aging, or a subjective sense of well-being, is not necessarily linked with socioeconomic advantages. But improved socioeconomic status does mean better access to health care and other resources that can greatly improve daily life.

Hazel, Sam, and Joe all appear to have aged successfully. Tom, sadly, is someone for whom the vicissitudes of life have only become worse with age. He seems full of anger and rage, but refuses any offer of friendship. He is alone and lonely, in a nursing home full of other lonely people.

> Wisdom, spirituality, coping strategies, and personality adaptations can moderate the effects of ill health.

Definitions of "success"

Joe enjoys economic security and is the only participant who would qualify under Rowe and Kahn's three-part model of successful aging, which includes low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life.

Joe also has the most formal education, but he does not appear to be striving for either wisdom or spirituality. He attends church activities, but his activities appear to be more social than spiritually meaningful. When asked about his reaction to the events of September 11th, Joe focused on to how well President Bush handled the crisis.

Hazel and Sam both have had difficult lives that included many obstacles and hardships. Today, each has serious medical problems that affect their physical functioning. But both are very positive, and their deep spiritually is apparent. Both empathize with the pain suffered by strangers and value their service to others.

Although Sam has less than a third-grade education, his sense of acceptance and understanding is an example of both wisdom and successful aging, in spite of very difficult circumstances. He described his reaction to September 11th: *I couldn't help but think of all the little children, who lost their parents. They weren't doing nothin' but doing their jobs. Those people were just working. And now all those children don't have parents, and don't have even anything to bury or know anything for sure.*

Hazel, Sam, and Joe all report a high degree of life satisfaction. For Hazel and Sam, satisfaction comes from their belief that God is with them. Hazel explained: *[Jesus] has taken care of us, and we are thankful for what he has given us. People expect to have everything so easy, especially young'uns, like everything handed to them. And they don't care that he died for us. They just want more.*

Smiling, Sam expressed similar sentiments: *The Good Lord has taken care of me this far, so I don't have no complaints. When he is ready to take me he will. But, I don't think he is ready yet.*

While Hazel and Sam would not qualify as "successful" using the Kahn and Rowe model, I suggest that both are true role models of successful aging, especially considering their present age and the obstacles they have faced in life.

Health disparities

There are no easy answers to solving the challenges presented by the intersection of aging, health, and racial disparities. In this study, successful aging, life satisfaction, and well-being were not found to be linked with socioeconomic advantages.

In fact, were one to generalize from this small sample, one could say that the experience of coping with adversities such as white rage, systematic racism, and oppression allows some African Americans to develop strengths that most whites will

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While obesity is a concern for all age groups, it is especially worrisome for the aging population. General awareness of the aging processes that favor obesity is essential. In addition, aging individuals can take small steps to avoid obesity and improve the overall quality of their lives.

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Elderly Refugees Need More Protection and Services

by Maureen Lynch, PhD, Director of Research, Refugees International

In theory, elderly refugees and internally displaced persons (IDPs) enjoy the same rights as younger people, even during conflict and displacement. In practice, however, their rights are often denied. Older people think that aid agencies are not aware of their needs and that they are not consulted directly about their concerns or what they have to offer.

The older people are right! Far more can be done to uphold the rights of older displaced persons, to provide them with equal access to assistance, and where necessary, to provide support without singling them out in ways that can cause resentment or abuse.

Unique vulnerabilities

According to the United Nations High Commissioner for Refugees (UNHCR), older persons make up an estimated 10 to 30 percent of refugees. In addition to facing the same war atrocities as other civilians, older individuals have unique vulnerabilities and needs that place them at particular risk.

As their communities flee, some older individuals choose to stay at home to avoid burdening their younger family members or because they fear a long journey or death in a foreign country. When they choose to leave, they may left behind because they cannot keep up with family or neighbors or climb into transport vehicles.

At the Sudan border, a sick and malnourished 75-year-old man who had been left behind by his immediate family was brought to a medical clinic by another in his clan. He could not speak and was severely malnourished. In another case, a Liberian man had been left by relatives a month earlier. His stomach was sunken, his ribs visible, and dirt literally had to be removed from his body with a wire brush.

The aftermath of genocide

Genocide has long-term consequences in contributing to the isolation later in life of people who were children at the time of the crime. Elderly Armenians in Cairo attribute their isolation to the fact that their extended family was wiped out 70 years ago. The consequences of the Rwandan genocide will be felt for generations, with children and elderly people bearing the brunt.

