Subjective Well-Being in Older Adults: The Role of Interpersonal Relationships

by
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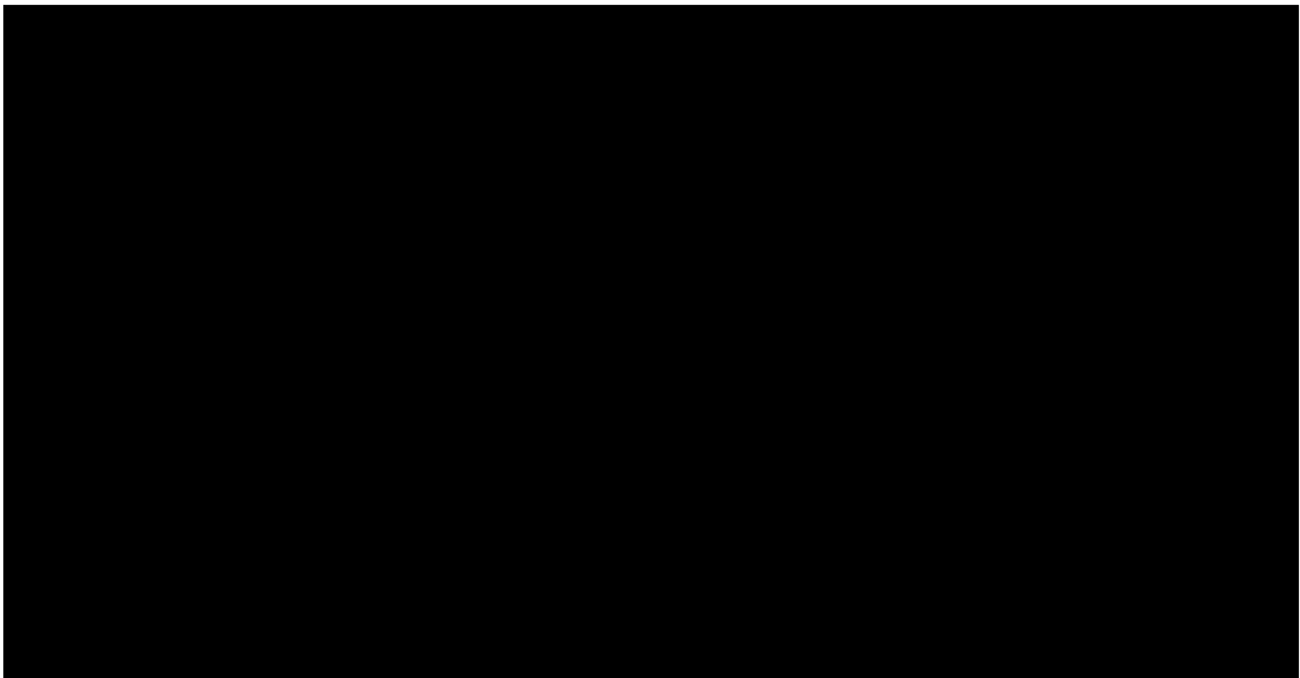

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Dedication

This dissertation is dedicated to the friends and family who sustained me through the process. Your support is much appreciated.

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Abstract

The purpose of this qualitative descriptive study was to discover how older adults explain their interpersonal relationships while relating their beliefs about successful aging. The participants were drawn from the Alameda County Study, a longitudinal investigation that began in 1965 designed to discover associations between social factors and health. After the 1999 follow-up survey, a questionnaire on successful aging was distributed to participants age 65 or older. Out of this cohort, 51 volunteers were interviewed regarding their concept of what constitutes successful aging. A research assistant conducted face-to-face interviews 60 to 90 minutes in length, which were transcribed verbatim. This project was a secondary analysis of 49 of these interviews. Using N-Vivo qualitative software, the interviews were coded and themes identified. All but five participants had children. The participants spoke of family relationships as very important to their well-being. The themes identified include freedom from family responsibilities, re-negotiating relationships with children, and re-connecting with spouse. Social comparison was identified as a major mechanism for defining oneself as an older person. In addition, gender differences were identified. A major task for women was balancing work with their family relationships. Men focused more on their relationships with children and spouses after they retired than they did while working. Overall, family relationships remain an important focus for older adults. Clinical and research implications include assisting elders to maintain their roles in the family and recognizing the importance of social comparison in self-definition.

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Subjective Well-Being in Older Adults: The Role of Social Relationships

Chapter 1 Background and Significance

Disease, disability, and the loss of peers are the major normative stressors of later adulthood (1996). Since the losses that accompany aging are noticeable, much research on later life focuses on coping with decline and death, that is, what we lose as we age. Indeed, 52% of people over the age of 65 have at least one functional disability (von Faber et al., 2001) and may appear to have a low quality of life. However, there is ample evidence that many older adults are satisfied with how they are aging despite illness or impaired function (Bryant, Corbett, & Kutner, 2001; Strawbridge, Wallhagen, & Cohen, 2002; von Faber et al., 2001). It behooves us to understand satisfaction in older adulthood because we are about to see the largest groundswell of people over the age of 65 on record. In all of history, half of all the people who have ever lived to the age of 65 are living today (Roszak, 2001). The 2000 census counted 35 million persons over the age of 65 living in the United States (Hobbs & Stoops, 2002), and this number is expected to grow to 70 million by 2030 (von Faber et al., 2001). The most populous age group in the 2000 census was that between ages 35 to 44, portending explosion of the older adult population (Hobbs & Stoops, 2002). People over the age of 65 currently comprise 13% of the US population; however, by 2030 we expect this group to constitute a full 20% (Administration on Aging, 2003). Because of increased longevity, this is a permanent demographic shift and the population will continue to have a larger proportion of elderly than in the past (Roszak).

Learning to age well or healthfully will have a huge impact on our society. To view late life as a dour series of losses is unrealistic because losses occur throughout the life span. Each life stage necessitates losses, which create an opening for the next phase

(Bowlby, 1969, 1973) Limiting investigations of aging to a loss paradigm fails to capture the full experience of aging and influences our perception of the value of longevity (Kayser-Jones, 1986; Virmani, Schneiderman, & Kaplan, 1994).

The purpose of this dissertation is to explore what characteristics of social relationships are associated with well-being. This chapter will review the research on how characteristics of interpersonal relationships in older adulthood are associated with well-being. It will review the current literature, explicate the current body of knowledge, and pose novel research questions. After delineating the process of review and defining terms, this chapter then explores objective and subjective assessment of aging well. Finally, it reviews studies that associate social relationships with SWB.

The Process of the Review

There is an abundance of literature on social relationships. The starting point for the literature search was contact with expert researchers who directed the author to classic articles in social support. Social relationships in this dissertation are viewed in the context of social support. The author searched PubMed, CINAHL, Sociology Abstracts, and PsychInfo databases using MeSH (PubMed) or key words (other data bases) social support, aged, well-being, subjective well-being, and social relationships in various combinations. Limits set were age greater than 65, English only, human, and the years 2000-2005. Once the researcher identified key authors, she searched by author. Hand search of related journals followed as well as researching references from key papers. The chosen articles are from peer-reviewed journals and are empirical studies or reviews of the literature. Conference proceedings for organizations involved with older adults were additional sources.

Definition of Terms

This section defines key terms frequently used in social support research. One of the challenges with this body of research is that the terminology is not universal (Barrera, 1986; Cohen & McKay, 1984; Finfgeld-Connett, 2005; Langford, Bowsher, Maloney, & Lillis, 1997). This dissertation uses the following definitions.

Relationships

Social connections are relationships, meaning any interaction between one person and another. That interaction may be a brief, chance encounter or weak tie (as when two strangers chat while waiting for a bus) or an intimate, long-term affiliation, sometimes called strong ties (such as marriage; Norbeck, 2002, personal communication). Social support, social relationships, and social connections are used interchangeably in this discussion and refer to interpersonal relationships. There is no assumption made that these encounters are wholly positive or negative; most relationships include both support and conflict.

The Convoy Model

Many studies use the convoy model as a rubric for collecting data and discussing findings. Each person moves through life surrounded by a group of people with whom he or she is related through the exchange of social support (Kahn & Antonucci, 1980). The convoy model heuristic consists of three concentric circles surrounding a target individual (See Appendix 3 page 187; expanded discussion in Chapter 2 Theory page45). Each successive circle represents social connections that are intimate, close, and then peripheral. A convoy travels with a person throughout their life, modulating in size and character based on attachment needs and role fluctuations throughout the life span. The convoy is a heuristic that can make comparisons between childhood experiences and adult life, honoring

the precept that personal history is a component of current life situation (Baltes, Reese, & Lipsitt, 1980; Kahn & Antonucci, 1980; Levitt, 2000).

Older Adult

Any definition of older adulthood is arbitrary. There is precedence in the literature for defining the beginning of older adulthood as early as age 50 (Friedman & King, 1994; Levitt, Antonucci, Clark, Rotton, & Finley, 1985a) and as late as age 75 (Hazzard, 1997). This paper will use the term older or later adulthood as that period in life after the age of 65. The term old-old or very old means those aged 80 and greater.

Social Integration and Health Continuum

Berkman, Glass, Brisette, and Seeman (2000) developed the Social Integration and Health Continuum model (SIHC; see Appendix 4 page 191) in an attempt to explain the connection between social context and health. This model describes four nesting levels (environment, network, interpersonal, and intrapersonal), each being derived from the previous. Chapter 2 further explicates this theory (see page 68).

Social Network

"Social networks are the collection of interpersonal ties that people of all ages maintain in varying contexts." (Litwin, 2001) p. 516 Support network and social network are synonymous in this document, although this does not imply that all aspects of the social network are supportive.

Social Support

Social support signifies the reciprocal exchange of assistance and protection—both tangible and intangible--that shepherd a person through life (Langford et al., 1997). There are four types of social support: emotional, instrumental, informational, and appraisal (Cobb, 1976). Social support exists throughout life, but the types of support people need or

want varies with age and state of health. In general, social support is helpful and protective; it is positively related to subjective well-being (Berkman & Syme, 1979; Langford et al., 1997; Pinquart, 2001). However, social connections are not beneficial simply by virtue of existing; they can also be harmful (Fingerman, 1995, 1996; Rook, 1984; Rook, Thuras, & Lewis, 1990).

Alternate definitions abound in the literature. For example, PubMed defines social support as; "Support systems that provide assistance and encouragement to individuals with physical or emotional disabilities in order that they may better cope" (Medline as accessed through PubMed, November 28th, 2002). PubMed's definition assumes that social support exists only when there is a stressor that the individual is unable to manage unassisted. However, the proposition of this paper is that social support is always present within a network and it affects well-being throughout life irrespective of the person's ability to manage independently.

Successful Aging

Rowe and Kahn (1987, 1997, 1998a,b) popularized the term successful aging in 1987 in a landmark article and later refined it. They rated aging as normal, usual, and successful using the criteria for success as the absence of disease or disability, avoidance of risk factors for major disease, and active engagement with life. The degree of success in aging is an objective evaluation.

Well-Being

Subjective well-being (SWB) has three primary domains: positive affect, absence of negative affect, and life satisfaction (Diener, 1984; Larson, 1978). Studies show that although positive and negative affect cannot exist in the same person concurrently, the frequency and intensity of these emotions over time have an independent influence on well-

being (Diener, 1984). Unless otherwise stated, SWB refers to Diener's definition and is the subjective measurement of the phenomenon described as successful aging by Rowe and Kahn (1987,1998b). Related concepts include successful aging, aging well, self-reported aging well, health, and quality of life. While only some share a domain with SWB, all attempt to describe or measure a desirable way to live as an older person. The diverse ways to describe living well in old age presents an additional challenge to this literature review.

What Does it Mean to Age Well?

Inspired by studies showing a connection between health and the physiologic changes resulting from stress, researchers began studying the connection between stress and disease (Selye, 1956, 1976). Interest in the role of social support in aging well began when studies showed an association between social connections and longevity (Berkman & Syme, 1979; Seeman, Kaplan, Knudsen, Cohen, & Guralnik, 1987).

While it seems obvious that it is desirable to live longer, ultimately the question of quality arose. Several theories arose that attempted to define what it meant to age well, including physical health and lack of disease (Rowe & Kahn, 1987, 1997), delaying disease to the last months of life (Fries, 2000), and compensating for changes that accompanying aging (Baltes & Baltes, 1990). This section will review studies explore different perspectives of what it means to age well.

Social Support and Longevity

Berkman and Syme (1979) were among the first to verify a correlation between social network and longevity using data from the first follow-up to the Alameda County Study on Health and Ways of Living (ACS; Chapter 3 Research Methods page 77). The ACS is longitudinal investigation started in 1965 to study how social factors are associated with health (N=6,928).

To establish this link between longevity and social connections, Berkman and Syme (1979) identified four sources of social contact (marriage, contact with close friends and relatives, church membership, and group association) that forecast longevity. Overall, each of these four types of contact predicted mortality independently from the other three; however, close relationships (such as marriage and contact with close friends) had a greater effect on longevity that did the more distant contacts (church or group association). Low social connection scores, as compared to the highest scores, correlated with an overall age-adjusted relative risk of mortality of 2.8 for women and 2.3 for men over the 9-year study period after controlling for physical health, socioeconomic status, health practices, smoking, obesity, alcohol consumption, physical activity, and access to health services (Berkman & Syme).

Subsequent studies confirmed the connection between longevity and social support and have established a link between mortality and lack of social ties in older adults (Friedman, 1993; House, Landis, & Umberson, 1988; Kaplan, 1988; Schoenbach, Kaplan, Fredman, & Kleinbaum, 1986). While extending life's length is an admirable goal, other researchers sought to describe what made those extra years worth living, including the contribution of social connections.

Connection with Well-being

There is evidence that social connections and well-being (positive emotion, absence of negative emotion, and life satisfaction) are associated (Bedford, Volling, & Avioli, 2000; Friedman, 1993; Friedman & King, 1994; Kawachi & Berkman, 2001; Levitt et al., 1985a; McAuley et al., 2000; Pinquart & Sorensen, 2000). Yet, how this connection works is not well understood.

Researchers have used a variety of objective measurements to determine how social connections might promote well-being, beginning with those most readily observable. Physical function is observable and measurable. It is an aspect of social competence because lack of mobility limits the opportunity for social contact. Good physical function can promote social contacts, which enhance well-being. In turn, social connections promote physical activity (McAuley et al., 2000; Ostir, Markides, Black, & Goodwin, 2000). There is also evidence that social contacts have some effect on physical function. Strawbridge, Cohen, Shema, and Kaplan (1996) found that having close personal contacts predicted maintenance of physical function, as measured by needing no assistance with activity/mobility measures over a six-year period (OR 1.82, 95% confidence interval [CI] 1.05-3.18).

So, social connections, physical activity, and physical function are interrelated. However, social connections also seem to have inherent value. Litwin and Shiovitz (2002) used structural equation modeling in their study of 4444 Israeli retirees to evaluate quality of life (measured by morale, life satisfaction, and satisfaction with use of time). They found that social contact was more influential in the experience of high life quality than was health or activity level. This is one example of how the subjective experience of well-being may not correlate with external measures. While measuring physical activity or physical function may yield some answers, it is important to know whether measuring objective data can reveal the subjective experience.

Objective Measurement Compared to Subjective Evaluation

Data suggest that the subjective experience of well-being in late life does not necessarily correlate with the observed (Bearon, 1996; Bryant, Beck, & Fairclough, 2000; Bryant et al., 2001; Daltroy, Larson, Eaton, Phillips, & Liang, 1999; Guse & Masesar, 1999).

Objective measurements may not contribute to understanding what it is about social connections are beneficial. To fully appreciate how social connections promote well-being, the subjective experience must be understood.

Testing the presumption that success in aging is dictated by imposed criteria, Strawbridge, Wallhagen, and Cohen (2002) analyzed data from a 1999 survey of Alameda County Study (ACS) participants (the ACS is described in Sample Characteristics, page 83). They found that objective measures did not correspond to subjective experience. Objective measurements were based on Rowe and Kahn's (1987,1997) successful aging criteria of the absence of disease or disability, avoidance of risk factors for major disease, and active engagement with life (measured by the absence of chronic conditions; non-smoking; and a body mass index < 30). Self-rated successful aging was measured by asking subjects how strongly they agreed with the statement "I am aging successfully (or aging well)."

Nine hundred seven participants completed these surveys, a response rate of 89%. Half (50.3%) of the subjects considered themselves aging successfully; however, only 18.8% met Rowe and Kahn's criteria. Of the 163 who were classified as successfully aged by Rowe and Kahn's criteria, 60 (36.8%) did not rate themselves as aging successfully. Of the 704 classified as not aging successfully by the Rowe and Kahn standards, 333 (47.3%) rated themselves as aging well. In other words, while a minority of participants met the Rowe and Kahn objective measures of successful aging, most participants classified themselves as aging well, despite how the objective criteria rated them. Thirty-seven percent of those who met the successful aging criteria did not rate themselves aging well; however, nearly one-half of those who did not meet the successful aging criteria felt they were aging well. So, either the Rowe and Kahn criteria are wrong, or the objective view of how well a person is aging does not correspond to the subjective experience. It seems likely that older adults use a

benchmark other than illness or disability to self-rate their success with aging. Two qualitative studies presented here are recent attempts to identify how older adults define SWB.

The Subjective Experience

Bryant, Corbett and Kutner (2001) found that illness or disability in later life did not predict SWB in a study of 22 older adults. They studied how older adults define healthy aging using participants who were under-raters or over-raters of their health on a survey compared to objective measures. Named "disparate cases," the researchers interviewed these elders who disagreed with their objective rating regarding their personal definition of SWB or healthy aging.

The researchers identified four categories: having something worthwhile and desirable to do; the ability to accomplish the activity; appropriate resources; and a positive attitude. All categories correlated "going and doing" with health rather than lack of disease and disability. Impairments were incidental to basic "going and doing" activities. As long as one had the ability to participate in a meaningful activity, disability did not hinder well-being. Often, though, the elders chose an alternate activity if disability curtailed the preferred activity.

Von Faber et al. (2001), found that older adults cited personal relationships as contributors to well-being. Using data from the entire population of 85-year-olds in Leiden, the Netherlands (N=705), they compared the results of objective measures of successful aging to qualitative interviews on a subset of 27. On the quantitative survey, the mean social functioning score on the Time Spending Pattern inventory (a standardized tool) placed these old-old participants in the "poor" category. These elderly were involved with one or two social activities per week on average; however, satisfaction with social functioning was not

tested. While two activities per week may be poor social function for the younger adults on whom the tool was tested, one or two outside activities may represent good social function for an 85-year-old. Also, the social functioning tool quantified the social contacts but did not measure types of social connections or their quality. To understand what was important to the participants, the researchers subsequently interviewed the subset of 27 for more detailed information.

In the qualitative interviews, the elders identified several elements of SWB that pertain to social contacts. First, although social contacts were few when compared to a standard, participants perceived them as a coping mechanism that decreased loneliness and boosted well-being. Second, investment in relationships at a younger age corresponded with the number and quality of relationships in old age. This is a concept sometimes called indirect reciprocity. For example, research shows that middle-aged daughters who live with their mothers prior to the mother's needing caregiving are less conflicted about their new role than those who move in together expressly because the mother needs care (Pohl, Boyd, Liang, & Given, 1995). Giving or receiving support (financial or social) earlier in life may be reciprocated later in life (Attias-Donfut, 2001; Moen, Dempster-McClain, & Williams Jr., 1992). Third, even having many social relationships did not compensate for the loss of one important person. For example, positive friendships did not counterbalance the loss of a sibling or a child. The study did not look at whether these characteristics were unique to older adults.

Aging Well

In these three studies, older adults fared worse overall on objective measurements of well-being as compared with self-rated assessments. Therefore, subjective data were more likely to be optimistic than were objective measures.

Strawbridge, et al. (2002) established that elders in the ACS did not rate their aging by the same scale as did Rowe and Kahn. Bryant, et al (2000) identified healthy aging as having a meaningful activity and the ability to do it, including "appropriate resources." Social relationships and support might constitute some of these resources needed to remain healthy. Von Faber, et al. (2001) identified social relations as bestowing unique benefits. These findings suggest that social relationships may play a role in SWB in older adults.

Since social relationships occur within a context, one must first understand how the environment influences social networks and hence social interactions. The next section will explicate the social context, from which comes the social network. The social network is the immediate context for interpersonal relationships.

The Social Context or Environment—the Macro Level

According to the social integration and health continuum (SIHC) model (Berkman et al., 2000) (See Appendix 6 page 191), the context of social interactions includes socioeconomic factors, politics, social change, and culture. These macro-level factors are the physical and social environments that provide the raw materials for interpersonal interactions.

Research on this level defines characteristics of the social environment, such as neighborhood characteristics, and informs exploration of how the macro level factors affect the personal levels. For example, the Whitehall I and II longitudinal studies of British Civil Servants established that higher SES was associated with better health and lower mortality than is lower status (Adelman, 1990; Marmot & Brunner, 2005; Marmot et al., 1991). Although the process by which this happens is not yet clear, factors on the macro level influence health on a personal level.

In the ACS, the association between socioeconomic status and the following have been studied: prostate cancer (Ernster et al., 1978); health status (Frank, Cohen, Yen, Balfour, & Smith, 2003; Kaplan, 1996; Slater & Carlton, 1985; Slater, Lorimor, & Lairson, 1985); poor health independent of personal habits (Haan, Kaplan, & Camacho, 1987); peptic ulcer (Levenson, 1997); and poor physical, cognitive, psychological, and social functioning (Lynch, Kaplan, & Shema, 1997). Area of residence has been associated with rates of depression and perceived health status (Yen & Kaplan, 1999b), physical function (Balfour & Kaplan, 2002; Yen & Kaplan, 1998), and mortality (Berkman & Syme, 1979; Yen & Kaplan, 1999a). Higher socioeconomic class is associated with more abundant social resources. Researchers have demonstrated a similar connection between resource-rich environments as compared to impoverished ones (Cattell, 2001) and differences in levels of well-being are attributed to social status (Bassuk, Berkman, & Amick, 2002); geographical distance from family (Levitt et al., 1985a); culture (Peek & O' Neill, 2001); neighborhood characteristics (Yen & Kaplan, 1999a, 1999b); and historical events (Capsi & Elder, 1986; Elder, 1974; Elder, Shanahan, & Clipp, 1997).

Cultural and Ethnic Influences

There are few studies on culture or ethnicity and social connections in older adults. Peek and O'Neill (2001) studied 4, 124 older African Americans (AA) and compared their social networks to European Americans (EA). They found that while the network sizes were similar, AAs had more kin in their networks than did EAs. In addition, church affiliation was stronger in the African American community. Snowden (2001) showed that AA men had a higher level of social embeddedness than did EA men, owing to greater involvement with church, visits from friends, and visits to friends; they also had a significantly lower number of symptoms of psychological distress. While EA women

seemed to have more social contacts than did AA women, there were no significant differences in their levels of psychological distress. So, race and gender influence some effects.

Other network characteristics seem to be attributable to age rather than ethnicity and showing that age differences in social network that transcend racial differences. Fung, Carstensen and Lang (2001) found a difference in network size between the oldest and the youngest groups in their study of European American (EA) and African American (AA) adults. A sample of 185 participants (age 18-94 years [M=54.9; SD=20.5], 100 female; 128 EA, 57 AA; 27% single, 40% married, 19% widowed 14% divorced) were divided into 5 age groups. All were English speaking; self-rated health was as "good" or better.

The mean number of social partners for the entire sample was 20.76 (SD=12.56). The mean of very close partners was 6.21 (SD=4.01) and the peripheral social partners 14.55 (SD=10.39). There were no ethnicity or age differences in main effect nor were there age by ethnicity interactions in number of very close partners. However, AAs had fewer peripheral partners than did their EA counterparts ($p=.001$). In both ethnic groups there was an age main effect on the number of peripheral social partners ($p<.0001$), confirming that older participants in both ethnic groups had fewer peripheral social partners than did the younger.

More studies are needed on the effect of culture, ethnicity, and acculturation in older adults. This is especially true for groups other than African American. In addition, these studies need to differentiate between age and environmental contextual factors, such as race, ethnicity, socioeconomic status, and gender. (Note: also see Reciprocity, page 25 for cross-cultural investigations.)

The Effect of Gender

Gender is another macro level factor because it further defines social environment and thus impacts the stressors and resources that act on males as compared to females. This section will focus on three areas of difference between the genders: the type of network participation, the degree of focus on family relationships, the types of social contacts that affect longevity.

First, network participation is different between men and women. Studies consistently show that women have more network members than do men (Levitt, Antonucci, Clark, Rotton & Finley, 1985). In addition, women comprise most network members for both genders (Antonucci & Akiyama, 1987).

Second, women focus on family relationships, whether or not they work outside the home. Roberto, Allen and Blieszner (1999) performed in-depth qualitative interviews with 34 women aged 55-88. The two most prevalent themes were, first, the centrality of their children and grandchildren and second, that these relationships contributed to their sense of self and family. They did not interview men, so they were not able to compare the genders.

Third, there are a plethora of studies that show social relationships affecting longevity differences between the genders. Berkman and Syme (1979), in their landmark study that linked social contact with longevity in the ACS, found that all measured social contact (marriage, contact with friends, group membership, and church membership) affected mortality; however, social connections had a greater effect on women than on men. The difference in relative risk of mortality between those men aged 60-69 with high levels of social contact as compared to low levels was 1.8; for women it was 2.7.

For men, being married, high contact with friends and relatives, and church membership correlated with increased longevity. For women, high levels of contact with friends and family, church membership, and group membership were significant predictors. For men, the age-adjusted mortality rate between being married and mortality was highly significant ($p \leq .001$); however, for women, it was not significant. For women, group membership was significant ($p \leq .05$), whereas it did not reach significance for men.

Subsequent studies have furthered Berkman and Syme's (1979) work by explicating the characteristics of social contact that affect longevity. Shye, Mullooly, Freeborn and Pope (1995) studied a 5% random sampling of members of a health maintenance organization (HMO) over the age of 65 (N= 455; men n=209; women n=246). They found that larger network size was associated with longevity for both men and women. Men were significantly more likely to be married and those who were had larger social networks and more frequent social contacts than did single men. However, women had larger network sizes than men, despite marital status. Men with larger social networks had better self-perceived health, but this association did not hold true for women. Fair to poor perceived health predicted mortality ($p<.01$) in both genders.

The finding that larger network size is associated longevity in women is further supported by Reynolds and Kaplan (1990), who found that socially isolated women had an elevated risk of dying of cancer of all types (relative hazard [RH] = 2.2 for all sites; RH= 5.7 for smoking-related cancers), while there was no such association for men.

Bassuk, Berkman, and Amick (2002) studied the effect of socioeconomic status (SES) on mortality in older adults. In a nine-year longitudinal study of four communities in the US, they found that higher SES (measured by household income, occupation prestige or education) was associated with longevity. While lower income was associated with higher

mortality in men and women, all three SES factors were associated for men. For women, only income was a significant contributor. Since education and occupational prestige are individual indicators while income was measured by household, the researchers surmised that high occupational prestige may actually be socially detrimental to women. They note that occupational prestige is a rarely studied variable, especially in terms of women's multiple roles.

Church attendance seems to have a different affect on longevity in women than it does in men, according to two studies drawn from the ACS. Strawbridge, Cohen, and Shema (2000) studied a 29-year period and found that weekly church attendance was predictive of longevity for women to the same degree as was smoking, alcohol ingestion, physical activity, and other social contacts. This association did not hold true for men. Strawbridge, Shema, Cohen, and Kaplan (2001) reported that those who attended weekly religious events were more likely to both improve poor health behaviors and maintain good ones than were those whose attendance was less or who did not attend at all. Weekly attendance was also associated with improving and maintaining good mental health, increased social relationships, and marital stability; however, the data showed a stronger effect for women than for men. These studies do not differentiate between church attendance and religiosity or spirituality.

Whether it is the social connections at church or a spiritual benefit is not clear. Boey (2003) studied how elderly women's life satisfaction and depressive symptoms related to religious belief in women in Hong Kong (N = 180, mean age = 74.2 years). She found that attendance at religious activities was not related to psychological well-being; however, subjective feelings that religious faith was a source of strength and comfort, and that it would help in times of difficulty were significantly associated with psychological well-being.

While studies indicate that social connections affect men and women differently, the mechanisms remain elusive. In addition to the effect of gender, the means by which other social factors affect health and well-being is not well understood. Making the macro-micro level connection is one challenge in current research on social support.

Connecting the Social Environment with the Individual-Mezzo Level Factors

Berkman et al. (2000) developed the Social Integration and Health Continuum (SIHC) model as a heuristic to study how the social context affects the individual. This model is discussed more fully in the Chapter 2 (also see Appendix 6 page 191). Briefly, the macro level provides the raw materials for the social network. The social network (mezzo level) bridges the interpersonal (micro level) and the environment (macro). So, the diversity, quantity, and quality of social interactions depend upon the content of the social network.

Network

The social network is the source of interpersonal relationships. A larger number of people in the network is associated with increased happiness in older adults (Wenger & Tucker, 2002). Wenger (1991; Wenger & Tucker) identified five network types for older individuals:

- The family-dependent network (a small grouping of close family members);
- The locally integrated network (a large grouping that includes family, friends and neighbors);
- The local self-contained network (a small, neighbor-based web, family at a distance);
- The wider-community-focused network (a large and primarily friendship-based grouping);
- The private-restricted network (consisting of minimal ties with neighbor and no kin).

Wenger's network types are highly related to morale and degree of loneliness or isolation. The social network type influences both the availability of social interaction and how frequently that contact occurs (telephone or in person; yearly or daily). For example, an older woman and her large family who have lived in the same neighborhood for years (locally integrated network) has more resources in times of illness than does an elderly woman who never married, has no children, and lives alone in a single-family dwelling (private-restricted network). Litwin (2001) found that those elders with a locally integrated network had better morale than those in private-restricted networks (Adjusted R2= .41). However, all network types have strengths and weaknesses (Wenger & Tucker, 2002).

Factors that affect network composition that have been studied include chronic illness and disability (Cohen, 1988; Friedman, 1993); race and culture (Fung et al., 2001; Peek & O' Neill, 2001), widowhood (Stewart, Craig, Mac Pherson, & Alexander, 2001), negative family relationships (Fingerman & Birditt, 2003), and retirement (Bosse, Aldwin, Levenson, Spiro, & Mroczek, 1993). It is clear that counting the number of social contacts is not sufficient to fully explicate how social network affects the older individual. A comprehensive picture of social network includes both the number and the quality of social contacts.

Retirement

Retirement is a common occurrence in later adulthood. It is a common belief that social network shrinks when a person retires from work. Conversely, Bossé, et al. (1993) found that network size shifted with age, but not with work status in their study of social contact after retirement. Using data from the longitudinal Veteran's Administration Normative Aging Study, they found that the types and emotional closeness of social contacts changed with age; however, work status did not alter network size.

They followed 1,311 men over a three year period and tracked work patterns, which were classified as stable (continuous full time work, continuous part time work, retired without work contact), changed (full to part-time work, full or part-time to no work), or increased (retired and returned to work). To their surprise, the researchers found that there was only minimal reduction in the number of social contacts in men with all work patterns after retirement; however, the quantity of contacts for all men decreased over time ($F_{[1,1101]} = 493.99$, $p < .001$). Overall, there was an increase in the perceived quality of social interactions over time ($F_{[1,1101]} = 20.64$, $p < .001$), but no significant differences by work status.

These findings suggest that there is an age-related increase in the quality of social contacts. Simultaneously, there is an age-related decrease in the number of contacts that is independent of work status. The process of enhancing emotional ties while limiting the number of contacts is consistent with the tenets of socioemotional selectivity theory (SST). This theory predicts that as people age, they intentionally narrow their social network to fewer but more intimate relationships (Lansford, Sherman, & Antonucci, 1998) so that in old age the quality of social interaction is optimized to enhance emotional ties (Lang & Carstensen, 1994). SST attempts to explain the difference between how older adults form and maintain social contacts when compared to younger. However, a myriad of other factors contribute to the unique relationships of older adults.

How Relationships Differ between Older and Younger Adults

Research shows that there is a qualitative difference between the relationships that older people cultivate as compared to younger. Marriage is one relationship that changes qualitatively with aging. In part, the years a couple spends together shape the relationship and a successful marriage adapts as the needs of the dyad evolve.

Synergy in Older Couples

Marriages last longer now than in the past, owing to increased longevity. Now one in five marriages can expect to make it to the 50th anniversary (Phillipson, 1997). This durability of spousal ties challenges couples to adjust to changes in physical and mental ability. While conflictual spousal relationships are associated with decreased well-being (Levenson, 1997), spouses are often the first line of instrumental and emotional support.

Racher's (2002) phenomenological study of 19 elderly couples in rural Canada showed how couples can thrive when one spouse requires assistance from the other. The participants' age ranged from 72 to 96 and they had been married an average of 52 years (range 20-67). The dyadic interviews revealed a range of support on a continuum classified as mutually supportive to "very fragile." The process of adaptation to increasing disability depended on mutual assistance and communication. In some cases, one partner was cognitively impaired while the other was physically impaired. Together they were able to remain independent, whereas each living alone would not have been able to manage. When the care needs of one partner increased beyond the point where the other could reciprocate, the partnership began to falter. In addition, the cognitive status of both partners directly affected communication. When communication became difficult, stress increased.

This synergy works in the context of a long-standing relationship, which is possible only with older adults. In addition, there is evidence that emotional ties, such as those in a marriage, are more significant to older adults than to younger adults. This increased emotional capacity may affect the type and number of relationships that older adults desire.

Emotions and Older Adults

Emotional goals are prominent in early childhood and again take precedence when time remaining is perceived as limited, typically in later adulthood (Carstensen, Isaacowitz, & Charles, 1999); this is a normal developmental change. There is evidence that older adults experience more positive emotions than negative. Older adults experience all emotions either just as strong or more intensely than do younger adults (Lang & Carstensen, 1994; Levenson, 1997).

Carstensen, Pasupathi, Mayr and Nesselroade (2000) studied 184 people aged 18-94 years, comparing the type and intensity of emotions comparing the older and the younger. The study substantiated that, while the intensity of emotions is comparable throughout adulthood, older adults experience negative emotions less frequently and for a shorter length of time than do younger adults. The absence of negative emotions is one aspect of SWB.

Seeking emotional ties is an age-related factor in the composition of social networks. A result of this penchant for positive emotions, older adults seek constructive relationships over negative (Lachman, 2003). Preference for fewer close personal relationships is a characteristic of normal development in later life (Lansford et al., 1998)

How Emotional Life Affects Network Size

Disengagement theory posits that older adults reduce the overall size of their social network to prepare for the end of life (Cumming & Henry, 1961). This reduction is involuntary and disengagement theory casts the older adult as a passive observer of the changes. Later researchers attempted to explain how older adults take an active role in structuring their social networks. Lang and Carstensen (1994) found that the overall size of the social network shrinks while the number of close emotional relationships (convoy

model's inner circle) remains constant. They attribute this to enhanced emotional life in later adulthood. Although the subjects did indeed have a smaller network size (network size versus age, $r=-.37$), the size was reduced from earlier adulthood by the reduction of less-close partners (convoy model's middle and outer circles) rather than by the diminution of intimate ties. There was a significant three-way interaction among level of closeness (very close, close, less close), type of relationship (nuclear family, kin, friends, acquaintances), and age-cohort group for those 70-104 years of age ($F_{[6, 924]}=2.52$, $p<.05$). In paired analysis, the only significant differences were in mean embeddedness scores between those with and without nuclear families (with M=9.2, SD =2.9; without M=7.7, SD = 3.3, $p<.05$). In general, those with a nuclear family felt more embedded; nevertheless, this difference disappeared if the subjects without a nuclear family had more than three close contacts.

These data show that older adults do indeed seek close ties with others at the expense of more peripheral ties. It may appear that they slowly close down relationships with others; however, it is the peripheral ties that are expendable. These data show that close emotional ties persist and that family or close friends enhance the sense of embeddedness.

Lansford, Sherman and Antonucci (1998) showed that older adults have smaller but more emotionally satisfying social networks than do younger adults. They analyzed data from two randomly selected, nationally representative samples (Americans View Their Mental Health [AVTMH], 1957 N =2,460 1976 N= 2,264; age 21-93 years; Social Supports of the Elderly [SSE] N= 718, age 50-95). They found that older adults, as compared to younger adults, reported fewer actual social contacts, even if the number of people in the social network remained constant. For the AVTMH sample, one-way ANOVA showed satisfaction with the number of current friends for participants in the 1957 sample ($p<.01$)

and in the 1976 sample ($p<.001$). The older respondents had fewer interactions than did the younger (1957 $p<.001$; 1976 $p<.001$). In the SSE sample, the frequency of social contact also decreased with age ($p<.01$). Nevertheless, significantly more of the older respondents than the younger reported being satisfied with their relationships (AVTMH $p<.001$; SSE $p<.001$). This was true despite the fact that the youngest respondents reported more frequent contact with friends and relatives (AVTMH, $F_{[4,2435]} = 21.80$, $p<.001$; SSE, $F_{[2,674]} = 6.82$, $p<.01$).

These findings may shed some light on the Faber, et al. (2001) study, where octogenarians had "poor social functioning" as measured by number of contacts on a standardized tool, yet they reported that they were satisfied with their social relations. Older adults are satisfied with fewer social contacts and there is evidence that they select relationships that are more emotionally satisfying. These data are also consistent with findings in other cultural groups, lending credence to the contention that they are age-related changes (Fung et al., 2001).

Conversely, other researchers have associated a lower number of social contacts to poor physical function rather than to age (Cavelli, Bickel, & Lalive d'Epinay, 2002; Pinquart & Sorensen, 2000). These findings support the contention that numbers alone are not sufficient to evaluate social networks in older adults.

Effect on the Pathways to Health

According to the SIHC, psychosocial mechanisms generate intra-psychic, behavioral, and physiologic pathways, which are the mechanisms that directly produce health (see Appendix 6). The pathways are considered here in reference to studies that explicate their connection with social relations.

Effect on Self-esteem

Social support can have a beneficial effect or a harmful effect on self-esteem, depending upon the quality of the relationship. Beyene, Becker, and Mayen (2002) found that Latino elders living in the US attributed self-esteem and subsequent well-being in later adulthood to social connections. For these elders, self-esteem is rooted in the family and is the result of healthy family functioning rather than individual factors. Many older adults expected that family members would encourage healthy behaviors as an indication that they care.

Other data support the contention that expressing interest in another's health practices affects self-esteem. Rook, et al. (1990) interviewed 162 older adults aged 58-90, asking who in their social network encouraged healthful behaviors. According to Rook, et al. (1990), social control theory explains how the social environment changes behavior through pressures or expectations placed on the subject by others in the social network. When referring to health behaviors, social control is the regulatory attempts by others (direct), and feelings of obligation or responsibility to others (indirect), that encourage engagement in a healthy lifestyle (Tucker, 2002, p. 59).

Approximately 75% of the respondents in the Rook et al. (1990) study indicated that members of their networks performed positive social control functions; that is, they provided motivation to adopt health promoting behaviors. Friends and adult children contributed the most whereas spouses and other kin performed secondary roles. Surprisingly, these control behaviors contributed little to the participant's health practices; however, they increased self-esteem and decreased loneliness in the participants.

Reciprocity

Many researchers have found that reciprocity is an important aspect of social support for older adults. It is the quality that differentiates social support from caring (Hegyvary, 2004). Participants in the von Faber (2001) study identified reciprocity as a critical feature of on-going relationships; however, the study did not investigate how this reciprocity functioned. Data indicate that the type of support exchanged is not as crucial as the fact that a trade occurs. For example, adult daughters gave more instrumental support to their elderly mothers, whereas mothers provide their daughters with more emotional support (Bromberg, 1983).

Even when in need themselves, there is evidence that elders take the time to support others. In analyses of activity diaries, Rankin, de Leon, Chen, Butzlaff, & Carroll (2002) found that unpartnered elders recovering from myocardial infarction spent time helping others.

Minkler, Satariano, and Langhauser (1983) found a relationship between giving and seeking advice and self-reported health status in their investigation of 678 older adult residents in Alameda County. Social ties were associated with positive self-reported health ($p<.001$). Seeking and receiving advice were highly related ($p<.0001$) and seeking advice was independently associated with self-reported health ($p< .0001$).

Liang, Krause, and Bennett (2001) developed a new model of social support and its effect on well-being that considered the elder giving support as well as receiving. There was a positive association between giving and well-being ($p<.001$). On the other hand, negative interaction ensued if others gave excessively to the elder without the elder reciprocating. The authors advocate for research on social exchange in the context of the relationship quality.

Schwartz C, Meisenhelder, Ma and Reed (2003) randomly sampled 2,016 adult members of the Presbyterian Church, who then completed a survey on giving and receiving aid. Regression analysis showed that both helping others and receiving assistance were significant predictors of mental health, after adjusting for age, gender, stressful life events, income, general health, positive and negative religious coping, and asking God for healing ($R2 = .27$). Giving help was a more important predictor of higher reported mental health than was receiving aid.