In Liberia, a white-haired great-great grandfather tells how he fell when fleeing from rebel forces. He now cares for his grandchildren who were displaced at the same time. They will remain together in a 200-person tent because he continues to be plagued by an injury and is not physically able to build a separate shelter for them.

> Older refugees have unique vulnerabilities and needs that place them at particular risk.

Economic disadvantages

During and after emergencies, older people suffer from a variety of economic disadvantages: loss of employment and markets, lack of pensions, and no access to credit. As custodians of the land, they may be more affected. They may not know whom to turn to for help or may have to pay for it.

A Colombian refugee in his 60s who had fled to Ecuador now cares for his orphaned grandchildren. The assistance provided when he first claimed asylum is long gone, and the neighbor who loaned them a mattress asked for it back. Formerly a farmer, he now earns a dollar here and there by doing odd jobs, but otherwise has no income. He cried as he explained that younger men get jobs illegally, but because of his age, it is not possible for him.

Physical and mental problems

Food rations provided by aid agencies can be difficult for older individuals to digest. One older Burundian refugee in a camp in Tanzania says: *The most important problem is with the food ration. My stomach hurts when I eat it.* She has to depend on farm-grown produce. That, however, is increasingly hard to come by because her daughter's husband can't get out of the refugee camp to farm since there are restrictions on movement and local people harass the refugees and take food or money from them.

According to a UNHCR study on assistance, older persons are more susceptible to traumatic disorder than younger people, and symptoms such as persistent recall of

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not develop, including a deep spiritual commitment. But this is not true for everyone, as Tom illustrates.

Health remains an important aspect of a person's well-being. But wisdom, spirituality, coping strategies, and personality adaptations can moderate the effects of ill health. As Sam commented: *The Good Master knows, and takes care of those who help others.*

Although Sam and Hazel have developed important coping strategies that have given them psychological strengths, the impact of legal segregation, existing de facto segregation, and continued systemic white racism and oppression remain barriers to their physical health. Hazel described being treated differently because of her race:

Stress? I've had stress all my life. ... Yes, you never forget about it. It's always there. It just never stops. And there is nothing that you can do about it. Yes, it hurts. But you can't let you bother you, or it would eat you up.

The sample was small, but other research confirms the racial disparities in health that are evident here. The population is rapidly aging, while, at the same time, the percentage of people of color is increasing. That means health disparities will become even more critical from both social policy and practice perspectives. Additional research is needed to learn more about the effects of stress caused by racism on the health of older African Americans.

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Fear of Crime and Criminal Victimization Among the Elderly

by Bruce K. Bayley, PhD, CFLE, Assistant Professor; and Jan D. Andersen, PhD, Assistant Professor, Department of Family and Consumer Sciences, California State University, Sacramento

The U.S. Census estimates there were approximately 35 million people 65 years or older living in the United States during the year 2000. As America's elderly population continues to grow, so do their concerns over crime and victimization. To better serve our nation's senior residents, it is important to understand how fearful they are of crime, how likely they are to be victimized, and most importantly, what steps can be taken to make their lives more secure.

Fear of crime

Criminologists consistently find that women and the elderly are more fearful than men and younger people. In fact, the most fearful generally tend to be Caucasian females, 65 years or older. Many fears are directly related to the individual's sense of reduced physical and cognitive abilities and, sometimes, prior victimization. The media's portrayal of national and regional crime also contributes to these fears. In addition, recent studies have shown that elderly respondents are less satisfied with both law enforcement and the court system. These perceptions may also play a part in their elevated fear of crime.

Victimization

While the elderly are often the most fearful of neighborhood crime, they also are among the least likely to become victims of criminal behaviors. According to the National Crime Victimization Survey, from 1993 to 2002, those 65 years of age and older were victims of crime at much lower rates than younger people. In terms of violent victimization, the U.S. Bureau of Justice Statistics reports that the elderly in general, and elder Caucasian females in particular, are the least likely to become victims of a violent crime. (The most likely are young white males.) On the other hand, seniors are more apt to experience fraud and financial crimes than younger people are.

Con artists, especially telemarketers, rely on the generally trusting nature of older people and their desire for interaction. According to the National Consumers League, telemarketing scams cost Americans over $40 billion annually. And AARP estimates that over half of all telemarketing fraud victims are persons age 50 or over.

Prizes and sweepstakes, magazine sales, and lottery schemes are among the top telemarketing frauds against seniors. But newer scams involving identity theft are a growing problem. Author Steve Weisman recently observed: "People over the age of 50 control at least 70 percent of this nation's net worth. Like the bank robber who said he robbed banks because that is where the money is, so do identity thieves steal from older people because that is where the money is."

Financial crimes against the elderly are, however, most often committed by trusted friends and family. Older people whose mental and physical health is deteriorating depend on others. Closer proximity, frequent contacts, and power of attorney give friends, relatives, and caregivers access to property, income, savings, and investments. Often the elderly do not realize that their financial resources are being stolen.

Even when financial abuse is discovered, the elderly often will not seek prosecution

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stressful events, depression, insomnia, nightmares, emotional numbness, and fear were markedly more common among older persons. The psycho-trauma of war and exile can weaken the immune system and has been shown even to accelerate the onset of senile dementia in certain cases.

Negative social selection

As families and individuals begin to integrate in new locations, negative social selection may occur with elderly left behind in camps, or collective centers, while younger people leave in search of greater security or employment.

Resettlement countries tend to judge resettlement cases on health status, employability, and general integration potential. The primary goal of reuniting elderly refugees with immediate relatives is often ignored. When conditions permit repatriation, older refugees may choose not to join their children in countries of resettlement. At the same time, they may not wish to return to their country of origin, may be unable to do so, or may have lost touch with home.

"Dying out of my land"

Finally, one of the greatest concerns for older refugees, the desire to die or be buried in their home country or ancestral land, is rarely mentioned. An older man displaced from the on-going fighting in Darfur and staying on the Chad border spoke without interrupting his work: *It is a sad situation we are in, but that isn't the key issue. I am concerned about dying out of my land, outside the land of my ancestors.*

Maureen Lynch, PhD

Though elderly persons represent a minority among displaced and war-affected communities, their rights and needs must be addressed. Governments should facilitate the process of status determination and regularization that allows older individuals access to assistance. Governments and humanitarian agencies alike can work harder to monitor and respond to the needs of older persons. Older people should be included in all program planning. Sometimes older people just need a little extra help and the feeling that someone cares before they can restart their lives and rebuild their communities.

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Intergenerational Community Programming: Fostering Resilience Among Adolescents and Meeting the Psychosocial Needs of Older Adults

by Stephanie Grutzmacher, MS, Doctoral Student, Department of Family Studies; and Bonnie Braun, PhD, CFCS, Extension Family Policy Specialist, University of Maryland

Sages of the Ages: Stories that Touch and Teach is a collaborative project of the Maryland Cooperative Extension Family Life Committee and the Maryland Family Community Education organization. *Sages* is a community and school-based approach to fostering the development of resiliency skills among young people by drawing on the reflections and experiences of older adults. Resiliency research, which generally suggests that individuals and families can develop protective and recovery factors to help them through the challenges of life, guides *Sages* curricula and initiatives.

The intent of *Sages* is to gather older adults' stories of getting through difficult times and share those stories with adolescents. Teenagers are filled with energy and a seemingly unending future, while older adults are filled with wisdom obtained from a past full of experiences. *Sages* brings older adults and adolescents together, in order to:

- Address the developmental needs of teens and older adults.
- Build resilience capacity through intergenerational storytelling.
- Promote intergenerational interaction.
- Encourage community involvement and service partnerships.

Meeting psychosocial needs of older adults

A large portion of family programming related to aging addresses caregiving and family support. While systems of care for older adults are essential to their well-being, their psychosocial and developmental needs are often overlooked.

As adults age, they reach a developmental stage of reflection, evaluating life's purpose and meaning. A goal of this stage is to accept choices and make peace with life as one has lived it. Older adults may determine the value of their life experiences and consider ways in which those experiences may help others. Sharing life stories with others has potential to meet the developmental needs of those in later stages of life, as well as foster intergenerational connections and resilience among young people.

Reflecting on life through storytelling

Older adults can establish important legacies through storytelling. Storytelling helps older adults to think about their lives, relive earlier times, and reflect positively on their experiences. The processes of reflection and making meaning of life can bring comfort and cultivate a sense of worth and dignity.

Older adults can establish important legacies through storytelling.

The nostalgia inherent in storytelling ignites memories of the past, allowing people the opportunity to share themselves with future generations. Having survived both individual and collective challenges, older adults have many stories that can help guide today's teens through their own challenges.

Watering seeds of community resilience

Adolescents and older adults are largely segregated in daily life, and intergenerational connections within families are often diluted by distance. To create opportunities for intergenerational interaction, community leaders must build bridges between adolescents and older adults through community initiatives. Using projects that unite these groups establishes more significant intergenerational relationships around a common interest and moves resiliency beyond the self into the community.