The importance of reciprocity does not seem to be culturally bound. How that exchange manifests differs between ethnic groups. Chi and Chou (2001), in their study of 1,106 elders in Hong Kong, found lower scores on the Center for Epidemiological Studies-Depression scale (Radloff, 1978; $R2 -.14$, $p<.0001$) in those who felt they helped others. In a qualitative investigation, Beyene et al. (2002) found that reciprocity was a norm in Latino families, where interdependence among immediate family members was highly valued. Children were expected to care for elderly parents in exchange for being raised by them; elders anticipated having a role in raising grandchildren.

Becker, et al. (2003) confirmed the importance of reciprocity in four ethnic groups—African Americans (n=59), Latinos (n=85), Filipino Americans (n=78), and Cambodian Americans (n=48). They interviewed each of 270 respondents (aged 50 and older) five times over a five-year period. They found that mutual assistance was critical in all groups as an element in intergenerational relations that represented continuity within the family. Nevertheless, there were differences between groups in overall approach to mutual assistance, the factors to which they assigned the greatest importance, and the degree of dissatisfaction expressed over family relationships. Elders maintained family continuity by having a social commodity to exchange and the ability to adjust to role changes in the

extended family. They concluded that social exchange is not only a means by which the elderly maintain power, but also a major mechanism for perpetuating continuity across the generations. When their opportunity to give broke down, elders suffered from loss of role resulting in feelings of powerlessness.

Coping

Coping is the action that a person takes to lessen or avoid the impact of life problems that is necessary when the effect of a stressor exceeds current resources (Lazarus & Folkman, 1984; Pearlin, 1989). In other terms, the question of the role of social support in promoting coping has been studied as the moderating effect of social support on stress. Although it makes intuitive sense that social support buffers the effect of stress, research yields mixed results (Baillie, Norbeck, & Barnes, 1988; Barnett, Kibria, Baruch, & Pleck, 1991; Kawachi & Berkman, 2001; Lefrancois, Leclerc, Hamel, & Gaulin, 2000; Roberts, Kaplan, & Camacho, 1990; Thoits, 1982).

An example is a study by Lefrancois, Leclerc, Hamel, and Gaulin (2000) of stressful life events in adults over 80 and the moderating effect of social support on psychological distress. They evaluated the frequency of social contacts and social support satisfaction in a convenience sample of 224 men and women aged 81-86 living in the community. Negative life events were significantly associated with psychological distress ($\beta=0.37$, $p< 0.0001$). Satisfaction with social support had a negative correlation with psychological distress ($\beta= -0.16$, $p<0.01$), but a high frequency of life event stress was a stronger predictor of psychological distress than was low social support. No interaction was noted in the regression model, indicating that social support did not exert a moderating effect (Bennett, 2000). There was an additive, unique contribution of social support satisfaction over negative life events, but taken together, both predictors accounted for only

17% of the variance. So low satisfaction with social support was related to psychological distress, but adequate social support did not temper the effects of stressful life events.

Understanding the moderating effect of social support would suggest interventions to avert psychological distress, including depression. Serious methodological barriers exist that impede progress in this arena. These include the conceptualization and operationalization of stress as well as confounding factors, such life change (Thoits, 1982). Many agree that faulty coping is a major contributor to psychological distress, notably depression.

Averting Depression

Depression is not a normal part of aging; in fact, the rate of depression in older adults is the same or less than that in younger adults (Nelson, 2002). In the ACS, Roberts, Kaplan, Shema, and Strawbridge (Roberts, Kaplan, Shema, & Strawbridge, 1997) found that depression in older participants was attributable to poor physical health and disability rather than age. People who have social contacts have less depression. Pain is a common predictor of depression in older adults and osteoarthritis is the most common cause of pain. Tak and Laffrey (2003) studied 107 women aged 60 and older with osteoarthritis to identify the relationships among functional disability, chronic daily stress, coping strategies, beliefs about personal control, social support, and life satisfaction in older women with osteoarthritis. Using a descriptive, correlational design, study participants completed six surveys. Bivariate correlational analyses showed that older women with poorer functional ability experienced greater chronic daily stress, reported more frequent use of emotion-focused coping strategies, and had a higher chance health locus of control. The hierarchic regression analysis showed that perceived social support and internal health locus of control predicted life satisfaction after controlling for demographic, illness-related, and stress-related variables.

These data were supported by Chi and Chou (2001) who reported significant bivariate associations between all dimensions of social support (network size, network composition, instrumental/ emotional support, social contact frequency, and satisfaction with support) and depression on a community-dwelling sample of 1,106 older adults in Hong Kong.

Sense of Well-being

According to the social integration and health continuum (SIHC), a sense of well being is a component of health. Bryant et al. (2004), in their qualitative study of members found that seniors considered social contacts and networks as important contributors to quality of life. Most studies attempt to measure SWB using tools that quantify one or more of its components—positive emotions, lack of negative emotion, and life satisfaction (Diener, 1984).

Pinquart and Sorenson (2000) synthesized results of 286 empirical studies on the association of SES, social network, and competence with SWB, in adults with mean age 55 and older. One qualification for inclusion into their review was that the studies measured at least one aspect of SWB as defined by Diener (1984). They found that those with higher SES (higher income), better social integration (high quality social ties), and higher competence (ability to maintain an independent life and meaningful activities) had greater life satisfaction. They also had higher self-esteem and greater happiness.

The quality of contact was more strongly related to SWB than is the quantity of the contact, as measured by size of the social network, frequency of contacts, or both. The association between life satisfaction and quality of contact explains 3.4 times more variance than does life satisfaction and contact quantity. Family contact was positively related to all

three measures of SWB; however, given equal numbers of social contacts, there were higher associations between friendship and SWB.

There was a significant association between life-satisfaction and quality of contact with adult family members that was significantly stronger than the quality of contact with friends. The number of contacts with friends is more strongly associated to SWB than is number of contacts with relatives, possibly due to level of physical competence or possibly because friends are chosen ties. There were, however, not enough studies with sufficient effect size to be certain of these results.

While the Pinquart and Sorenson's (2000) meta-analysis makes an important contribution to the field of social support, it suffers from the diversity of definitions mentioned earlier. Pinquart and Sorenson used studies that measured any one of Deiner's domains (positive emotions, lack of negative emotions, and satisfaction with life) as the dependent variable. There were not enough studies that used a uniform definition of SWB to do a targeted meta-analysis.

Social contacts can promote a sense of well-being and diminish loneliness. Shu, Huang and Chen (2003) investigated the effect of ADLs, sex, and subjective well-being affected self-concept in residents of a retirement facility (n= 37) as compared to community-dwelling elders (n= 28) in Taiwan. Residents of the care home had lower self concept and female elderly individuals had significantly higher scores than males in family self and social self, and satisfaction. The authors conclude that designing programs for the elderly that increase interaction with others will help them establish new social networks for them which may enhance a sense of positive self-concept.

Relationship History

Peters and Liefbroer (1997) applied a life course perspective to marital status and its relationship to partner history. They found that the partner status of older adults and aspects of their partner history affected SWB in later life. A stratified sample (region, gender, and year of birth) of 3,390 people in the Netherlands aged 55 to 89 were interviewed in their homes. Information collected included the size of network and social support, well-being, life history, social background (SES), and personality. The results indicated that single males and females are much more lonely (a measure of negative emotion) than those with a partner ($p<.01$), but those who were never partnered are less lonely than those who were partnered in the past. Those who experienced multiple partner dissolutions (death, separation, or divorce) were lonelier than those who had one dissolution ($p<.01$), even after controlling for age, gender, network size, and health. Both the numbers of dissolutions and the time elapsed since the most recent termination were more influential factors than whether the loss was due to divorce or death of a spouse. Time (>=10 years), high health status, and large social network reduced but did not obliterate the degree of loneliness.

So again, relationships can have a beneficial or a harmful affect on well-being. In this case, the absence of a close partner or the dissolution of an intimate relationship had a detrimental effect on well-being. However, it is important to appreciate what makes a relationship injurious or favorable. Relationships can have positive or negative qualities.

Negative Interactions

Rook (1984) identified negative interactions and relationships as problematic for older adults in a study on older widows. Negative relationships are those that generate conflict, frustration, and disappointment (Akiyama, Antonucci, Takahashi, & Langfahl, 2003). Chipperfield, Perry and Weiner (2002) found that although older adults have more

positive and fewer negative emotions, not all relationships elicited the positive. Perceptions of support resulted in affirmative emotions, whereas other relationships elicited harmful emotions. So while emotional ties are important, these relationships should be caring and beneficial.

STT would predict that older individuals would limit their exposure to negative social interactions (Lang & Carstensen, 1994). Older adults do identify relationships with relatives as problematic (Fingerman & Birditt, 2003). However, sometimes life-long toxic relationships are difficult to dissolve because of relationship history (Krause & Rook, 2003).

Because marriage correlates with longevity (Berkman & Syme, 1979), there is a misconception that it is always good for an older person to be married. Akiyama, et al. (2003) found that although in general older adults had fewer negative interactions than did younger, this trend did not hold for spousal relationships. James Coyne found that heart patients who had negative spousal relationships were 1.8 more likely to die within four years than those with positive relationships (Lerner, 2002). Even a marriage that is good earlier in life can be a source of chronic stress in old age. Spouses often become caregivers for a disabled partner; caregiving is notoriously stressful and can create chronic stress (Pinquart & Sorenson, 2003). Most relationships are neither wholly beneficial nor detrimental, so it is not always easy to sort the favorable from the harmful qualities.

Challenging the conventional view that positive social support yields positive consequences and the reverse for negative social relationships, Bedford, Volling and Avioli (2000) found desirable consequences in adult life from childhood sibling conflict. While this sounds contradictory, the authors recognized that relationships are multifaceted. In this descriptive, retrospective study the authors asked 40 participants, aged 45-81, how conflicts with siblings, both in childhood and currently, have benefited them throughout their

adulthood. Respondents reported learning skills from these interactions that stayed with them throughout life as long as there was also affection and warmth in the relationship. Most of the participants reported benefits throughout adulthood resulting from sibling relationships in childhood, including improved parenting skills, social competence, depth in the ongoing sibling relationship, and the development a sense of self.

Studies on Social Support in the Alameda County Study

Epidemiological studies on social contact do not differentiate positive or negative relationships. While the qualities of social interactions are not delineated, the epidemiologic investigations in the ACS have yielded some landmark findings on social support. Minkler, Satariano and Langhauser (1983) identify a central question in the epidemiology of aging as learning why some people experience high rates of illness and disability while others do not. Berkman and Syme (1979) were the first to establish a relationship between social support and health, using data from the first nine years of the ACS. Seeman, Kaplan, Knudsen, Cohen and Geralnik (1987) confirmed these findings. Because they had 17 years of data, they were able to look at changes in network characteristics as participants aged. They confirmed the relationship between social network and mortality in middle aged adults and established it in adults age 70 and over. Their findings included that marriage was significantly associated with lower mortality for those age 38-59 (relative hazard [RH]; 1.6 95% CI 1.12-2.29 age 38-49; RH 1.4; 95% CI 1.02-1.91 for those aged 50-59) but not for the older age groups. Membership in church groups, but not other types of groups, was associated with lower mortality risk in all age groups except for those aged 50-59. Although an association between social networks and mortality is illustrated by these data, the reasons are not evident.

Berkman and Breslow (1983) summarized twenty years of research on social connections and health in their book *Health and Ways of Living*. In it, they describe the motivation for the ACS. This project was designed as an epidemiological, population-based longitudinal cohort study based on the concept that health and diseases arise from the social environment and to develop surveys appropriate for population-level analysis.

Kaplan (1988) found a link between social connections and mortality in those with ischemic heart disease. Subjects over age 50 with a low social index score (SNI) had an ischemic heart disease mortality relative risk of 2.86 (95% CI 1.65-4.96) over 9 years as compared to those who had a high social index score. Reynolds and Kaplan (1990)studied cancer risk in 6,848 (total sample minus those with diagnosed cancer) of the original ACS sample in 1965 over the ensuing 17 years. For women, those with low SNI scores had a relative hazard (RH) of 2.2 for all cancers when compared to the women with high SNI scores; for smoking-related cancers the RH was 5.7 ($p<.05$ for both).

Strawbridge, Cohen, and Shema (2000) studied a 29 year period and found that weekly church attendance was predictive of longevity for women to the same degree as was smoking, alcohol ingestion, physical activity, and social contacts other than church attendance. This association did not hold true for men. Strawbridge, Shema, Cohen, and Kaplan (2001) tested the hypothesis that weekly attendance religious services would improve and maintain good health behaviors, mental health, and social relationships. They studied data from 2,676 participants for the period between 1965 and 1994. Those who reported weekly religious attendance in 1965 were more likely to both improve poor health behaviors and maintain good ones than were those whose attendance was less or who did not attend at all. Weekly attendance was also associated with improving and maintaining good mental health, increased social relationships, and marital stability. Again, the data showed a stronger

effect for women than for men, but the study was not designed to show why this difference occurred.

Some researchers hypothesize that decreased physical ability translates into lower social competence (Pinquart & Sorenson, 2000). Kaplan, Lazarus, Cohen and Leu (1991) studied the association between demographic, socioeconomic, and psychosocial factors related to physical activity. Using the self-reported physical activity data from the initial 1965 survey and the follow-up 1974 surveys, they found that for both men and women social isolation predicted a decrease in physical activity over the study period. For women, lack of membership in non-church group and for men, lack of membership in a church group, predicted decreased physical activity independent of confounding psychological variables, such as depression.

Lynch, Kaplan and Shema (1997) investigated the association between economic deprivation and decreased social functioning, measured by the number of social contacts per month. Participants with two or fewer contacts per month were considered socially isolated; there was no significant relationship between the lack of social contact and economic hardship. Although this study showed that a low number of contacts (termed social isolation) was detrimental, the quality of the social contacts and the reason for these interactions (or lack of interactions) was not investigated.

Levenstein, Smith and Kaplan (2001) studied 2,357 subjects who were free of hypertension in 1974. Social alienation had a significant association ($p<.05$) with the development of diagnosed hypertension by 1994, primarily in women. The risk was associated with health risk behaviors and with psychosocial factors such as stressful job and anomie (social discontent). They did not examine interpersonal ties.

Two studies using data from the ACS illustrate a relationship between social ties and successful aging. In addition to the Strawbridge, et al. (2002) study discussed earlier, Strawbridge, Cohen, Shema and Kaplan (1996) studied 356 participants in the ACS aged 65-95 prospectively for six years to identify predictors for aging successfully. Positive correlations were found between absence of depression (OR=1.94, 95% CI 1.10-3.12) and having close personal contacts (OR=1.82, 95% CI 1.05-3.18). They did not examine the nature of these personal contacts (who they were, under what circumstances, or how the participants experienced the contacts.

The ACS is the source of seminal work on social epidemiology. While the some critical connections have been made, others await discovery as the participants of the ACS age. Qualitative studies on this population can add depth to our understanding of social contacts and health by describing the social relationships.

Synthesis

What we know

The specific task for this chapter was to investigate known principles about the relationship between social support and well-being in older adults. Berkman (1987) delineated network size; frequency of contact; network density; intimacy; durability; geographical dispersion; and reciprocity as areas studied in social support. However, the established connection between social ties and physical health, mental health, and longevity stimulates further investigation. Beginning with this topic, this section will summarize areas of social support and well-being research and then propose questions for this research project.

Health and Longevity

Higher levels of social connections are associated with longevity and health (Bassuk et al., 2002; Berkman & Syme, 1979; Schoenbach et al., 1986; Seeman et al., 1987). Researchers have identified the following factors as related to social connections: cancer risk (Reynolds & Kaplan, 1990); having close personal contacts predicts the maintenance of physical function (Kaplan, 1992; Kaplan et al., 1991; Strawbridge et al., 1996). Social connections are associated with quality of life more strongly than are health or activity level (Litwin & Shiovitz, 2002).

Gender differences

The types of social contact that are beneficial seem to differ between men and women. For women, the number of social contacts correlates more strongly with well-being than it does for men (Pinquart & Sorensen, 2000). Social factors have a greater effect on mortality for women than they do for men (Berkman & Syme, 1979). Yet, certain types of social contact seem to have a greater affect on longevity for women, such as church attendance (Strawbridge et al., 2001) or group association (Berkman & Syme, 1979). This perhaps explains why women have more network members and, unlike men, have similar network sizes despite marital status (Levitt et al., 1985a; Shye, Mullooly, Freeborn, & Pope, 1995). Most support network members, for both genders, are women (Antonucci & Akiyama, 1987). Also, some data suggest that women focus their conversations on family relationships (Roberto, Allen, & Blieszner, 1999); however, there is no evidence that this is unique to women. Sons tend to understand parents needs better than do daughters, although daughters do most of the actual caregiving (Halpern, Shroder, & Citera, 1996).

Subjective Experience versus Objective Measurement

With regard to well-being or self-perceived successful aging, subjective experience does not necessarily correlate with objective measures (Bryant et al., 2001; Strawbridge et al., 2002; von Faber et al., 2001). Therefore current criteria used to determine if a person is aging successfully are not necessarily indicative of how the person feels about how he/she is aging.

Networks

There are different network types that reflect the number and type of social contacts (Litwin, 2001; Wenger, 1991; Wenger & Tucker, 2002). Other factors that influence the availability of social network are geographical moves (Levitt et al., 1985a); illness and disability (Friedman, 1993); and work situation, although retirement does not necessarily reduce network size (Bosse et al., 1993). Aging itself changes the importance of emotional ties as well as the number and type of network members desired (Carstensen, 1992; Carstensen et al., 2000; Carstensen & Turk-Charles, 1994; Fredrickson & Carstensen, 1990; Lang, 2001; Lang & Carstensen, 1994).

Close Relationships

Some evidence supports that older adults intentionally reduce network size to maximize close emotionally, but more satisfying, relationships while discarding some less important social ties (Carstensen et al., 1999; Fung & Carstensen, 2004; Fung et al., 2001; Fung, Carstensen, & Lutz, 1999; Lang & Carstensen, 1994; Lansford et al., 1998). Perhaps this is because older adults feel emotion more intensely than do younger adults, have more positive than negative emotions, and hold positive emotions for longer than they do negative (Carstensen et al., 1999; Carstensen et al., 2000). These factors appear to be age-related rather than dependent upon ethic group or culture (Fung, 2002; Fung et al., 2001). Marriage,

or close long-term partnership, is unique among relationships in that older couples who have lived together over years learn to support each other and can maintain independence. While there is evidence that marriage is associated with longevity (Berkman & Syme, 1979), some loss of marital partners contributes to loneliness that persists throughout life (Peters & Liefbroer, 1997; Racher, 2002).

Longstanding relationships are especially important and close emotional ties are not easy to replace. Having one important relationship can be a major source of emotional and tangible support and make a major contribution to health.

Pathways to Health

Self-esteem can be affected by social network ties and can be a personal experience or felt at the level of the family (Beyene et al., 2002). Attempting to control others' health behaviors can have a beneficial or detrimental effect on both behaviors and self-esteem, depending upon who gives the support and how they give it (Rook et al., 1990; Tucker, 2002).

Relationships are neither wholly positive or negative. Negative relationships can have a detrimental effect by destroying life satisfaction and inciting negative affect. Or, a person can learn skills from a negative relationship that will enable that person to create better relationships in the future (Bedford et al., 2000). Typically, an older adult will reduce negative contacts; however, relationship history can make negative ties difficult to break (Lachman, 2003). Marriage can promote well-being, or can be the source of chronic stress (Levenson, 1997). Caregiver stress is a well-known phenomenon (Baillie et al., 1988).

Summary

The experts call for study in specific areas to further illuminate the link between social support and well-being. The lack of explicit theory and terminology in the social

support literature renders it difficult to synthesize (Barrera, 1986; Finfgeld-Connett, 2005; Langford et al., 1997). Barrera notes that isolating specific aspects of social support for study will help explicate concepts and reconcile findings. He uses the term social support as a general description of interpersonal relationships.

Kaplan (1988) concluded that we need to know more about which aspects of social ties are most important. Pearlin (1989) emphasizes the need to learn more about the interaction and the form of social support and its contribution to well-being. Yen and Syme (1999) discuss the importance of separating the individual and social-level factors, including the quality of the environment. In 2000, Berkman, et al. identified the following as important factors that deserve investigation in older adults: emotions or affect, frequency of face-to-face contact, routine contacts (those so common they may not be mentioned), frequency of non-visual contact, frequency of organizational participation, reciprocity of ties, duration, and intimacy. While knowledge in all these areas would expand our understanding, measuring frequency still does not reveal the subjective experience.

Kawachi and Berkman (2001) summarized four insights in their review of literature on social ties and mental health. The first is that social support affects mental health through main effects and by buffering the impact of stress. The second is that the protective aspects of social ties are not uniform across society—some people have more access to resources than do others. The third is that social capital affects embeddedness of individual social ties within a network and the fourth is that further research is needed to understand the design, timing, and dose of interventions that work, as well as the characteristics of the person who will benefit the most.

Overall, the ACS studies are epidemiological and quantitative. This method achieves the original purpose of the study—to learn the association between health and the

environment. The ACS has been critical in the development of social epidemiology; however, population-level studies cannot illuminate subjective experience as can qualitative research (Marshall & Rossman, 1999).

To date, there are no completed qualitative investigations in the ACS on social connections. While the frequency of contacts and the duration of social ties are described statistically, features such as intimacy and the nature of reciprocity lack full illustration. The subjective experience of these connections, positive or negative aspects and what actually occurs in the interpersonal relationship, are not questions of host or agent and traditional epidemiological methods do not capture these processes.

What Qualitative Research Can Contribute?

Although Berkman et al. (2000) identified many areas in which they felt we need to innumerate aspects of social contacts, qualitative research cannot fill this gap. It can, however, add description to the phenomena that have been counted. The qualities that require more study are the design, the timing, and dose of social interventions that are supportive to health (Berkman et al., 2000). We know the constitution of social networks in older adults, but we know little about the changes that take place with disability or illness, except that competence affects the number of social contacts. Ethnic differences in the composition of the social network (friends versus kin) have only been minimally explored.

While many components of social interactions in older adults are known, rich descriptions are missing from the current body of research. Maintaining an interpersonal relationship requires moderating the harmful with the constructive. The mechanisms by which older adults achieve equilibrium in their social connections have not been investigated. In addition, the role of social control in adopting health practices in older adults is not well understood. However, these characteristics of interpersonal relationships

in older adults are critical to understanding how social ties promote well-being in older adulthood.

The research questions for this project are the following:

- What are the qualities of social relationships that older adults describe (in the context of interviews on successful aging)?
    - What types of relationships are described?
    - How do older adults describe their relationships with others, such as kin, peers, neighbors, friends, and paid helpers?
    - How do they describe the characteristics of relationships that promote or hinder well-being?
- Is there a gender difference in the description of relationships?
    - Do older women describe different qualities in relationships than do older men?

What differences are there between men and women in their descriptions the characteristics of relationships that promote or hinder well-being?

It is imperative that we understand the positive aspects of old age as well as the disadvantages. Elements unique to late life are wisdom gained from experience and the ability to reminisce (Erikson, Erikson, & Kivnick, 1986). These elements as well as emotional maturation create an opportunity for a depth of interpersonal relationships that is not possible earlier in life. There is evidence that later adulthood is marked with a richer emotional life that can result in greater satisfaction with interpersonal relationships (Lang, 2001).

What Will this Study Contribute?

Using qualitative descriptive methodology (Sandelowski, 2000), the goal of this research project is to identify how older adults in this sample discuss their social relationships and whether men verbalize their relationships differently from women. Any description of the nature of social interactions or social connections makes a unique contribution to our understanding of the ACS participants, for whom 40 years of quantitative data is available. This project will not include triangulation with the quantitative data; however, the data and analysis will be available for prospective projects. While answers to the qualitative study are illuminating in themselves, the author intends to also identify areas for future research.

As noted earlier, a major challenge in social support research is that there are no uniform definitions or a unifying theory. A common language is imperative to promote understanding between researchers and to consolidate what is known into one cohesive body of knowledge. To this end, the next chapter will review theories that are useful in understanding the characteristics of social relationships.

Chapter 2 Theory

Popular western culture represents old age as a time of decline, disease, and dependency (Covey, 2000). It is true that the incidence of illness and disability increases with age. In 2000, 42% of people age 65 or older and 72% of those over 85 reported at least one disability (Gist & Hetzel, 2004). However, this high rate of disability does not mean that older adults do not value their lives. While objective assessments might categorize disabled elders as "unsuccessful," external measures do not correlate with subjective experience (Bryant, et al., 2001, Strawbridge, et al., 2002, von Faber, 2001). Theory can explicate how to reconcile objective observations with subjective experience.

Bengtson, Rice and Johnson (1997) define theory as "the construction of explicit explanations in accounting for empirical findings (p. 5)." Theory creates a structure to analyze and explain evidence. It is an essential antecedent to scientific progress because research evidence must be accumulated systematically to build knowledge (Bengtson et al., 1997). Yet, a survey of empirical studies in gerontology 1990-1994 showed that 72% of the 645 articles reviewed made no mention of theory as a structure for explaining results (Bengtson, et al.). Although it is likely that theory is embedded in every study, this neglect of explicit hypotheses prevents critical analysis of the underlying assumptions that guide the research. Overt use of theory authenticates a body of knowledge and links studies to one another.

This chapter will examine prevailing theories that explain the role of social relationships in promoting or hindering subjective well-being in a social context. A specific focus is on factors that impact interpersonal relationships. These theories are the underpinnings of the data analysis; they explicate the perspective of the researcher.

Purpose and Background

The question of how to age well is critical because the population of older adults is growing at an unprecedented rate. Although the population over the age of 65 currently comprises 12% of the US population, by 2030 this group will count 72 million members, or 20% of the population (Administration on Aging, 2003; von Faber et al., 2001). The average life span of a child born in the United States in 1900 was 48 years, yet a baby born in 2001 can expect to live 77 years (Administration on Aging, 2003). Some theorize that we have reached the maximum physiological life span while others conjecture that modern science can further prolong longevity (Doblhammer & Kytir, 2001; Fries, 2000). In either case, the 21st century will witness the largest number of people worldwide over the age of 65 in history (Roszak, 2001). This demographic shift could herald economic disaster as the shrinking numbers of "productive" youth support a burgeoning population of older adults. Alternatively, prolonged longevity could represent a revolutionary opportunity to recreate later adulthood (Roszak).

Theory defines a perspective that can either pathologize aging (Estes & Binney, 1989) or explicate it as a normal life stage. While many theorists posit that physical health or function define successful aging (Ford et al., 2000; Rowe & Kahn, 1998a; Rowe & Kahn, 1987; Rowe & Kahn, 1997, 1998b, 1999), others speculate that social relationships grow in importance in later adulthood and may be more essential to well-being than physical condition (Carstensen, 1992; Carstensen et al., 1999; Carstensen et al., 2000; Carstensen & Turk-Charles, 1994; Fung, 2002; Fung et al., 2001; Fung et al., 1999; Lang, 2001; Lang & Carstensen, 1994). Blending theories from different disciplines creates a more comprehensive view of the interaction between the individual and society. Sociologic perspective describes the context in which an individual dwells; psychological theories

explicate the intra- and inter-personal features. Integration of both disciplines into nursing broadens our view of person-environment and person-to-person interactions.

The construct of interpersonal relationships is catalogued in the literature as social support. The use of the word *support* is not precise. This chapter contends that older adults live within a social network, or number of interpersonal ties that may be supportive or harmful. The terms social network or interpersonal relationship are preferred over social support because they are more specific. A social network surrounds a person through life, although the character and the constitution of that network changes with life phases.

Life course theory situates personal development in context. An overview of the life course theory will launch the discussion of interpersonal relationships that adapt over time within a social context. Life course recognizes normative and non-normative events as well as cohort influences as a basis for identifying major stresses of older adulthood.

Major Concepts of the Life Course Theory

Life course theory views psychological and developmental precepts within the context of social environment, personal biography, and historical time (Bengtson & Allen, 1993). Age-cohorts (those born in the same decade and place) share common experiences. Alternatively referred to as a framework; a theory; and a perspective, the life course views a person within his or her social structure. This context includes culture, interpersonal relationships, historical period, and life trajectory (Bengtson & Allen). There are three life-course themes: timing, process, and context (Baltes, Reese & Lipsett, 1980). Timing is the order of events, process refers to transitions between roles, and context is the environment.

Timing is the incidence, duration, and sequence of roles or events in the life course (Bengtson, 1973; Rankin, 1995; Rankin, 2000). This could be a pattern of employment over adulthood—a person graduates from college at age 24, enters a junior

position, progresses into management at age 40, and retires at age 65. Timing also refers to events that usually happen at a specific time in the life course, such as young adulthood being the most common period for marriage and growing a family.

Process includes role transition, or how a person adjusts to a change, such divorce or the death of a spouse (Baltes et al., 1980). Timing and process taken together determine trajectory, or long-term patterns of stability and change (George, 1996).

Context implies the circumstances of a person's life, such as education, marital status, or socioeconomic class (Moen et al., 1992). The context of an individual's life has personal, social, and cohort factors. Personal factors are stressors that are classified as age-graded normative, history-graded normative, and non-normative (Rankin, 1995).

Age-Graded Normative Events

Age-graded normative events are those in which the timing and process are highly correlated with chronological age within a culture. The timing of these events meets the person's expectations and coincides with the experiences of age-cohorts (Baltes et al., 1980; Lazarus & Folkman, 1984). An example is that young adulthood is the age-graded "normal" time for a first marriage in the US, followed by the addition of children. Life changes are easier when they come on schedule with an age cohort because we have others who are in the same stage of their lives (Hagestad, 1986). For example, most women in the US give birth in their 20s (United States Census Bureau, 2004, 2005). A woman who has a first child when she is a teenager and unmarried or when she is over 40 has relatively fewer same-aged friends in the same situation. This reduces her contact with those with whom she can share the day-to-day joys and sorrows of early parenting. Sharing milestones with cohorts creates the opportunity to commiserate and to learn from each other. Age-cohorts fulfill basic support needs because they can empathize with life-events they share.

History-Graded Normative Events

Normative history-graded factors include historical events and sociological changes that affect a particular birth cohort (Giele, 1998; Rankin, 1995). Examples of normative history-graded events for our current older adults are the Great Depression and World War II (Rankin, 2000). For the baby boom generation, the assassination of President Kennedy, the Vietnam War, and 9/11 are history-graded events. Those who grew up in each cohort share common experiences that those who grew up later may find difficult to understand. Historical events can influence disability and mortality, well-being, sense of self, and attitudes (Elder et al., 1997). Effects can persist for 50 years or more, and thus have a powerful influence on a person's life (Elder, 1974; George, 1996).

Non-Normative Events

Non-normative factors are those unexpected personal events not experienced by a cohort as a whole (Rankin, 1995). The death of an adult child, for example, is a non-normative event. Although chronic diseases are prevalent in later adulthood, disease is another non-normative event. Because older adults have more time to accumulate physiological damage, they have a higher incidence of disease (Hayflick, 1998b). Non-normative events alter the life trajectory in unpredictable ways (Pearlin & Skaff, 1996).

The accumulation of life experiences and opportunity for disease increases the range of what constitutes normal in older adults, rendering increased heterogeneity a hallmark of later adulthood (Hazzard, 1997). Longevity also affords greater opportunity to accumulate irreversible social changes, such as education or the size of family (Riley, Foner, & Riley, 1999). In this way, environment has a greater influence on the lives of older adults than it does in younger people.

Stress and Life Events

Hans Selye (Selye, 1956, 1976) defined *stress* as the discrete physiological response that a living organism mounts as a defense to noxious external stimuli (Lazarus & Folkman, 1984). His writings on General Adaptation Syndrome (GAS), or the physiological adaptive mechanisms mounted in response to stress, explicated a mechanism by which external stimuli affect physiology. GAS explained how one's perception of life events influences physiology and spawned research on life events and health.

Psychological stress occurs when one must respond to a situation for which one does not have adequate coping skills (Cohen, 1988; Lazarus & Folkman, 1984). In the field of psychology, stress research traditionally emphasizes event analysis and ignores the context in which this stress takes place (Lazarus & Folkman, 1984; Pearlin, 1989). In contrast, theorists in sociology accept change as a normal and inevitable feature of life and aging. It is not change per se, but the effects of change within a context that creates stress. How one manages stress depends upon the availability of both personal and social resources within the social environment.

The life course perspective unifies personal biography with historical or social time, and therefore places stress in context (Bengtsen & Allen, 1995). In general, life events that occur out of the expected time in the lifecycle are more stressful than those that are predictable (Lazarus & Folkman, 1984; Pearlin & Skaff, 1996). Aside from specific events, some life situations are inherently more stressful than others. Living in poverty, being the member of an ethnic minority, and existing in a restricted environment are situations with high ambient stress levels (Capsi & Elder, 1986).

It is important to have a framework for considering stress in the context of social support because many theories envision social support as mediating or moderating stress.

Viewing stress within a life course framework requires consideration of the life situation or context in which one lives because this context is where social support originates.

A Sociological Theory of Stress

Whereas psychological inquiry seeks to uncover the processes within a person, such as coping or mastery, social inquiry identifies patterns shared by groups of people. A sociological perspective attempts to answer the question: Why do those with similar social characteristics and circumstances have different outcomes? Pearlin's (1989) concept of sociological stress explains how the social context interfaces with the individual to affect intra-personal factors and interpersonal interactions.

Pearlin (1989) postulates two major factors that account for the disparity in the experience of stressors. The first is the context (including socioeconomic status, ethnicity, gender, and geography), which contributes patterns of stressors that surround an individual. The second factor is values. The social milieu defines values, which the individual then uses to judge the meaning of a situation. The life course theory establishes a basic structure in which this process takes place.

Life events

Life events are episodic stressors that affect an individual, whether the event is positive or negative. Pearlin and Skaff (1996) argue that normative changes are usually not the cause of stress. For example, a child leaving the home in young adulthood to pursue marriage and raise a family is expected. Parents may anticipate grand-parenting as a delight. Consider, however, the grandparent called upon to raise grandchildren. This is a stressful circumstance, requiring a complete overhaul of the household schedule and budget. These changes interfere with the elder accomplishing his or her normal developmental tasks (Lever & Wilson, 2005).

Changes that are unscheduled, undesired, and non-normative require a different quality of adjustment than do normative changes, while chronic stressors mandate continual adaptation (Pearlin, 1989). The occurrence of a stressful event makes additional stresses more likely. Stressful events beget more stress in two ways—through creating additional stressors and by producing chronic strain (Pearlin).

Primary and secondary stressors

Stressors rarely occur singly because one event often begins a concatenation of stressors. Primary stressors result in additional stressors that are termed secondary because of the order in which they occur rather than the amount of stress they generate. For example, one woman, Ms. Black, is diagnosed with breast cancer and loses her job as a teacher because her employer feels that she may not be able to complete the entire teaching year and this would burden other employees at the school. Ms. White has the same diagnosis; her principal assures her that her job will be held for her no matter how much time she takes off work. Her colleagues rally and provide dinners for her and the family and donate their sick time to supplement hers. Ms. Black experiences a life-threatening illness, complicated by the secondary stressors of economic hardship, which results in marital strain. Ms. White deals primarily with the cancer, and less with the other stressors.

This clustering of stressors can explain, in part, the differences between those who suffer the same life event yet experience different sequelae (Pearlin, 1989). In addition, some life situations, such as being a member of an ethnic minority, are more inherently stressful than others and result in chronic strain.

Chronic strains

Chronic strains, or quotidian stressors, are enduring problems or conflicts that occur in social roles or environment and persist over time (Pearlin, 1989). Marginalized

persons, such as elders and members of minority groups, are under constant stress. High levels of stress are associated with many diseases and with psychological distress (Cohen, 1988; Selye, 1956, 1976).

Roles and role changes may cause stress. Many roles are dependent upon other roles, which a person may not choose. For example, one cannot be a wife without a husband. Widowhood is one common chronic strain in later life that forces a woman out of the role of wife. This change is accompanied by shifts in financial and social status (Stewart et al., 2001), which create more stress and can lead to chronic strain.

Pearlin (1989) identifies six types of chronic strains:

- Role overload (demands exceed capacity);
- Interpersonal conflict;
- Inter-role, such as work-family;
- Role captivity (restriction to an unwanted role, such as housewife or retiree);
- Role restructuring, as it occurs through life transitions; and
- Ambient strains, such as living in poverty or having a chronic illness.

Chronic strains link to events in three ways. The first is that events lead to chronic strain. An example is when the death of a spouse leads to financial strain, creating a stressful life situation. Conversely, strain can lead to an event, as when chronic marital discord culminates in divorce. Finally, strains and events provide meaning and context for each other (Pearlin, 1989). For instance, retirement can be a release from an oppressive job, freeing time to pursue desirable activities. But retirement is altogether different for a surgeon who experiences the loss of both status and skills that took years to develop.

Research that merely correlates events and stress does not capture the dynamics between the antecedents and consequences of strains and life events (Pearlin, 1989). In

addition, chronic strain creates an environment ripe for the proliferation of stressful events. When one event occurs, subsequent events are likely. However, people are not merely passive recipients of stress; how a person interprets an event is critical.

The Influence of Values

Values regulate the meaning and the importance of an experience (Lazarus & Folkman, 1984). Psychology assesses meaning by delving into an individual's value system and cognitive process. Sociology views values as a system that ranks relative desirability, worth or goodness (Johnson, 2000). Shared values define a culture (Johnson), yet little research focuses on the relationship between cultural values and stress. People from different cultures attribute varying meanings to loss, unfulfilled needs, the violation of self-image, and blocked aspirations. They interpret stimuli within socioeconomic class, race, ethnicity, gender, age, and disability. For example, discordant couples, or those partnerships in which each person comes from a different socioeconomic class or religious background, have ambient stress in their marriages (Pearlin, 1989). High levels of ambient stress require constant adjustment; coping and social support are frequently identified as moderators of this stress.

Coping

Coping is the action that a person takes in an attempt to lessen or avoid the impact of life problems when the effect of a stressor exceeds available resources (Lazarus & Folkman, 1984; Pearlin, 1989). Coping skills are learned within a group and are therefore are influenced by culture.

Effective coping skills are those matched to the stressor (Pearlin, 1989). The primary function of coping is to eliminate or reduce the stressor by challenging its source. Failing this, a secondary aim of coping is to manage the meaning of the situation to keep the

stress within bounds. Values determine meaning; hence, they are integral to coping (Pearlin). As people grow older, re-interpreting meaning becomes an important strategy for managing stress (Pearlin & Skaff, 1996). Older adults cope with many changes, such as physical alterations, role variation, modification of living situation, death of peers, and retirement. Social support enhances coping because it is a source of additional coping strategies (Cohen & McKay, 1984) (Pearlin).

Social Support as a Source of Coping

Research on social support often focuses on social network, which mirrors the organization of one's engagement with the larger society (Pearlin, 1989). Social network is the source of social support; the content of the network determines how much and what type of support is available. Examining perceived support as it occurs within the social network reveals the link between an individual and their degree of social integration (Berkman et al., 2000). Most research counts the number of social contacts and misses the characteristics.

Social networks are dynamic and the need for a specific type of social supports shifts with time and circumstances. Characteristics that determine whether support is welcomed or rejected are its timing, the conditions under which it is offered (Jacobson, 1986), and the person providing it (Weiss, 1974). Another critical component is reciprocity, without which one person risks feeling dependent upon another (Antonucci & Akiyama, 1987; Attias-Donfut, 2001; Jacobson, 1986). Pearlin (1989) describes well-being as a desirable consequence of social interaction or support (see Appendix 3 page 187).

Well-Being

Subjective well-being (SWB) has three primary domains: positive affect, absence of negative affect, and life satisfaction (Diener, 1984). Positive affect encompasses feelings

of belonging and happiness. In contrast, measures of loneliness and feeling blue indicate negative affect (Diener). The third domain, life satisfaction, is a broad subjective assessment of being contented with all aspects of life (Diener).

Positive affect and absence of negative affect may at first glance seem identical. Yet, studies show that although positive and negative affect cannot exist in the same person concurrently, the frequency and intensity of these emotions over time have an independent influence on well-being (Diener, 1984; Ostir, Markides, Peek, & Goodwin, 2001; Peek & Lin, 1999). So, experiencing positive feelings frequently and negative emotion rarely is a pattern that promotes well-being. It is imperative to consider well-being in context, that is, to recognize that the environment influences stress. A person who feels distressed regularly may be reacting appropriately to a dismal situation (Stewart, Ware, Sherbourne, & Wells, 1992).

Life satisfaction is the most difficult factor to measure because it is a global, subjective assessment (Diener, 1984). While affective states can be measured by testing, life satisfaction is gleaned from self report. The strongest correlate with high life satisfaction is self esteem (Diener).

A review of research studies dated 1949-1976 identified health as the major determinant of high SWB in older adults. Social factors that influence SWB include sufficient income, moderate educational level, possibly race (confounded by the differences in SES), and being married (Larson, 1978). Other aspects of subjective well-being are interpersonal relationships (Stewart et al., 1992), cohort effect, and history. For instance, Capsi and Elder (1986) documented long term effects from deprivation during the Great Depression in a cohort of young women in the US. Comparing one group from a lower SES with one from a higher group, they found that the lower class women were affected for

life by the hardship during those few years in their young adulthood. These women carried the strains of surviving through the Depression into their adulthood and most likely into their old age.

Well-being is a concept that applies throughout the lifespan. Successful aging is an associated concept that applies exclusively to older adults. An understanding of successful aging is essential to appreciating our societal expectations about old age.