Efforts to unite generations through community programming can reduce the isolation that sometimes characterizes life as an aging person and provide significant role models for adolescents. In addition to sharing experiences about life's storms and rainbows with young people, forging connections between generations can give older adults a renewed sense of belonging in their communities.

As we move from personal experience to our collective experiences as members of a family, community, and world, we can learn new ways of coping with difficulties and challenging circumstances. Inter-generational community programming has the potential to help communities collectively endure difficult times and come through them stable and strong.

Curriculum materials

Sages exists as a curriculum for home, school, or community-based use. Parents, teachers, and youth leaders can explore the existing materials and obtain copies by visiting the website site at: *www.hhp.umd.edu/FMST/Sages/home.htm*. As stories are collected, they will be added to the website. In the future, we hope to engage youth in development of *Sages* as an electronic, interactive curriculum. In all formats, *Sages* focuses on fostering resilience among youth and meeting psychosocial needs of older adults.

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VICTIMIZATION *continued from page F36*

because they love the perpetrator, feel embarrassed or ashamed, or fear that reporting will result in further loss of their independence. It is commonly believed that only 1 in 5 cases of financial abuse is reported to law enforcement agencies. John Wasik, author of *The Fleecing of America's Elderly,* disagrees. He estimates that only 1 in 25 incidents is ever reported. If correct, Wasik's figures would indicate that full reporting could account for approximately 5 million victims of elder financial abuse annually.

Over half of all telemarketing fraud victims are age 50 or over.

Many states have amended their constitutions to include certain rights for victims of crime – including seniors. The most common are:

- The right to be notified of when and where one's case will be heard.
- The right to reasonable protection from the perpetrator.
- The right to have input during the sentencing phase.
- The right to restitution from the offender.

Protective measures

Although elderly people are, as a group, the least likely to be victims of crime, it is still wise for them to take the following protective measures:

General Personal Safety

- Walk together in groups.
- When possible, stay in well-lit, public places.
- When using an answering machine, avoid giving out personal information such as your name or address, or the fact that you're living alone ("This is Mary, I'm not home right now"). Instead, re-state your phone number and say, "We're not available right now."
- Trim the trees, shrubs, and bushes in front of your house–burglars often use these to hide in–and be sure all windows and doors have secure locks.
- Contact your local law enforcement agency and inquire about a home safety inspection. Many agencies provide this service free of charge and often know of reliable contractors who can provide any needed improvements for free or at low cost to seniors.

Fraud Prevention

- Never buy from a company you're unfamiliar with.
- Remember that it's illegal for a company to ask you to pay or buy something in order to win a prize.
- Always ask for and check out a company's personal information before purchasing on-line.
- When purchasing online, always pay by credit card–this allows you to dispute any fraudulent charges.
- Place your telephone number on the national "do not call" list (1- 888-382-1222 or *www.donotcall.gov*)

To learn more about fear of crime among the elderly, victimization, or protective measures, contact your local law enforcement agency or see the following sources:

- Federal Bureau of Investigation, *www.fbi.gov*
- National Criminal Justice Reference Center, *www.ncjrs.org*
- National Fraud Information Center, *www.fraud.org*

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Perspectives on Aging

"I am luminous with age."
– Meridel Le Sueur, American poet

"At 77, it is time to be earnest."
– Dr. Samuel Johnson, English author, lexicographer

"We did not change as we grew older; we just became more clearly ourselves."
– Lynn Hall, American author

"I prefer old age to the alternative."
– Maurice Chevalier, French singer, actor

"To me, old age is always 15 years older than I am."
– Bernard Baruch, American financier

"The tragedy of old age is not that one is old, but that one is young."
– Mark Twain, American author

"Of all the self-fulfilling prophecies in our culture, the assumption that aging means decline and poor health is probably the deadliest."
– Marilyn Ferguson, American author

"Do not deprive me of my age. I have earned it."
– May Sarton, American author

Internet Resources

AARP. This website offers sections on computers and technology, health and wellness, legislative issues, leisure and fun, life transitions, money and work, research and reference, and volunteer experience. ***www.aarp.org***

Administration on Aging. This division of the Department of Health and Human Services advocates for seniors and their concerns. The Administration on Aging works with other federal, state and area agencies on aging, to develop community services for older Americans and their caregivers. ***www.aoa.gov***

AgingStats.gov is the website of the Federal Interagency Forum on Aging-Related Statistics. It includes *Older Americans 2000: Key Indicators of Well-Being*, which covers 37 key indicators selected by the Forum to portray aspects of the lives of older Americans and their families. This report is divided into five subject areas: population, economics, health status, health risks and behaviors, and health care. It is available in both html and PDF formats. ***www.aginingstats.gov***