Successful Aging

Rowe and Kahn (1987,1997) popularized the notion of successful aging, defining it as the absence of disease or disability, avoidance of risk factors for major disease and, active engagement with life. Baltes and Baltes (1990)defined aging successfully as selective optimization with compensation. This means that people adapt to aging by altering activities to compensate for changes in physical and mental function that accompany aging. Fries' (2000) concept of morbidity compression visualizes successful prevention of and treatment for disease, so that elders live healthy lives for a longer period of time. Ideally, one becomes disabled only shortly before death. Still other authors identify the subjective experience of aging successfully or aging well, which is a concept similar to subjective well-being (Bryant et al., 2000; Bryant et al., 2001; von Faber et al., 2001).

For this project, successful aging will refer to the objective measurements of aging well (the Rowe and Kahn criteria) and SWB will represent the subjective feeling of satisfaction with how one is aging and its accompanying affect. Social support means interpersonal resources that assist in managing life's problems. Theory shows the connection between support and well-being.

What is Social Support?

This section will consider social support within a social network by reviewing the work of prominent theorists. First, the section will cover Cobb's (1976) initial description of support types through Finfgeld-Connett's (2005) latest concept analysis. Next, Kahn and Antonucci's (1980) convoy model is a heuristic of social support that can frame discussions of the social network as it changes through life. Then, Wenger's (1991) concept of network types gives us a structure for evaluating why some networks work better than others. Finally, socioemotional selectivity theory poses emotional development as the framework for how network structure changes throughout the life span.

The Structure of Social Support

Cobb (1976) defined social support as information that belongs to one or more of these categories:

- Information leading the subject to believe that he is cared for and loved,
- Information leading the subject to believe that he is esteemed and valued, and
- Information leading the subject to believe that he belongs to a network of communication and mutual obligation (p. 300).

In this work, Cobb differentiates social support from the provision of goods and services because supplying assistance may foster dependency while the provision of information promotes independence. However, later theorists, including those in nursing, include tangible or instrumental support as a type of social support (Norbeck, 1988b). Lansford, Sherman & Antonucci (1998) delineate four types of social support that emerged from the literature: instrumental, emotional, informational and appraisal. Instrumental support is the provision of goods and services, which family usually provides.

Informational support is the acquisition of knowledge that leads to an increased ability to problem-solve. Emotional support is offering caring, love, trust, and empathy and communicates honor and respect. Emotional support is significant because it is helpful in a wide variety of situations while the other forms of support are assistive only in specific situations (Weiss, 1974). Appraisal provides facts relevant to self-evaluation. Peers most often provide this type of support (Lansford, et al., 1998).

Social support benefits a person by facilitating the ability to cope with crises and adapt to change, including life transitions. Social support enables or hinders transitions by exerting both main and moderating effects on the environment (House, 1981; Lansford et al., 1998), although the mechanism by which social contacts accomplish this is not clear. Antecedents to social support include a social network and social embeddedness.

Finfgeld-Connett's (2005) meta-synthesis of 44 qualitative studies on social support came to yet another conclusion. She identified the antecedents of need, social network, and social climate as well as the outcome of improved mental health. However, Finfgeld-Connett could only recognize two types of social support—emotional and instrumental. She argues that the preferred source of social support is non-professionals. She appeals to nurses to shift their efforts from providing support to facilitating support from the client's own family and friends (Finfgeld-Connett).

Social Network

Understanding social network is the key to appreciating one's social life and capacity for well-being (Pearlin, 1989). Social network is all the people with whom a person interacts and the context in which they provide social support (Norbeck, 1988a). Social support occurs within the social network, or an interactive community of people who provide help for each other. The size of one's network does not necessarily correlate with

the amount of support. Appendix 4 (page 189) is a schematic of social support embedded within a social network. The differentiation between social network and social support is mutable. The interrupted line between the social network and social support in the diagram indicates this changeability. The amount and type of support a person provides fluctuates with time and circumstance.

Not all people in a social network are supportive and most interpersonal relationships are neither wholly positive nor negative. For example, a relationship with a mother-in-law could be mostly positive, but the expectations she places on the family around holiday time may create tension and conflict. Nevertheless, what appears negative on the surface may have positive consequences. Some researchers identify conflictual relationships as training grounds for learning coping skills (Bedford et al., 2000; Fingerman, 1995). These skills benefit a person by enabling him to build stronger and more intimate relationships.

There are people who are tangential to the social network who provide support, as the crescent labeled area three in the Figure 2 denotes. An example is a chance conversation with a stranger while riding a bus that provides guidance through a difficult life situation (Fingerman, 2004). Norbeck (1988a, b) places health care workers in this category for three reasons: the relationships are not reciprocal, support given is role-dependent and occurs within the context of heath care delivery, and the support ends when the professional relationship ceases. However, Finfgeld-Connett (2005) refutes this, claiming that only non-professionals provide social support. Most theorists agree that social support comes from a variety of sources within a person's social environment.

Wenger's (1991) typology identifies the variety of social structures in which older adults live. Wenger identified five network types for older individuals:

- The family-dependent network (a small grouping of close family members);

- The locally integrated network (a large grouping that includes family, friends and neighbors);
- The local self-contained network (a small, neighbor-based web);
- The wider-community-focused network (a large and primarily friendship-based grouping);
- The private-restricted network (consisting of minimal ties with neighbor and no kin).

Wenger's network types are highly related to morale, loneliness, and isolation. The social network type influences both the availability of social interaction and how frequently that contact occurs (telephone or in person; yearly or daily). Research on network type increases understanding of structures that promote well-being. However, a typology alone will not explain how the network structure shifts over the life span. The convoy model explains changes in network structure over the lifespan (Levitt, 2000).

The Convoy Model

Kahn and Antonucci (1980) created the convoy model based on research in life-span development, attachment, and social roles. The convoy model provides a global theoretical framework of interpersonal relationships over time; it is a dynamic description of the social network. The convoy model is a heuristic tool for analyzing how the social structure remains stable and yet is able to adapt through life transitions. The model predicts that stress increases the salience of social support because it tempers the negative consequences (Levitt, Weber, & Guacci, 1993).

Anthropologist David Plath coined the term convoy to describe social networks (Kahn & Antonucci, 1980). Each person moves through life surrounded by a group of people with whom he or she exchanges social support (Kahn & Antonucci). Convoy further

describes the social network by capturing both the protective and dynamic natures. A convoy from which social support emerges travels with a person throughout his or her life, modulating in size and character based on needs and role changes. This model of social development can potentially unify child and adult literature by recognizing that the nature of adult life, including stressors, is dependent upon personal history (Kahn & Antonucci; Levitt, 2000; Pearlin, 1989).

A graphic representation of this heuristic model (Appendix 5 page 190188) is three concentric circles surrounding the focal person. Each circle represents another level of closeness to the person. The most significant support exchanges are with members of the inner circle, who are the people with whom the focal person feels very close. This is a cadre of family and long-time friends with whom the focal person exchanges most social support. The middle circle suggests a degree of closeness that is more than the simple fulfillment of role requirements, but not quite as close to the focal person. The members of the third or outer circle are those who interact with the focal person within a very role-prescribed manner, such as co-workers.

Some parts of the social structure remain stable while others change, particularly across life transitions. Relationships on the outer circle change rather frequently; for example, when the focal person retires he will no longer have contact with many co-workers. New relationships will fill the gaps as the focal person joins a club or begins new employment.

Members of one circle may move to another, but usually relationships go to the next proximal level. Members of the inner circle are few and these relationships take time to cultivate. The loss of a member of the inner circle is difficult to replace. Those who enter the inner circle to replace a lost relationship are often a long-time member from the middle

circle. For example, if a spouse (inner circle member) dies, it is rare that a co-worker (outer circle) will move into the inner rung. More often, a long-time friend who occupies the middle circle will, over time, assume a closer relationship to the focal person.

The convoy model goes a long way to explain the structure of the network in which social support occurs, but it does not describe the characteristics of that support. This model, while mutable, does not predict the factors that determine how close relationships are or how the relationships flux with role changes. The socioemotional selectivity theory, borrowed from social psychology, investigates the relationship between cognition and the social environment, and predicts how the network evolves in concert with life transitions through later adulthood.

Socioemotional Selectivity

According to Pearlin's (1989) framework (see A sociological theory of stress, page 51; see Appendix 3, page 187), social support is the environmental mediator between a stressor and the outcome. In addition, psycho-cognitive factors, such as mastery and coping, interact with the environment. Social psychology, as a framework of inquiry, postulates a cognitive motive to social interaction-- that people are consciously creating and managing a social network through their interactions with others. The socioemotional selectivity theory (SST) explains how the function of interpersonal relationships changes over time resulting in modification of the social network structure as a person ages. This theory is a tool for explaining why social networks in 90-year-olds and 20-year-olds differ.

In older adulthood, the decline in social interactions has been interpreted as gradual withdrawal from social connections in preparation for death (Cumming & Henry, 1961). SST frames the shifts in social network that occur with aging as normative. They are proactive adjustments in network composition consistent with alterations in values that

accompanies aging. As people age, they intentionally narrow their social network to fewer but more intimate and satisfying relationships.

SST postulates two broad classes of social goals—knowledge seeking and the search for emotional gratification. The importance of these two motives varies throughout the life span. Future-oriented goals predominate when a person perceives the end of life as distant (Lang, 2001). These goals emphasize making new social connections and increasing knowledge. Expansive modes are common with younger adults.

In contrast, older adults, or those who perceive a limited life, maintain a few intimate and valued relationships. This change in priorities is related to emotional development. Emotions are salient during infancy and early childhood. Their importance lessens during later childhood and then re-emerges as primary in mid to late life. In the language of the convoy model, SST predicts a drop in peripheral social partners with aging (outer circle) accompanied by an increase in the quality of inner circle relationships with aging. This is a modification in the structure of social network that maximizes emotional ties.

This purposive selection suggests that older adults optimize social interaction so that precious time remaining yields the most satisfaction (Lang & Carstensen, 1994). Although normative with aging, researchers also observe this phenomenon as a reaction to situational changes in younger adults (Lang, 2001). Younger adults choose similarly to older adults when given a scenario that simulates an ending, like a move across the country (Fredrickson & Carstensen, 1990), the change in governmental control in Hong Kong (Carstensen et al., 1999), or immediately post the tragedy of 9/11/2001 (Fung, 2002).

Understanding that older adults choose emotional closeness does not explain what types of support different relationships provide. Social embeddedness, social climate,

social competence, and social isolation are other terms useful to this discussion regarding social network. These are all characteristics of the network that influence how the network functions. Social embeddedness refers to the quality, including the depth and the strength, of relational ties people have with significant others within their social network (Lansford et al., 1998). Social climate is the nature of the environment, including the experience of helpfulness and protection. Social climate grows out of one's network and embeddedness and results in social competence (Langford et al., 1997). Social competence includes social skills required to develop and maintain relationships (Bedford et al., 2000) as well as the physical ability to make social contact (Pinquart & Sorensen, 2000). Social isolation is the result of inadequate social competence. These descriptions of precursors and results of social support are essential for understanding the process, but the role of support is also important to appreciate. Theorists have identified types of support, the source of support, and the need for reciprocity.

The Function of Social Support

Weiss (1974) identified six types of social contact that characterize different relationships: attachment; opportunity for nurturance; a sense of reliable alliance; obtaining guidance; social integration; and reassurance of worth. Using the convoy heuristic, the inner circle of closest contacts illustrates the function of the first two types --attachment and the opportunity for nurturance. Attachment provides a sense of security or place gained by a committed relationship. Marriage is one example of a relationship providing attachment; other relationships that can provide this are mother-daughter, sibling, and close friendship. A sense of attachment is critical to feeling at home and the absence of this type of tie results in an individual feeling lonely and restless.

While many relationships provide the opportunity for nurturance, Weiss' second provision, caregiving relationships, are archetypical. They provide critical support for the recipient and a sense of being needed for the caregiver. A person with caregiving responsibilities will often cite this responsibility as a reason to maintain health or to go on living.

The convoy model's middle circle represents the third and forth qualities--a sense of reliable alliance and obtaining guidance. Kinship relationships often have these qualities, for example, a mother who supports her son through a murder trial without regard to his guilt. Dependable partnerships are critical in a time of crisis, even in the face of moral disagreement. Sources of reliable alliance are not contingent on reciprocity and are often those most useful in providing the guidance to cope with a stressor.

The outer circle of role-dependent relationships provides the fifth and sixth conditions-- social integration and the reassurance of worth. Both are features of collegial relationships that attest to one's competence. These relationships of common concern are marked by the ability to commiserate. These connections are also a base for support and understanding summoned in times of need. In addition, they may provide one specified aspect of support, such as referral for employment.

Weiss (1974) proposes that a healthy social life is manifest by the availability of all six provisions. Often a specific relationship provides a particular form of support, so a person in one role cannot substitute for the loss of a person in another role. For example, friends do not replace the loss of a spouse, nor does a spouse compensate for the lack of friends. Therefore, loneliness or negative affect can occur in the face of many support resources when one significant person is missing (Norbeck, personal communication, 2002).

Support Specificity

Jacobson (1986) defined support specificity as a person who provides a particular type of support who is a critical factor in accepting support. For example, for an older person with a new disability, a spouse is often the only person from whom the subject will accept physical assistance. Perhaps some feel awkward asking neighbors for assistance with personal needs, or it could be that some support is accepted with dignity only when the person in need knows that he would also offer similar support in exchange. Reciprocity, defined as the exchange of support, is an essential feature of most relationships (Stewart et al., 1997; Norbeck, 1988a).

Reciprocity

Providing support involves some expenditure of time, energy, and material. Few are willing or able to sustain a relationship in which they give support without receiving some type of support in return (House, 1981). This reciprocity may be an immediate exchange or may occur over the duration of a relationship. For example, women whose mothers helped them raise their children are more willing to provide caregiving for their elderly mothers when needed as compared to women whose mothers did not assist (Sheehan & Donorfio, 1999).

Reciprocity is crucial in healthy caregiving relationships between two adults, whereas in those between a child and an adult the child is expected to be dependent (Beyene et al., 2002; Cohen, 1988; Lefrancois et al., 2000; Stewart et al., 2001). Older adults with disabilities who require assistance and are not able to reciprocate report feeling dependent and having lower self-esteem than those who can give in return (Cohen & McKay, 1984).

Social Support, Stress, and Subjective Well-Being

Berkman and Syme (1979) were among the first to establish the link between social contact and health. Using data from the ACS, they found that people who had weak network ties were 2.5 times more likely to die than those with strong social ties during a 9-year follow-up period. Cohen and McKay (1984) postulated two mechanisms by which social support could buffer stress and therefore contribute to well being. The first is by intervening between the stressor and the target's interpretation of the stressful event, thus attenuating or preventing a stress response. The second is by interceding between the event and the stress response. Subsequent research into social connections and health has established the existence of many benefits for older adults, including a lower incidence of depression (Coyne & Downey, 1991) and a lower incidence of stroke (Ostir et al., 2001). However, the evidence is inconclusive that social support impacts health by buffering stress (Lazarus & Folkman, 1984; Lefrancois et al., 2000).

Social Integration and Health Continuum

The concept of sociological stress places social interaction in an environmental context. However, understanding the connection between social environment and SWB is more than identifying a social interaction that tempers the effects of a stressful event. Berkman, et al. (Berkman et al., 2000), acknowledge that coping with stress and the study of networks are parts of a larger, more complex scheme. Criticizing work on social support for using terms loosely and inconsistently, they attempt to consolidate a myriad of factors into a single model, borrowing theoretical orientations from diverse disciplines (Appendix X) (Berkman & Kawachi, 2000b).

The social integration and health continuum (SIHC) is a framework for studying how environmental factors provide the raw materials for the social network, which then

affects interpersonal mechanisms, and ultimately leads to the subjective experience of health and well-being. Berkman et al. (2000) combine Durkheim's (1966) concept of the interaction between social integration and health with Bowlby's (1969, 1973) work on human attachment to represent both the stabilizing and mutable aspects of social connections.

Durkheim's (1966) classic work identified suicide as a social rather than a personal action. An individual's connection with society is the result of tempering attachment with regulation. Attachment refers to the extent of the bond an individual has with network members while regulation is the degree to which an individual is embedded in culture, values, and norms. The interaction between these two factors determines individual behavior (Berkman & Glass, 2000).

Durkheim's seminal work on suicide stemmed from the observation that rates of suicide within a populace (e.g. geographical location or social group, such as widows) remained relatively stable even though the people who constitute these populations change over time. Using the example of suicide, religious norms are a regulating factor while family ties are a form of attachment. Durkheim noted that suicide rates in Catholic countries were lower than in Protestant, despite similar culture and family structures. This discrepancy was stable over time, that is, the effect of the culture was similar on individuals who lived in different eras. He surmised this was true because, although both religious dogmas shunned suicide, Catholicism has a more structured social organization, which exerts a more consistent cultural influence on its faithful than does the variety of Protestant doctrines.

Bowlby further developed the concept of attachment. Inspired by his clinical work as a physician caring for adolescent delinquents, Bowlby theorized that faulty mother-infant attachment resulted in the child being unable to establish healthy social bonds throughout life. The initial mother-infant bond served as the prototype of subsequent social

relationships. Longitudinal studies ultimately established that infants who formed a connection with a reliable caregiver later showed a greater social integration as adolescents and young adults (Target, 2005). This work also supported Durkheim's contention that the strength and nature of social ties tempers an individual's behavior, with the strength of intergenerational family connections exceeding marital ties (Berkman & Glass, 2000).

Berkman et al. (2000), using Durkheim and Bowlby's theories as a foundation, unite research on social support with research on the social context to tie individual health with the environment. This endeavor is an attempt to solve one of the great mysteries in the social support arena—how do the contextual and individual levels influence each other?

Social-structural conditions constitute the macro level of Berkman's model. Culture, socioeconomic factors, politics, and social change interact to provide the underpinnings for social network. This macro level has been poorly explored in research about interpersonal relationships (Berkman et al., 2000; Pearlin, 1989). The study of social structure is imperative to unraveling mysteries such as how apparently high levels of support can be associated with poor health outcomes or maladaptive behavior, such as in the spread of HIV in a homosexual community through "unsafe sex."

The mezzo level is the social network, which evolves from the social structure. The macro and mezzo levels, including network structure and characteristics, are *upstream factors*. Resources must exist upstream to be present in the micro level, or *downstream factors*.

The micro level, consisting of psychosocial mechanisms, comes from opportunities provided by the network, including social support. This is where Bowlby's attachment theory applies. He contends that there is a human need for intimate, affectionate bonds. The attachment figure (mother for an infant) creates a secure base from which the person can venture and explore. In the infant, he documented that the maternal-infant bond

actually influences blood pressure and temperature control (Berkman & Glass, 2000). The quality of the initial attachment is the prototype for all future close relationships.

Adult relationships are the result of the dynamic processes of attachment, loss, and reattachment (Berkman & Glass, 2000). The attachment figure for an adult is the spouse or life partner. A secure marriage bond provides security, a sense of safety, and builds self-esteem. The other psychosocial mechanisms at this third level include social influence, social engagement, person-to-person contact, and access to resources and material goods. The provision of tangible support works by providing a sense of belonging, leading to increased security and self-esteem.

Social support buffers the effect of stress by raising self-esteem (Berkman et al., 2000). The fourth level, and second downstream factor in Berkman et al.'s model, includes health behaviors, self-esteem, a sense of well-being, and physiological mechanisms.

Gender Differences

In the SIHC model, gender is a macro-level factor, because gender identification influences social factors that affect an individual. This section seeks to answer the question: can we assume that men and women will experience social relationships in the same way? Candib (1994) asserts that the notion of separateness or individuality as a goal of development derives from a gendered construction of development. The tradition male perspective of human development begins with Freud's contention that the infant sees himself as part of his mother. Increasing separation from the mother is a hallmark of development. Evoking the writings of Erikson (1986) and Brazelton (19XX) as exemplars of archetypal child development, Candib (1994) shows that male models of child development emphasize autonomy and independence. Rowe and Kahn's (1987, 1997)

concept of successful aging promulgates this view, carrying the paradigm from childhood and younger adulthood into old age.

Chodrow (1978) argues that girls evaluate identity in terms of sameness to others rather than by individuality. This perspective reveres connection with each other as opposed to an objective, static standard. Gilligan (1982) portrays moral development in girls as the result of tempering the needs of one individual with another. In contrast, she argues that males evaluate an action based on predetermined, external measure of right versus wrong.

Feminist theorists contend that measures of success that apply to men as the dominant gender in our society are not directly transferable to women. In addition, the elderly, as a marginalized population, probably do not adhere to the same standard of success as do younger, white males. The power gradient between the male-dominant society paradigm and older adults as a marginalized group may account for the failure of research to confirm a correlation between subjective and objective measures of successful aging. This gradient is more severe when considering women from marginalized groups. Moreover, men from other marginalized groups often do not comply with the dominant societal image of success. These groups include lower SES; lesbian, gay, and bisexual (LGB) elders; and those who identify with an ethnic minority.

Im and Meleis (2001) propose six features of a gender-sensitive theory that considers women's health: (a) has gender as a basic feature and a central agenda; (b) composed of women's own voices and experiences; (c) includes the diversity of women's experiences; (d) reflects on theorists' own androcentric and ethnocentric assumptions; (e) considers the sociopolitical context; and (f) includes empowerment guidelines for raising consciousness and to guide activism. Applying these criteria to a theory of aging, one might

add reflection on ageist assumptions to point d. Such a theory would by definition arise from qualitative work and would emerge from the study of women's words and actions.

Self-in-relation theory posits that females develop self-identity through their relationships with others (Candib, 1994). Identity shifts over time and depending upon the circumstances of one's social network. From this perspective, the focus is on how relationships evolve through the life-span. Success is a consequence of maturing connections with others.

That women define themselves in terms of relationships is a concept at odds with the predominant social paradigm of independence as a measure of maturity. Rowe and Kahn's (1987, 1997) criteria for successful aging would have little meaning if older adults base their self-concept in the context of interaction with others. A more accurate assessment would use the same criteria women use—evaluating who they are in relation to the others and in the context of caring practices.

According to Gilligan (1982), men evaluate their progress by comparing their function to an external scale while women develop and grow in the context of giving and receiving care. A measurement of successful aging that looks only at the target person is blind to relationships with others and the exchange of caring.

Life Course and Social Factors

Studies in the ACS were instrumental in developing the study of how social factors contribute to health and disease, or social epidemiology. Socioeconomic stratification, social networks, work demands, and social control are examples of phenomena studied under the rubric of social epidemiology (Berkman & Kawachi, 2000b). A developmental or life course perspective, when viewed from the perspective of social epidemiology, poses one of three hypotheses that attribute health to social influences:

childhood experiences shape adult lives, only recent experiences affect current health, and the concept of cumulative disadvantage (Berkman et al., 2000).

The first hypothesis is that events in childhood affect developmental processes through adulthood. This perspective holds that sentinel experiences that occur during childhood development affect adult relationships. An example is that conflictual sibling relationships in childhood can teach coping skills that lead to strong social skills in adulthood (Bedford et al., 2000). Another illustration is Capsi and Elder's (1986) study on the consequences of the Depression on women from two different social classes. The women from the lower social class suffered severe distress during the Depression that followed them through their adult lives whereas the women from the higher SES did not.

The second hypothesis accepts that although influential events occur in childhood, only recent events affect health in adulthood. In other words, events in childhood affect the person only while young and are resolved before adulthood. The third hypothesis is that of cumulative disadvantage, or that negative life experiences accumulate over time. This would include living in poverty, being a member of a racial or ethnic minority, or living under political oppression. In all three instances, the context rather than individual factors explain the distribution of illness.

The first and the third hypotheses support life course framework. The effect of personal history suggests that even events in childhood affect the person throughout the lifespan. An accumulation of multiple negative events over time sets the context for events during adulthood.

Summary

Later adulthood is part of the continuum of growth and change; older adults are not resigned to live in decline until they die. The nuances of the older adults' social lives are

not yet fully appreciated. The burgeoning population over age 65 affords us the opportunity to fully investigate the potential of growing older.

The theories in this paper guide an understanding of the later stages of life. The sociological theory of stress explains social support as a moderator of stress to enhance well-being within a context. The convoy model is a heuristic structure illustrating how people move through life in relationship to their social system. It is also a framework for discussing the composition of a social network, including the number of people and their closeness to the individual through life transitions. Wenger's network typology is an outline for analyzing what about the social network is helpful. However, these models do not explicate how social ties change during the life span. SST helps explain how social connections in older adulthood are different from those in younger adulthood and how they are molded proactively to match shifts in values and meaning in life as we age.

The SIHC is an attempt at a unifying theory of social support that explains how environmental context influences psychological factors. One of the tenets of this model is that for characteristics to be present to downstream levels, they must be available upstream. Elements in the macro level (ageism, culture, socio-economics, and laws) are not well studied with regard to how they influence social support. Social structural factors affect the timing of retirement, the availability of educational opportunities, and living situation. The SIHC situates the psychosocial and personal factors within the context of the environment.

Conclusion

The overarching theoretical framework of this study is social support in a social context. The environment in which the support occurs influences the type and quality of support available. One difficulty in studying social support is the vagueness of the field. There are no standardized definitions and no one single unifying theory.

A major gap in the field is in explaining how the environment affects intrapersonal processes, such as well-being. Most theories on social relationships focus on one level, most often the social network. A huge body of work describes social networks, nevertheless, there is little work done on why the network is composed as it is. What interpersonal dynamics work to harm or expedite well-being? If a network is not as strong as it should be, what changes will improve it and how can those changes be initiated?

The concept of aging well or successfully is a social construction, composed by interpersonal interactions that take place in a social context. Although this study will not look at the content of the interpersonal relationships, it will look at how the participants spoke about their relationships with others in the context of an interview about aging well. Because the ACS has data on these participants dating back to 1965, analysis of the qualitative interviews will yield information that can guide questions that may be answered using this quantitative data. This will be one more step toward unifying the macro level factors with the personal experience.

Chapter 3 Research Methods

The purpose of this study is to describe the characteristics of social relationships of older adults, with attention to the qualities that impede or promote well-being in later life. This chapter describes data collection, analysis and representation. Historically, the Alameda County Study (ACS) has been an important source of data on social support and health; however, these studies have been epidemiological. There are no qualitative descriptions of the characteristics of social connections. Epidemiological and qualitative approaches yield entirely different types of information.

An Epidemiological Approach

Epidemiology is the study of how and why health and disease are distributed within populations (Susser, 1973; Valanis, 1999). It strives to reveal how conditions such as environmental factors and lifestyle affect health (Thomas & Weber, 2001; Valanis, 1999; Yen & Kaplan, 1999a, 1999b; Yen & Syme, 1999). Based on the precept that health is not distributed randomly, epidemiology seeks to identify the patterns of health and illness in the human population. The three main factors of host, agent, and environment explicate causation (Yen & Syme, 1999). The units of analysis in epidemiology are case studies, laboratory studies, or populations (Susser, 1973).

The purposes of epidemiology are:

- To identify the etiology of deviations from health;
- To provide the data necessary to prevent or control disease through public health intervention; and
- To provide data necessary to maximize the timing and effectiveness of clinical interventions (Valanis, 1999, p. 7).

Although modern epidemiology is based on the germ theory of disease, epidemiological methods are used to identify both communicable and non-communicable diseases as well as social processes related to health (Thomas & Weber, 2001). Social epidemiology is a branch that studies social determinants and distribution of health and disease (Berkman & Kawachi, 2000a). This area of inquiry focuses on the influence of socio-environmental exposure on health. Epidemiology can tell us the incidence and patterns of factors that contribute to health and disease; however, it cannot delineate the qualities of those factors.

Qualitative Inquiry

A qualitative descriptive study is an opportunity to analyze the participant's words. This may answer questions such as does the subjective experience of aging well differ from conventional objective criteria because the objective criteria do not consider interpersonal relationships? Or perhaps it will reveal what it is about social relationships that contribute to well-being and health. Having a clearer understanding of what is important to older adults and why is essential for planning appropriate physical and mental health care.

Pyett (2003) notes that valid qualitative questions emerge from the population or community studied. This study seeks to further explicate the epidemiological information gleaned to date in the ACS. The source for the research questions in this project were a pilot for a study on successful aging that the researcher conducted for a qualitative methods research course in 2000-2001. The researcher interviewed five adults aged 80-89 years individually for 45 minutes to one-and-one-half hours as a pilot for the principal investigator of a qualitative study on successful aging. All were Caucasian and living in the community, three with a spouse, one with a daughter and son-in-law, and one lived alone. These

interviews were remarkable in that each participant acknowledged the importance of family relationships or frustration caused by a paucity of desired family contacts.

While the pilot interview questions aimed to extract the subjective experience of aging successfully, the participants volunteered information about family and other social contacts. An opportunity then presented itself to analyze interviews that were recently completed by a research assistant on 51 ACS participants. These interviews were collected as part of a sub-study of the ACS entitled "Successful Aging for People with Chronic Conditions" (funded by the AARP-Andrus Foundation, William Strawbridge, Principal Investigator and Margaret Wallhagen, Co-Principal Investigator). After the 1999 questionnaire for the ACS was returned, participants who were 65 or older were sent a supplemental survey on aging successfully (or aging well). The respondents for the Successful Aging Study were chosen from the pool of ACS participants who responded to the questionnaire and agreed to a personal interview. Having this interview data were an opportunity for the researcher to study social relationships in the context of aging well. Although personal relationships were not a focus of the Successful Aging Study, this researcher felt that the participants would attribute aging well primarily to their social contacts. In addition, extracting information on social relationships would add another dimension to the Successful Aging Study without the expense of collecting new data.

Qualitative description was the method chosen for this secondary analysis. In qualitative inquiry, the researcher is the instrument. Qualitative research does not pose a hypothesis for testing; the research question arises from the researcher's interpretation of an observation. It is therefore essential to understand the biases of the researcher. To this end, a personal reflection by the researcher follows.

Personal Reflection

Going into this project, I expected that the participants would explain their experience of successful aging in terms of their social relationships based on my clinical experience and on my experience interviewing subjects for the pilot. From my work in skilled nursing facilities, I saw many people who were living in a manner in which I would never want. I also heard people say that they would never want to live in a nursing home. Yet, when they suffered a disability requiring nursing home care, they often changed their minds. And I believed that ultimately many of these people revered the life they swore they would never tolerate.

I also saw many families suffer because they had promised a loved one that they would never put them in a nursing home. Yet, in some circumstances, such as a Alzheimer's disease (AD), I have seen these patients adjust well and sometimes enjoy life in the nursing home. Sometimes the behavioral symptoms of AD, such as agitation or insomnia, render a person nearly impossible to be managed by one caregiver at home. Sometimes family members accepted this and relinquished their guilt. Other times, family members suffered for years because they felt they condemned their loved one and reneged on a promise. I wondered if this emotional suffering was justified, or whether situations and the actors in them legitimately changed. I wondered if I was observing a developmental change in people—perhaps as a consequence of aging or as a response to illness or disability.

Studies and creative works on older adults often emphasize the losses inherent with aging. I felt that if aging is all negative, I would not have seen as many people as I did with a strong will to continue living. I wanted to uncover something that was enhanced with aging.

In the five pilot interviews, the participants spoke of their relationships with others. All pilot participants spoke of their families as very important to them. Those who did not have the desired contact with their families mourned their loss. The one married couple in the pilot attributed their longevity to their marriage. I found these perspectives intriguing.

Based on these personal experiences, one major assumption I had going into this project was that elders would talk about social relationships when they discussed successful aging. Although I remained open to the data taking different directions, I assumed they would talk about relationships and that those will be important factors in determining the quality of their aging.

I also presumed that elders would receive more support than they give, especially instrumental support. I imagined that they would refer to long years of productivity as an indication that old age is the time in their lives when they deserve to receive. I thought they would rather socialize and live with older people, with whom they have more in common, than with younger. Children leaving the home and forming their own families would leave a hole in their lives that they would spend their old age trying to fill, sometimes by making demands upon their adult children.

The fact that they brought up relationships when not specifically asked about them would be stronger evidence that relationships are important than if they were specifically asked. Because this was a secondary analysis, I had no opportunity to influence the sample selection, the interview questions, or the original methodology. Qualitative description seemed the most appropriate method because the purpose was to inspect these interviews and see what was there regarding interpersonal relationships.

Qualitative Description as a Research Method

Qualitative analysis is the appropriate method to investigate these issues. Qualitative description renders a straightforward illustration of a phenomenon (Sandelowski, 2000). As a form of naturalistic inquiry, qualitative description is less interpretive than other qualitative methods, such as grounded theory or phenomenology. Although theory did inform the research questions, there was no commitment or intention to conform to a particular theoretical perspective during analysis. It is a reporting of what is in the data; however, as subjective inquiry there is some degree of interpretation.

Thorne (1994) further qualifies the methodology as "retrospective interpretation," which is an appropriate method to investigate questions that arose after or as the result of parent study data collection (p.266). Husserl's (1913/1962) concept of comprehending content over time also supports secondary analysis because the research questions arose after the primary study was completed. In addition, the study questions are closely related to the questions in the primary study, so the data is pertinent to the current study question and will enhance other analyses done with the same data.

Qualitative content analysis is the process used to render the description. Unlike quantitative content analysis, in which the researcher composes a coding scheme in advance, qualitative content analysis is an iterative process. Codes evolve as the analysis progresses (Sandelowski, 2000). Description of the data should accurately convey events in the sequence in which they occurred, rendering a qualitative description study amenable to verification by audit; another researcher examining the same data is able to verify the researcher's analysis.

This project is a secondary analysis of qualitative interviews conducted as part of a follow-up investigation to the 1999 wave of the ACS. The participants for this study were

respondents from a large, longitudinal research project entitled Health and Ways of Living and often referred to as The ACS. The ACS started in 1965 with random household selection yielding 6,928 participants. Follow-up surveys were conducted in 1974, 1983, 1994, 1995 and 1999. The longevity of this cohort study provides a rare opportunity to study aging. There are currently approximately 2,500 subjects remaining, who range in age from 50-100. To expand our understanding of what it means to age well, participants in the 1999 follow-up aged 65 and older answered a supplemental survey on successful aging. Nine hundred nine participants responded, representing an 89% response rate of those in the targeted age group. Individuals completing this survey indicated if they would be willing to be interviewed; those who answered in the affirmative entered a selection pool. As a supplement to the 1999 aging questionnaire, 51 of these participants were interviewed by a research assistant in 1999-2000 regarding their subjective experience of aging and successful aging (or aging well) (See Appendix 2 page 184).

Sample Criteria and Characteristics

Of the group of respondents over the age of 65 who agreed to an interview, 51 participants were chosen for the parent qualitative study. This selection was purposive and based on the following criteria: (a) all identified members of ethnic minorities; (b) equal numbers of men and women; (c) representing a broad range of ages (ages 66-93); and (d) still living in the greater San Francisco Bay Area. The analysis for this project was limited to 49 of these 50 previously collected interviews and to descriptive statistical data collected in the previous waves of the ACS. The researcher eliminated one interview because a husband and wife were interviewed as a pair. Since the unit of analysis for this study was the individual, a dyadic interview would yield data that differed qualitatively from all of the other interviews.

The fact that two subjects were interviewed together accounts for the apparently discrepant numbers of 51 participants, 50 interviews, and 49 analyzed (N=49).

Although the interest of this investigation is interpersonal relationships, the researcher did not observe those directly. The analysis was based on what the participants say about their relationships with others.

Sample Demographics

While there were not adequate numbers to make comparisons between ethnic groups, there are nearly equal numbers of male (n=21; 43%) and female (n=28; 57%) participants (see Table 1, page 94). The ethnic composition is White 31 (63%), African American 11 (22%), Asian 3 (6%), Hispanic 3 (6%), and Native American 1 (2%; percentages rounded). This distribution is similar to that of the parent ACS. While these demographics are not representative of Alameda County today, they do reflect the ethnic mixture in 1965 when the ACS began.

The age range of the participants is 66-93 (years), mean 75.65 (standard deviation [SD] ± 6.6), mode 72. Average age for females was 75.43 (SD±6.1) and for males 75.95 (SD±7.3). Since 26 of the participants were in their 70s, this study primarily represents those in their eighth decade. Only three participants were in their 90s, 11 in their 80s, and 9 in their 60s.

Five participants did not have children. Of these, two were women and three were men. One of the men identifies himself as gay and was never married. There were no questions on the survey that would enable the researcher to determine whether they were childless by choice or by circumstance.

The ACS uses educational level as a surrogate for SES. One reason why this is considered a valid surrogate measure for older adults is that after retirement, income alone

does not sufficiently reflect resources (Strawbridge, 2005, personal communication). In this sample, the educational level (years) ranged 3-17, mean 12.49 (SD±3.5), median 12.00, mode 12 (n=18). There was no statistically significant difference between sex and educational level (Pearson Chi Square 10.23, df=11, p=0.51); or between sex and age (Pearson Chi Square 21.642; df=22, p=.481).

Successful Aging Interviews

Gender and Ethnic Identification of Participants

Table 1

	Total	**African American**	**Latino Latina**	**Native American**	**Asian**	**European American**
Male	21	4	1	1	2	13
Female	28	7	2	0	1	18
Total	49	11	3	1	3	31

Human Subjects Review

As secondary analysis, no additional data were collected. Nevertheless, the project required the usual ethical consideration and consequently underwent extensive institutional review. The ACS complies with the U.S. Department of Health and Human Services Regulations for the Protection of Human subjects. Funding for the 1999 data collection on aging was from the National Institute on Aging. Initially, two human subjects review committees approved the study protocol: the Committee for the Protection of Human Subjects, California Health and Human Services Agency and the Institutional

Review Board of the Public Health Institute. Each participant signed a consent form prior to the interview. In addition, the Committee on Human Research at the University of California, San Francisco reviewed and approved the secondary analysis (Approval number H-6362-222321-03).

Confidentiality

The only data available to the researcher were the interviews and aggregate statistical data collected in the ACS. The Project Director for the ACS instructed the author on confidentiality before granting access to the interviews. Each interviewee has a unique identifier (ID) supplied by the ACS. The files that relate the ID to the respondent are available to project center staff only. The identifying information and the interview consent forms are kept in separate secured files; all are stored in a locked area with limited right to use. This research did not require access to that secured area. There were no personal health information or personal identifiers attached to the interviews, so the project met Health Insurance Privacy and Accountability Act (HIPAA) confidentiality requirements.

For reporting purposes, pseudonyms were assigned to each participant and any potential identifiers (such as the names of cities) were omitted or disguised. Demographic data, including gender, race, and age was included and tied to the pseudonym only.

Data Collection

A sole research assistant (RA) collected the data in 1999 and 2000, using a semi-structured interview format (see Appendix 2, page 184). Because this was secondary analysis, data were limited to the questions posed by the RA in the 1999 Successful Aging Survey and the answers obtained at that time along with the interviewer's field notes. The qualitative interviews were on successful aging, not social relationships, as is the focus of this project. This is a limitation of the study; however, the premise was that if social

relationships were an important factor in promoting successful aging, the respondents would talk about these ties even when not directly questioned.

The interview questions were based on the questions the participants answered in the successful aging questionnaire distributed in 1999. Beginning with an open-ended question, the participants were asked to clarify their answers to questions on the pen and paper survey. The first question was, "When you wrote about what you thought was the best part about getting older you mentioned ______________. Can you tell me more about this? How did you come to this answer?" Depending upon how the participant responded, the interviewer then asked probing questions, such as, "Are there other "bests" you could add?" or "Some people have said that one good thing about getting older is being released from some of the constraint and judgments that they experienced when they were younger. How do you feel about this?"

The remainder of the interview consisted of questions regarding the worse parts of aging, what a person who is successfully aging look like or act like, how does chronic disease affect aging, what is the effect of sense of control, and what the participant would ask were he or she conducting the interviews. Each interview was unique because the interviewer followed a line of questioning that further clarified each respondent's answers to previous questions.

One reason the researcher selected secondary analysis of these particular interviews is because of the wealth of statistical data available for possible validation or triangulation. While use of the quantitative data is not anticipated for this project, there is potential to use this in the future. Possibilities include comparing the content of the qualitative interviews to a social support scale, a depression scale, functional assessment, or

response to questions on successful aging. All these data are available in the quantitative data set.

Data Analysis

Although the participants were not specifically questioned about their interpersonal relationships in these interviews, respondents spoke about the people in their lives they considered important while responding to questions on successful aging or aging well. These interviews were not previously analyzed with regard to what they say about how friends, neighbors, and kin contribute positively or negatively to subjective well-being.

After verbatim transcription, the interviews were maintained in print and in electronic format (Microsoft Word and rich text format). The researcher read each interview and created a "map" of the content. They were then imported into Nvivo 2.0 and coding proceeded. The transcriptions were coded for references to interpersonal relationships and their effect on the subjective experience of successful aging. In keeping with the iterative qualitative descriptive process, the coding was open to constant reflection and was modified when it no longer seemed to reflect the data (Sandelowski, 2000).

The author's original plan was to keep four graphs—positive support given, positive (helpful) support received, negative (not helpful) support given, negative support received. Contrary to the author's expectations, the participants' discussion of social relationships did not fall into distinct positive and negative categories. In fact, these older adults barely mentioned what others did for them. Most of the discussion revolved around the meaning of their relationships or what the older adults did for others. These findings required a shift in assumptions about older adults from being recipients of care to being active participants in their relationships.