Alzheimer's Association. Excellent information about Alzheimer's disease and other forms of dementia for caregivers, healthcare professionals, researchers, and others. ***www.alz.org***

American Geriatrics Society. This organization of health care professionals works to improve the well-being and health of seniors. It promotes research, shapes health care policies for the elderly, and provides educational opportunities for geriatrics professionals and the public. ***www.americangeriatrics.org***

Centers for Disease Control and Prevention, Healthy Aging. This website includes health data related to the aging population, as well as links to pertinent government agencies and other organizations. ***www.cdc.gov/aging***

FirstGov for Seniors. This portal site includes information on consumer protection; education, jobs, and volunteerism; federal state agencies; health; laws and regulations; retirement and money; taxes; and travel and leisure. ***www.firstgov.gov/Topics/Seniors.shtml***

The Gerontological Society of America is a non-profit that provides researchers, educators, practitioners, and policy makers with opportunities to understand, advance, integrate, and use basic and applied research on aging to improve the quality of life as one ages. This site includes links to the Association for Gerontology in Higher Education, which is an educational unit of the Gerontological Society, and to the National Academy on an Aging Society, a policy institute of the organization. ***www.geron.org***

The National Alliance for Caregiving is dedicated to providing support to family caregivers and the professionals who help them and to increasing public awareness of issues facing family caregivers. This website includes materials for family caregivers and research reports. ***www.caregiving.org***

The National Family Caregivers Association supports, empowers, educates, and speaks up for the more than 50 million Americans who care for a chronically ill, aged, or disabled loved one. This website includes tips and guides, as well as links to other Web resources. ***www.nfcacares.org***

National Institute on Aging. Part of the National Institutes of Health, this agency conducts and supports studies related to aging, disseminates research findings, and provides research training. This site includes publications for the general public, including a selection in Spanish. ***www.nih.gov/nia***

Profile of Older Americans. This annual report, prepared by the Administration on Aging, provides statistical data topics such as current population and projected growth, marital status, living arrangements, racial and ethnic composition, geographic distribution, income, housing, employment, education, and health. The 2004 report is available at ***www.aoa.gov/prof/Statistics/profile/2004/profiles2004.asp***

U.S. Census Bureau. The "Age Data" section provides information on aging topics. Many full-text reports are available in PDF format. ***www.census.gov/population/www/socdemo/age.html.***

U.S. Senate Special Committee on Aging. This committee conducts studies related to the concerns of seniors such as health, income, and housing. This website also includes information on the fraud hotline maintained by the Committee on Aging. ***http://aging.senate.gov/public***

Aging by the Numbers

36.3 million
The number of people 65 and over in the United States on July 1, 2004. This age group accounts for 12 percent of the total population. Between 2003 and 2004, 351,000 people moved into this age group.

4.9 million
The number of people 85 and over in the United States on July 1, 2004.

86.7 million
Projected population of people 65 and over in the year 2050. People in this age group would comprise 21 percent of the total population at that time.

3.6 million
Number of elderly persons who lived below the poverty level in 2003. This was 10.2 percent of the total. Another 2.3 million or 6.7 percent of the elderly were classified as "near-poor" (income between the poverty level and 125 percent of this level).

416,000
Approximate number of grandparents aged 65 or more with primary responsibility for grandchildren who live with them.

$11,845
Median income of older females in 2003. Older males had a median income of $20,363.

18.2 years
Average life expectancy of persons reaching age 65 (19.5 years for females and 16.6 years for males).

147%
Projected percentage increase in the 65-and-over population between 2000 and 2050. By comparison, the population as a whole would have increased by only 49 percent over the same period.

33%
Percentage of Americans over 65 who receive 90 percent of their income from Social Security Benefits.

17.6%
Percentage of minorities among persons age 65 and over in 2003: 8.2 percent were African American, 2.8 percent were Asian or Pacific Islander, and less than 1 percent were American Indian or Native Alaskan. Persons of Hispanic origin (who may be of any race) represented 5.7 percent of the older population. In addition, 0.5 percent of persons 65+ identified themselves as being of two or more races.

71%
Percentage of older men who are married. Older men are much more likely to be married than older women. Only 41 percent of women are married. Half of women over age 75 live alone.

Sources: The U.S. Bureau of the Census, the National Center on Health Statistics, and the Bureau of Labor Statistics.

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