After coding 15 interviews for the persons with whom the participants had relationships, the researcher found that these codes did not explicate the participants interpersonal relationships. While the researcher felt that the participants would identify how their family and friends helped them age well, the process of comparison came to the forefront. The codes were then arranged into one cluster (node) of social relationships and another of social comparison. All 49 interviews were then coded with the new categories.

After completing the coding, the author identified themes to illustrate the similarities between the interviews and then selected interview excerpts to illustrate the themes. One interview that did not reflect the usual themes is presented as contrary case.

The second phase of the analysis deals with the gender differences in the relationships discussed. Using the codes from the first phase of the study, the interviews for female and male participants were separated and compared for similarities and differences.

Representation

Qualitative description is an interpretative process in which the researcher reports a subjective interpretation of a phenomenon observed in a naturalistic context (Sidani & Sechrest, 1996). Although qualitative description is less interpretive than other methods, the postmodern perspective of multiple realities acknowledges that a narrative may have one meaning to the respondent and quite another to the researcher (Pyett, 2003). When representing the data, the researcher makes some associations of which the participants are not aware. In this project, descriptive prose and quotations from the participant interviews illustrate themes identified by the researcher. The interpretation of the data reflects the perspective of the researcher.

Validity

Many researchers apply standards for validating quantitative research to qualitative studies. While it is true that quantitative methods are objective and qualitative methods are subjective, researchers from both traditions are concerned about accuracy, relevance, reliability of measurement, and rigor. However, unlike a quantitative study that tests a hypothesis, this qualitative research project does not aim to measure or make generalizations. The purpose is to understand, represent, and explain. Good qualitative research should stimulate discussion rather than provide a definitive answer (Flyvbjerg, 2001).

In reference to the appropriate criteria for evaluating qualitative research, Pyett (2003) poses the question, "How can we have confidence that our account is an accurate representation?" (p. 1170) Rigor is the assurance of adequate methods to assure relevance, validity, reliability of measurement, and accuracy of the research project. Description of the data should accurately convey events in the sequence in which they occurred, rendering a qualitative descriptive study amenable to verification by audit. Another researcher examining the same data should be able to identify the passages that the researcher reports and follow how the researcher reached her conclusions.

To establish validity, the theoretical biases are clearly explicated so that the reader can consider the context in which the researcher analyzed data. To establish accuracy and reliability of measurement, each code was defined within N-Vivo. This identification will allow others to peruse and verify the coding procedure. In addition, the researcher maintained a record of memos and field notes.

Positivistic scientific method requires adequate numbers of subjects to prove or disprove a theory or hypothesis. While empirical methods are imperative to understanding

many phenomena, it cannot explain exceptions. The purpose of this qualitative study was to represent the perspective of the participants as individuals while identifying themes that explicated commonalities. Because the sample was not randomly selected and the methodology did not identify numbers sharing the same perspective, this study is not generalizable to a population. In addition, the participants volunteered to be interviewed. This study renders a portrayal of the participants, who may or may not be representative of the older adult population as a whole. Every attempt was made to report findings that are true to the data.

Yet another element of rigor is validation of the results as being true to life. The researcher's advisor and a peer group of researchers familiar with qualitative research and gerontology discussed the findings. These colleagues agreed that the results were verifiable in their own experience with older adults. In addition, current literature supported the findings.

What Will this Study Contribute?

The goal of this research project was to identify how older adults in this sample discuss their social relationships and whether men verbalize their relationships differently from women. Any description of the nature of social interactions or social connections makes a unique contribution to our understanding of the ACS participants, for whom 40 years of quantitative data is available. While answers to the qualitative study are illuminating in themselves, the author intends to also identify areas for future research.

Chapter 4 Results

Characteristics of Social Relationships

Most research on social relationships or social support count the number and identity of social contacts. While studies show a correlation between the number of social contacts and longevity (Bassuk et al., 2002; Berkman & Syme, 1979; Kaplan, Seeman, Cohen, Knudsen, & Guralnik, 1987; Kotler & Wingard, 1989; Roberts et al., 1990; Schoenbach et al., 1986; Seeman et al., 1987; Shye et al., 1995; Wingard, 1982; Wingard, Berkman, & Brand, 1982) and health (Berkman & Glass, 2000; Cattell, 2001; Cohen, 1988; Friedman, 1993, 1997; Hartel, Stieber, & Keil, 1988; House et al., 1988; Kaplan, 1988, 1996; Kawachi & Berkman, 2001; Levitt et al., 1985a; Liang, Krause, & Bennett, 2001; Minkler et al., 1983; Reynolds & Kaplan, 1990; Schwartz et al., 2003; Siriphant & Drury, 2005; Yen & Syme, 1999), unanswered questions regarding the nature of these contact remain. This descriptive research was designed to address these gaps.

This qualitative study was stimulated by an interest in how elders decide they are aging well in terms of interpersonal relationships. The analysis revealed that older adults measure success by a myriad of parameters, only some involving social relationships. Some participants focused more on their relationships while others spoke about interests, projects, and activities. In addition, when asked to describe the best parts of aging, participants listed elements different from those they used to explicate successful aging. Most participants, but not all, noted relationships and/or family were the best part of aging. However, they related to their families differently from when they were younger.

With regard to interpersonal relationships, major themes were freedom from family responsibilities, renegotiating relationships with children, reconnecting with spouses,

and comparison mechanisms to maintain a sense of oneself. The gender differences noted were manifest in how men and women spoke about family relationships.

While none of these findings is new, this study illuminates these themes. Freedom from the mundane maintenance chores of family life opened up time to pursue preferred activities—hobbies, career, and time to spend with loved ones in pleasurable activities. Despite rejoicing in the personal freedom, many participants identify their families as the most valued aspect of their lives. Nevertheless, as children grew into adults and had families of their own, a different parent-child alliance formed. In addition, the children leaving home meant having more time to spend with spouses; the spousal relationship also changed.

The ensuing chapter presents excerpts from the data that illustrate how these themes manifest. Quotations are attributed to participants using pseudonyms. The age of each participant is noted in parentheses after the alias. The separation of themes into categories does not imply that the styles are mutually exclusive. Most participants did not exhibit solely one category but characteristics from each. Sections of participant interviews were selected to highlight a specific point rather than to pigeonhole the participants.

Major Findings: Themes Characterizing Social Relationships

Now it is My Time: Freedom and Changes in Family Relationships

The interviews were remarkable for describing freedom in old age: having the power to control time, being released from a work schedule, and caring for your own needs without first caring for family. As Barbara (77) notes, "I like to go out and get what I want because I have sacrificed for other people and gone without and done without for other people. Now it is my time."

Children leaving the home and retirement from a job were not usually described as crises. Contrary to the paradigm of the empty nest (emotional suffering after children leave the home), these data reflect that, by and large, older adults are thankful to be free from family responsibilities and to move on to a different phase of life. It is a time to experience family life in a different way rather than ending relationships with their children. In addition, some participants felt they had more time to pursue relationships with others.

Work and Retirement

The participants in this study did not describe many losses from retirement. Even those who had an engaging career found that later life offered an opportunity to pursue other matters. Shirley (67) values not having to get up for her business

> I was self-employed for 20 some odd years and I ended up working like 90 hours a week sometimes, so it was hard and I had to be well dressed and that was a big thing so that was something I really appreciate. People ask me, oh I know you miss your business. Wrong. I don't miss it at all. I'm perfectly happy with what I'm doing now. And that's it. I can do what I want to do. That is what I like. Not working.

For women, having a career often meant having to balance taking care of a family with career. What Sally (70) says is typical of sentiments predominant in the data. She says,

> When I was younger and I was in my career, all of my hours were pretty much geared to working and of course when I had a family too. But my kids have been gone for a long time. So between taking care of the children and taking care of the house and then starting a career there was just not enough time to pursue the things that I wanted to do…And that only happens because you grow older and you retire from your job and your kids grow up and then you have more freedom.

Being free from the distraction of work enabled elders to have control over their own time and choose how to spend it according to their values. The major reason people cited for working was to support a family. Ironically, working consumed the time and energy needed to maintain family relationships. When freed from work, they had more time and energy to enjoy their families.

Most men in this sample supported a family, which was a formidable task that required constant attention. For many men, their lives were entirely regimented until retirement. Dan (77) says,

> The beauty part of getting old is that you don't have a schedule to go by all the time. You can get up, if you want to get up at six in the morning you can. If you want to sleep till noon you can and it's just like -- you know all during our lives, from the time you go to school you have to be at a certain place at a certain time. Then you get out of school and got into the service and I had to be at a certain place at a certain time. I mean that was a must. And then after the service I got a job, a good steady job, but there again I had to be somewhere at 8:00, rain or shine. I had to be there. But now that I am retired and older I don't have to do those things. If I am painting a house (I do volunteer maintenance work) if I don't finish painting or if I get tired I just relax and paint it tomorrow or the next day.

Release from family obligations opened other possibilities, such as volunteering in the community. And they now had more time to look after their own needs and interests.

Everything has a time

While many in this sample did not regret caring for their families, they felt they had performed their duties and it was time to move on to another phase of life. Robert says, "There is a time to do everything. Time not to work. Time to work. Everything has a time." Ellen (67) would perhaps categorize later adulthood as the time to focus on herself. She says,

I suppose as you are raising you family, working at a job or being committed to your children or your husband or your parents needs you, the word beholden is what I used so you really feel obligations that are there and you take care of them, which you are happy to do. But once those have been taken care of and once you feel like you have done your job, then, I don't know if I am answering this correctly, but you have less responsibility so then you can concentrate on yourself more.

When asked about the good parts of growing older Robert (72) replies that he values family, health, and his free time. While younger, men might return from work stressed and irritable; repetition of these negative moods day after day affected family relationships. Joe (69) says,

I thought on what made me feel at ease now that I've retired. It was those things. Not having the pressure of work on my shoulders constantly which kept me from talking with my family. I'd come home and be grumpy, spend more of my time thinking how I left the job and what I was going to do to rectify an existing problem than I was involved in my own family.

Joji (71) talks about retirement as an opportunity for a new life as well as a time to get to know his family. He now has experiences he never imagined when younger. And he has come to truly appreciate his family. Joji describes his new interests, saying,

I shouldn't say was, I probably am still a country bumpkin. I was born in [rural town] and spent my growing up years there, living on a farm or different farms and not having very much. Not interacting very much with the outside community hardly at all. It was strictly a Japanese community that was developed through need for the older Japanese to be together and have things to do, have social interaction.

That's where I came from and we really didn't have much and didn't have any great expectations for having any much more.

So when I was able to retire and have the fun to travel and do things that I never dreamed I could it is really, really enriched my life… And there are often times you wake up and think wow, this is a wonderful life. Probably a lot has to do with being relaxed and knowing that you don't have any real responsibilities. Looking forward to seeing your family. This is probably one of the most enjoyments I get in life, and that's to be with the family. There isn't a whole lot of interaction involved, it's being around the family and their kids are noisy and we are trying to play cards or talk or whatever. But it's just being with all of our family, our daughter-in-laws and grandchildren. One of the joys of our life.

Despite reveling in the freedom, there was an overwhelming sentiment that family was the most important thing in their lives. While at first this seems contradictory to the concept of freedom, the respondents indicate that they enjoy their children in an entirely different manner than they did earlier in life.

In addition to rediscovering the joys of the family, later adulthood could also be a time of self-discovery—a time to evaluate your life. Geraldine (72) did not have time to reflect on her life until she became seriously ill. She said,

> I had to lie in bed quietly and I did a lot of reflection and that's when I started to reflect on things. Before when you're so busy with a family and children you don't have time to reflect. You are just going all the time or you are thinking about or planning ahead, the meals or carpooling or how are you going to -- I took care of the bills. How are we going to pay bills this month? You are just not reflecting on other things in life.

She ultimately came to the conclusion that if she did not make herself happy, she would not be able to give her best to her family. She goes on to say,

> But before that it was like I was on a--up early, to bed late trying to get everything done and meeting myself coming and going and taking care of the kids and being pregnant. And then I thought that was the way women were supposed to be. Selfless and you don't think about yourself and your own being. You think about others. You think about your family, your husband. So when I started reflecting I thought well wait a minute. I don't think this is right and I don't think it's good for the family either. Not in the long run. That took a while to evolve.

So Geraldine went back to caring for her family with a renewed sense of her importance in the system. She came to the conclusion that caring for herself was essential to caring for her family.

Rather than no longer caring about their children, Geraldine's concept of putting herself first seemed to be more reflective of how parents viewed their new found freedom. Children were still very important in the participants' lives. Mildred, although glad to be retired from work and homemaking, realizes that you never stop parenting. The release is from the drudgery and the scheduling, not from the relationship with their children. She says,

> I think that now that I am older and I don't have to go to the job and my children-- I still worry about my children, I guess you never stop worrying about your children-- but you just have this peace that you don't have to get up early in the morning and go.

Although most parents have separated from the caregiving relationship with their children, they will never stop being parents. In middle age, parents are concerned with launching their children into a life of their own. Older adults need to develop a new relationship with their children, one based on more equal footing.

Parenting in Late life

As parents age, the parent-child relationship shifts from one of dependency to one between two adults. Bowlby (1969, 1973) describes relationship development as a process of attachment, separation, and reattachment. The initial attachment occurs in childhood. One way of viewing the child leaving home is as a form of separation, one that usually occurs when the parents are middle aged. As the adult child's independent life stabilizes, a new alliance between the middle-aged child and the older parent ensues. This reattachment creates a new relationship, one where the parents see their children as adults (Ryff, 1996).

These participants showed not only that they enjoyed freedom, but also that they had freed their children. Then, most participants took on one or more of four roles in the reattachment phase: adults but still kids, near peer, historian and kin-keeper, and role model. Many participants describe a process of *renegotiating* their roles relative their children. Most of the participants describe building relationships with their children based on activities other than caregiving.

This section will illustrate how participants described changing their parenting roles in two parts. First, while the separation phase occurred during the parent's middle age, the reattachment phase that takes place in late life consists of a final *letting go* of the earlier relationship in deference to a mutually independent adult-to-adult bond. Some older adults are still involved with providing instrumental support for their children, yet they must do this in a way that is appropriate between adults. Second, the roles parents recreate (adults but still kids, near peer, historian and kin keeper, and role model) are exemplified.

Letting Go

The separation phase is one of transition rather than relinquishment. It is accompanied by a desire to maintain contact, but on a different level. By late life, it seems that this phase is established and is manifest by accepting the child as an adult. Nancy (73) says,

> My children are a pleasure. They are very kind to us and we feel like we are equals with our children. When they are little you are the responsible adult but when they are grown up you are on an equal basis. We just interact as equals.

Another quality participants described is acceptance of their children's life choices, even when they may not agree. Margery's (72) is still fully involved with her children; however she separates her identity from theirs. While no longer caring for them on a daily basis, she remains close. She talks of spending time with her children and grandchildren and of having fun. She says,

> And then, of course, my own children and, of course, they have their own lives to lead and I'm not ever trying to tell them what to do in their lives. I might make a suggestion now and then, but they're on their own. They have to make their own

decisions. I do feel it's important for me to have my own circle of friends and my own life and not just live through my children.

So, Margery has a new way of relating to her children. The process of letting go also means that the parent is independent from the child. This desire for independence is mutual—the elder does not want to be dependent upon the child. Louise (72) is a widow who mourns the loss of her husband of 55 years and her older son from cancer, yet has no thought of clinging to her remaining son. She maintains an adult-to-adult relationship and has no thought of having him care for her. She says,

> He has a townhouse in [city] and he lives alone. Just as happy as you can be, just like I am. When my husband passed away, they said "I guess you and [son] will live together." I said oh no we would kill each other because we are both set in our ways. We are both independent about what do. But we keep in touch. He comes by every weekend and checks on me. He calls and sometimes he calls me from work.

This notion of independence from the adult child is also expressed as a concern about being dependent upon their children in the future, as Sarah (80) illustrates when she says,

> I always felt I didn't want to be a burden on my children or anyone else. When I get so I can't do things for myself or handle myself like I think I should I'd rather be gone. I would. I'd rather be gone. Where I wouldn't have that responsibility on others.

And it is a joyful release. Like Sarah, Mary (76) expresses no sadness about being separate from her child. Rather, she is able to pursue other interests. She expresses it like this:

> This is a real luxury [the interview]. Having somebody listen to what I'm saying. Often times when I'm with my children, that's two girls and their two men, half way through I think, 'I'm not really interested in anything they are saying,' and I'm sure they would not be interested in what I would like to offer so I say good night and go home.

Randall (80) notes that he and his wife have little control over their children and less over their grandchildren, and that is not necessarily negative. Releasing control is also discharging primary responsibility. He says,

> We certainly don't have to bring up children any more however, so that's a big elimination or something you don't need to be worried about and there isn't a durn thing we can do about our grandchildren.

So, the participants in this section indicate that they accept that they are no longer responsible for their children and that they prefer the freedom is mutual—that their children are not accountable for them. However, the children remain central in the elders' lives. Nancy accepts her children as equals and Margery recognizes that she cannot live her life through her children. Louise maintains her independence by living alone while enjoying frequent visits with her son. Having the ability to come and go means that Mary can have a relationship with her daughters on her own terms. Randall appreciates no longer having to be responsible for his children and recognizes that they, no he, are responsible for the grandchildren.

The participants quoted in this section demonstrate *letting go*, or releasing the parent-child relationship in favor of one that is between adults. However, there are participants who described continuing to provide instrumental support for their children. Because the child is now an adult, the care takes place in a different manner.

Re-creating Relationships with Children

Parenting in middle age is marked by worry and concern that the children would successfully initiate their own careers and family. In Bowlby's terms, they are undergoing separation and on their way to re-attachment, which prompts a re-creation of a parenting role in late life. While parenting styles were not the focus of the interviews, some respondents' indicate how they develop new relationships. For some parents, remaining involved as a caregiver was perceived as necessary—either for the parent or for the child, yet they gave support in a different manner. However, for most participants, this new relationship was not based on caregiving. Most older adults in this sample enjoy their children as adults, becoming family kin keepers and historians, or being role models for children and grandchildren. These are not distinct roles, but mutable functions with areas of overlap. These four styles are illustrated in this section.

Adults but Still Kids

Not all participants cherished freedom. To some, having obligations to family was essential. Some participants continued caring for their children on a daily basis. At times this was by choice, expressing a fear of being alone. Others felt continued caregiving was a necessity. They were aiding a child who was not doing well or a grandchild who needed care. Yet, the fact that they felt an obligation did not mean they were not happy with their situation.

Some participants felt abandoned when their children left. Mildred (71), an African-American woman, was sad to have her youngest child leave home. She says,

> When my youngest son left home, and he bought a house when he was 22 years old, 'cause he was working at [city] and I was afraid for him to drive from [city] and on top of that he had this sleeping sickness, narcolepsy. I was so afraid he would fall

> asleep and have an accident. So when he left home I had the empty nest syndrome...It was very depressing. You have this big, warm house with all these smiling children and all of the sudden you have an empty house. He was the last one to go. And I heard he was depressed too.

Although saddened by her son's move, she ultimately adapted and was able to develop a new relationship with him as an adult. The only one of her children that she sees regularly, she says, "He comes over nearly every day and I cook dinner for him."

Another situation in which parents do not have freedom is when they choose to care for children who are having difficulties in their lives. Juan took one daughter back in because she was divorcing her husband and had to care for two children on her own. He did not speak of this as a hardship, but as an expectation. When asked to confirm that he felt health was the most important aspect of later life, he says,

> That's number one. And number two is estrangement from your family. If you're estranged from your family. But fortunately I am not, I have very lovely children...I have two granddaughters and I am very attached to them, I see them quite often... If you don't have that, I think it's a tragedy.

Having the children in his home impacted his freedom; however, it seems that his priority is to have good relationships with his children and that providing instrumental support is what he needs to do. When his other daughter was going through a divorce, he welcomed her back into his home along with her two young daughters. When asked if he felt released from constraints of external judgments as he got older, he replies,

> No, in my case it wasn't. Because the little girls I had to raise here in this house for five years. It was an obligation, a heavy obligation, however, I felt what was needed the most, a good home environment and I took her to the right school. I have a

sister that would pay for school and I would drive her to school and pick her up until she left. My daughter, she's a nurse in [hospital], and until she left and got herself straightened out, of course when you get divorced, there were extra bills that they had, it took them a couple of years to recover.

I have four bedrooms and she stayed with me. . . so I felt good about that because I gave them a chance. And I'd take 'em to school and I'd take them here and there. And they were very, very happy, as the results show now. So then she decided the kids should have a home of their own. I helped with the down payment. And the children are established in the schools.

He helped them financially and emotionally. Again, reflecting his family values, Juan helped his grandchildren maintain ties with their father. About this he says,

Oh for the first 5 years, I felt, they were torn away from their father. They loved him and he loved them... So I felt that was important regardless of what the result would be. I helped them and I stay [sic] and have a good relationship with their father because, after all, you have to interact with him until the children are 19, 20.

Providing help was a conscious decision rather than a default position. He indicated that he made a difficult situation satisfactory by weighing the effect of providing the assistance with how he would feel if he did not offer it. When asked if providing this support was difficult, he talked some about the inconvenience it was to have the grandchildren. However, he did not agree that it was a burden. He said,

You know, it isn't, to a degree. It takes a lot of my time and it constrains me in a lot of ways. But I have to look at it and say well, OK. They're small and you know the help you can give and so you do it. But other than that, it slowed me down a little bit as far as, a few times I had to go to the functions of the Shriners or something

like that. So I could not go because of that. But I don't think it's something that is that difficult, because you have to weigh the consequences.

He cared for a second adult daughter because she had problems with alcohol and became unable to care for herself. He was happy to support her through her quest for sobriety. This story reflects his commitment to his daughters. He says,

> She was divorced . . because she lost her job and was going to be out in the street and much as I, much as it caused a lot of discomfort to the family, I could not leave her on the street. So she moved in with me. She got a job, and I tried to help her out. She was an alcoholic. She is an alcoholic, but she's been in recovery for about six weeks now. So I figured, well, I'll help her, and I explained to her, you have to help yourself. So she is doing that so far, she works, she drives a Yellow Cab. So I think she is going to be OK. You have to learn to forgive. I know friends of mine, especially at the lodge, they get angry with their kids and stop talking to them, it's a tragedy. Because you have to have the intelligence to realize that hey, life's too short. I don't want to do that. No matter what my children did to me. I would forgive them to a degree.

Judging from his definition of successful aging, Juan would not have felt good about himself had he not supporting his daughters through their difficult times. Rather than rejoicing in the freedom like other participants did, he values obligations to others as an element of personal satisfaction. Juan notes,

> To me successful aging would be to have a lot of commitments to other people, family all established and financially stable and be in good health. If you don't have those three, if one of them is missing, to me that's not successful.

Constance (78) might agree with him. She rose to the occasion when her daughter died and left dependent children. She does not complain about caring for them, she simply does it. Here she describes some ways she became involved with the grandchildren. She remarks,

> My daughter died and left five kids. Her youngest one when she died was four and the oldest one was 10, so I raised them five kids. Then I started kind of to slowing down. Cause I would--I had to tend to the kids. Then some of them was in like Head Start. I'd go around to Head Start and sit with them until they got them. Then I'd start to working for the school, so I could be with the kids so I worked for the school about 15 1/2 years. That's where I retired from the school... To be with my grandchildren. So then after they got grown, then my oldest granddaughter, she had a baby. Then I raised her. Then my next one, she had one, but she raised her own. Then my other granddaughter, she had a baby, so I babysitted her and that little boy there belongs to her. Then my great granddaughter, she had that little girl, so I'm babysitting her.

Constance never leaves the role of caregiver, she just periodically moves down one generation. For her, it seems that caregiving is integral to her self concept.

These participants are clearly still parenting. Mildred and her son have worked out a way to live independently while maintaining frequent contact. Juan experienced boomerang kid phenomena when both daughters returned to the home during life crises. Constance just keeps caring for dependent children because this need persists in her family.

They do not mourn the loss of their freedom. Rather, they seem comfortable in their roles and, as Juan indicates, see continued caregiving as essential to their well-being. Other participants take on different roles with respect to their children. The next role that the participants described is one where they accept each other as mutually independent adults.

Near Peers

One challenge for older adults is to develop a satisfying adult-adult relationship with their children, yet the relationship is not one of peers. Even relationships that appear to be egalitarian consist of two people of different generations. The developmental tasks of a middle age child are not those of the elder parent; in addition, historical and personal histories differ between the cohorts.

Perhaps the most striking example of an elder assuming a near-peer role with her child is Amparo (72). She is especially close to one daughter because they are both widows. They live next door to each other, providing companionship and often sharing social activities. Although in some ways they are now peers, their relationship is not that of siblings or friends. She and her daughter fulfill camaraderie needs for each other; however, they have a personal history of parent-child. The usual sequence of events means that Amparo will die long before her daughter does. Amparo worries how her death will affect her daughter. She says,

> I guess because you feel that you are getting older and you are going to die and leave your family behind and you worry what is going to happen to your kids. Especially I have a daughter that lives next door to me. We have been very close because she lost her husband also. A year before I lost my husband. The two of us have been very close. And then I keep on thinking. I have been helping her so much. What is

> going to happen to her. I am afraid that because I am already in age I am going to die soon. And what is going to happen to her. And if my other kids going to look after her? That is the only thing I keep on thinking.

One notable aspect of this excerpt is that Amparo states, "I have been helping her so much." She seems to feel that she provides a unique and essential functions in her daughter's life that cannot be replaced by others.

Another common topic in near peer relationships is that of enjoying activities with the children and grandchildren. Margery (72) involves them in her life by allowing them to use her home. In the process, she meets their friends and her own world expands. She says,

> I enjoy getting the family together here...I always want them to have a good time at Grandma's house. The other night they phoned and said they wanted to watch the boxing match in Las Vegas and I had cable TV and they were going to get the little filter they can put on so they can get the fight over the television. And I said that was fine. I would be happy for them to come over. So I ended up with about six different men here watching the fight. It was great! I like them to come and use the house.

Margery included her grandchildren and their comrades in her social life and enjoyed them as she would her peers. One of the benefits of intergenerational relationships is that younger people can be a rich source of social support. Unlike an elder's age peers, they are unlikely to die and are less inclined to become disabled before you do.

Another benefit of intergenerational family relationships is that they give the elder a way to give something to children and grandchildren that they do not have—family

history. Sharing family stories—current and past—is a way to hold families together, to disseminate wisdom from experience, and to share memories.

Kin Keeper and Historian

Margery (72) has become kin keeper, or the person who facilitates the connections between family members. She describes her role as essential to the extended family, functioning to hold the family together and to share stories of current events. She lives apart from the hectic world of her children, who are balancing career and family. She says,

> I try to be the one that keeps them all together. Yeah. Cause otherwise I'll say -- like my daughter is a dentist and she is very, very busy but she does take good care of my teeth. And I'll say have you talked to your brother lately. Well she is so busy. No I haven't had a chance to see what they are doing. So then I can tell her. So I kind of phone all of them and tell each one what everybody else is doing. That keeps them all going.

Keeping the family together and recording the family history adds richness to family life. It is a position in which an older adult can make a unique contribution to their descendents. Some older adults find value as protectors of the family history and may even constitute a reason for living. Marta (80) says,

> I have two more things that I want to do. C[daughter] the one that has the children in the foster home, she asked me if I would write down, like in a ledger or something, kind of a family history...My [other] daughter ...wants me to write the things she'd be interested in and the silly things that have happened to me over the years.

Marta was delighted to get this request and was looking forward to getting started on her task. Children and grandchildren connect the elder with the future because they will live longer than the older adult. They can then teach their children, who then will carry the information to subsequent generations. The participants frequently express satisfaction that their children carry on for them.

Mentor and Role Model

Older adults can offer the gift of wisdom as an elder with knowledge to share. Dan (77) recounts why he considers it essential to share lessons from life experience with the next generation. He says,

> Well as we get older we can watch our children grow older too. In some cases, as you are getting older you have more experience and you can teach the younger generation, like our two sons. A lot of the skills I had I can pass on to them because over the years you get a lot of knowledge and lot of operations of home improvements that you don't get while you are young yet. Maybe I didn't put that over right, but its nice to know I can help somebody, even though I am getting older and share my experiences, not just war stories.

Sarah (80) sees her knowledge gained through a long life as the most valuable thing she can give her family. She notes that the desire to share knowledge is new to her and not part of her relationship with her children earlier in life. She says,

> I feel that they are part of me...Maybe it is something in me that maybe I will be able to share with someone else that I wouldn't have even thought about when I were younger. It does. It make me feel good to know I am able to share some things with someone that maybe when I were younger I didn't even think about it. But now I think about things I can share, maybe to a younger person, that I can share something that might help them as they grow older.

One might say that wisdom comes from experience and takes time to evolve, so it is not accessible to younger people. It is a precious commodity that many want to share; it is something only older adults can offer. While there is much discussion of wisdom in relation to older adults in the popular literature, the definition of wisdom is elusive. Is it simply the accumulation of knowledge? Grace (71) sees wisdom as a melding of experience with emotion. She says,

> I feel that the knowledge I have is also involved in my feelings and come from the heart. I think that is what makes wisdom. I think that, that I'm grateful for this. I've had so many varied experiences in my life that, that with what little knowledge I have...that's a plus.

Because older adults have amassed a variety of experiences, some feel a responsibility to pass that on what they have learned. A mentor whose aim is to set an example for younger people is a role model. Some participants displayed this as their predominant parenting style. This style is born from a strong belief in a value system that one feels responsible to pass on.

Being a role model can be demanding because one must always be attentive to how he or she appears to others. Robert values relationships with others and describes

interpersonal ties as a source of pleasure. He sees being a role model as a responsibility of older persons. He notes,

> I feel that you have to live up to those promises that you have made in the past. You have to walk right because people are watching you. You might think not, but somebody got their eyes on you all the time. I mean that's the way I feel. I think everybody in my house think that. Because if they don't do right, either my wife or myself will know about it. We keep the grandkids. We got to walk right too. We got to do what's right to keep the life we are living.

Robert has lived his life according to standards he identifies as living well. He values his memories of those who went before him and he takes pride in carrying on in the memories of his children and grandchildren. His legacy is the memory of a life well-lived. Reflecting on the work of Becker, et al. (2003) on social exchange, one can imagine that Robert does not feel that a release from social constraints comes with aging because his example of a life well-lived is a precious gift he can pass on to his descendants. Several times in the interview he says that he is not rich, so all he has to give is himself. He goes on to say,

> What I would rather be remembered by is, when I pass on to the next section, is to be remembered that I was a good person. I've never been in jail. I've never been no where near the jail. A lot of people just can't stay out of it.

For Robert defined his role as parent and grandparent to teach by example. He was proud of how he lived and passing his values on seemed to make him happy, and parenting may increase his SWB. Deiner's (1984) definition of SWB includes positive emotions, absence of negative emotions, and life satisfaction. There were some references in the material to these components when the participants spoke of their children.

Parenting and Well-being

Of the 49 participants in this study, all but six are parents. There were many references to children, a number of those directly relating their children to their SWB. Many participants spoke of how their children made them feel happy and some even related successful aging to successful parenting. Eileen's (70) comments are archetypical. She says,

You know, I look at my kids. They are very self-confident, they have high self-esteem and they feel good. I mean they are really good and that of course as a parent I feel very happy about, I'm successful.

Geraldine (72) talks about deciding to be happy and looking at the positive when she intones, "Life is OK. Look at the positive. Look at all the things you have. Look at your children. They are all productive citizens."

While being productive is important to most, simply liking your children means that you approve of how they represent you. Ernie (68) says, "I like my family and I like my grandkids. You see your grandkids and your kids as an extension of your life and they're doing so well." Ernie goes on to say,

> Yes, my son is very active in Boy Scouts. He got some awards. I find myself, almost tears in my eyes bubbling up so happy that he is doing well. I figure that's part of me...And the kids are carrying on in a very good way that I like. Makes me happy.

Rodney (76) identifies raising a family as success. He acknowledges that the relationships with children are different, but they are still satisfying. In fact, he correlates children being successful as contributing to his own feeling of success. When asked what successful aging is, he replies,

> I think anybody that can raise their family and maybe when they retire and get older still keep relationships going within their family I think they would be successful. I mean it is nice to look back and see children being successful.

Sarah (80) describes her children as being nice to her. She describes the emotional support she gets from her children, saying,

> But I have four children and they are very nice to me. They help me a lot. I thank God for those because I think some of the time what would I do without having those children, but they are great. I have six grandkids...So that make me feel good because they come around me all the time and that helps me...Yes... That's the reason I say that without them, even with me growing older I think about without my children or my grandkids what would I do? How would I be without them? So that's a big part of my life. That really helps me.

Ernie (68) has noticed that his kids are protective of him. This passage is notable in that he mentions qualities of the relationships that please him. In the context of discussing how happy he is with family life, he says,

> I notice my kids, they seem to try to help me more than they used to because they figure if I'm old I'm going to fall down or something. When my kids are around me, both my son and daughter, they are kind of protective.

Ernie interpreted his children's attempts to protect him as an expression of care. Sarah's family promoted SWB by being there and showing concern for her. Both Ernie and Sarah imply that having such considerate children was rewarding because it indicated that they were good parents.

Reuniting With Partner

In the nuclear family typical of this generation, the normative route in adulthood was high school, military service, work, marriage, family, and retirement. The typical married couple was alone together at the beginning of their marriage and again after the children left home and they retired from their jobs. The interviews reflected a rejuvenation of the marriage in later adulthood. The couple who started out to forge a life together were often busy with opposing tasks while children were in the home and did not have much time for each other. As elders, they are reuniting with their partners.

Marriage is normative in the US because only about 5% of older adults have never been married (United States Census Bureau, 2004-2005). In this sample, only one participant never married. Freedom from daily chores freed time and energy for spouses to focus on getting to know each other, or becoming reacquainted. Ellen (67) notes that once your children leave home, you can say to yourself, "I've done my job; I've done it now I can think about myself or think about if you are a husband and wife you can think about each other. Or think about what you really like doing." Dan (77) identifies having time to enjoy his relationships as one of the best parts of aging. He says, "My wife and myself we like to go places like an ocean cruise or travel with Navy veteran friends that we get together with. And now that we are older, we can do those things."

Perhaps because he believed the myth of the empty nest, Joe (69) expresses surprise that he is enjoying the relationship with his wife in an entirely new context. He says,

> We thought that was going to be traumatic because we no longer had the kids around us. It turned out to be beneficial. She and I then learned how to be with one another, enjoy one another, since I was retired and not working there are other problems that kept me from enjoying her. Now I enjoy her. And enjoy life, because

when I was working I was stressed by the job, constantly worried about it, then when I came home and had two days of free time I didn't spend those two days relaxing and enjoying myself. I spent those two days of free time picking up dog droppings, mowing the lawn, painting the house and doing things that kept things up.

Growing old usually coincided with losing the pressures of daily work and ability to spend time with a spouse. Older adults are the only age-group who can experience a long-lived intimate relationship. And this is available only to those fortunate enough to have a compatible pairing early in adulthood. They must then persevere through raising a family, nurture each other through middle-age, and live long enough to share the rewards late in life. Ernie (68) says,

I've been married 40 some odd years and the same wife and we get along great. She can look at me and tell what I'm thinking and I can tell what she's thinking so I make sure I'm not thinking anything bad. Anything else? I like to spend time with my family, that's number one with me…And I like to do things with my wife.

Another long-standing marriage is that between Randall (80) and his wife. When talking about the best parts of aging, he says,

For instance 57 years of marriage and still in love with one another. We are happiest when it's just the two of us at the cabin on the lake.

Joji (71) grew up in a Japanese American community in rural California. Earlier in this chapter, Joji was quoted as saying that he was surprised at how much he enjoyed life in late adulthood. He had opportunities he never anticipated, including his relationship with his wife. He says,

I don't know how I came to it, but I know that in many respects this is the best time of my life. Sure, I suppose, you think back to your younger days when there were

> other good times, but this is a different kind of a good time. My wife and I are settling through being together and knowing each other's likes, dislikes and so forth and we are very comfortable with each other. That's a real nice thing.

That comfort with each other does not just happen. It takes time and effort. But older adults are able to accept each other in a way that younger people cannot. Perhaps this tolerance is learned through trials and tribulations or perhaps it is the result of psychological maturation. Rodney (76) relays the following about his marriage,

> Along the way we have had many, many problems. We've had many problems with sickness, we've had many problems with children. We have many problems with heartaches and living from year to year, and month to month. I think if you can get over some of those particular things and get to later on in life you kind of accept each other more like you are, then be looking for always that thing that you don't have that somebody else has . . .We've been through many things, sickness, and with our children, that we could have maybe said well let's call it off...So I think when you get older and married for a long time you kind of just accept each other more and you are not looking for perfection or not looking for fantasies I guess.

However, when able to spend time with their spouses, some people could not accept what they saw. Sometimes more familiarity means finding out things about your spouse that perhaps you would rather not know. In describing her initial disappointment with retirement, Fran (69) says,

> I was under the impression, my feeling is that it was going to be wonderful. I was going to be happy and my husband and I were going do these things, wonderful things and travel. We were going to have a great time when we retired. He had been retired for about eight years prior to that. Well, that didn't work out because when I

> retired I still brought a lot of my own unhappiness home with me and also found out things about my husband that I didn't like very well. Mainly that he drank and it bothered me a lot.

Few participants in this sample shared Fran's situation. However, she showed the ability to adapt and the willingness to change. She became involved with a 12-Step program and began to transform herself.

> That was the most wonderful thing I could do for myself, my life. Instead of going there and trying to find ways to get him to stop I learned a lot about myself. I'm still going and still finding out about myself.

What is remarkable about his quote is that Fran shows that she could tackle a problem and achieve happiness by changing herself. As previously noted, adaptation to change is a key attribute of older adults because later adulthood is marked by physiological, psychological, and social change.

Widowhood is common in old age and requires many adjustments. Seventeen of the participants were widowed—five men and 12 women. Many refer to adjusting to the loss of their dreams about spending time with their spouses. Amparo (72) says,

> Well, I really enjoy my retirement. The only thing I miss is my husband, that he is not here with me to enjoy our retirement, the two of us together. He passed away just before I retired. So we didn't have time to be together in our retirement. That is what I miss the most. Even so now, after 15 years I am doing pretty good. I'm going ahead and doing a lot of things with friends.

Over and over, the participants show their ability to adjust as the context for relationships change. In addition, normal psychological development prompts alterations in the structure of the social network and emotional satisfaction gleaned from interpersonal

relationships. The socioemotional selectivity theory contends that as a person ages her or she intentionally reduces the number of peripheral relationships while maintaining close interpersonal ties. Simultaneously, emotions mature so that emotional ties with others are more satisfying. Rather than old age being a static period in which a passive person demands assistance, these elders show that they are continually learning, developing, and actively participating in their relationships.

These changes translated into a renewed ability to be in a relationship with a spouse. The participants discussed two ways they were able to situate themselves into the relationship that differed from earlier in life. The first is that they spoke of valuing relationships differently than they did when younger. The second is that they spoke of the ability to respond to others in such a way as to get the outcome they felt would make them most happy. So, the way they were in close relationships differed qualitatively by virtue of being older.

Learning to Live In-Relation to Others

Contrary to expectations, many participants spoke of their families being central to their happiness simply by virtue of their presence rather than any specific type of support they supplied. It seems that elders appreciated their interpersonal relationships more than they did earlier in life. Fran (69) indicates that the significance of family ties have changed for her over time. She says,

> Definitely a big part of it. Relationships . . . what else is there? There are certainly things in our life, material things, material things. I always looked for material things to bring me happiness. I did for a period of time, but that's changed. Now I don't know if that has anything to do with aging or just the way I'm changing. Probably a combination of both.

Jim (67) describes learning how to have a spousal relationship through his four marriages by changing his perspective of what is important. His parents had rigid ideas about what was correct behavior. They fought constantly and there was violence in the home. He carried these habits over to his adult life, although as he ages, he notices that he views his role in his marriage differently from when he was younger. He says,

> I think for me the best parts [of aging] are realization of what are the important things about having a happy and productive life and realizing that a lot of other things that have seemed important to me during my middle age and before are not important. Finding the ability to discard some of those things and concentrate on those things that do seem to be a lot more important...The thing that seems better, that seems to be the major change for me is just being able to look at two competing things I need to be doing and decide to do that which is going to really bring me happiness, satisfaction.

This ability to weigh the consequences of two events and choose an action based on the desired outcome is reflected repeatedly in the data. Increased flexibility seems to be a trait many elders possess, manifest either by choosing specific actions or by accepting change. Rodney (76) says,

> I think being more satisfied and accepting as things are. Happiness to me means that something that is making you feel good. When I drink a beer I'm feeling good

because I'm happy. I'm having a beer. But I think if you use a word like more satisfying I think that includes the other person and another part of your life.

He goes on to talk about his relationship with his wife, saying,

Me and my wife, we are still struggling to go along here. At least when you get older you can get upset with each other and say things to each other and it passes. It isn't like the young people are now, when somebody gets upset about something. Hey man, this is it, we are going to get a divorce. We just pass it along.

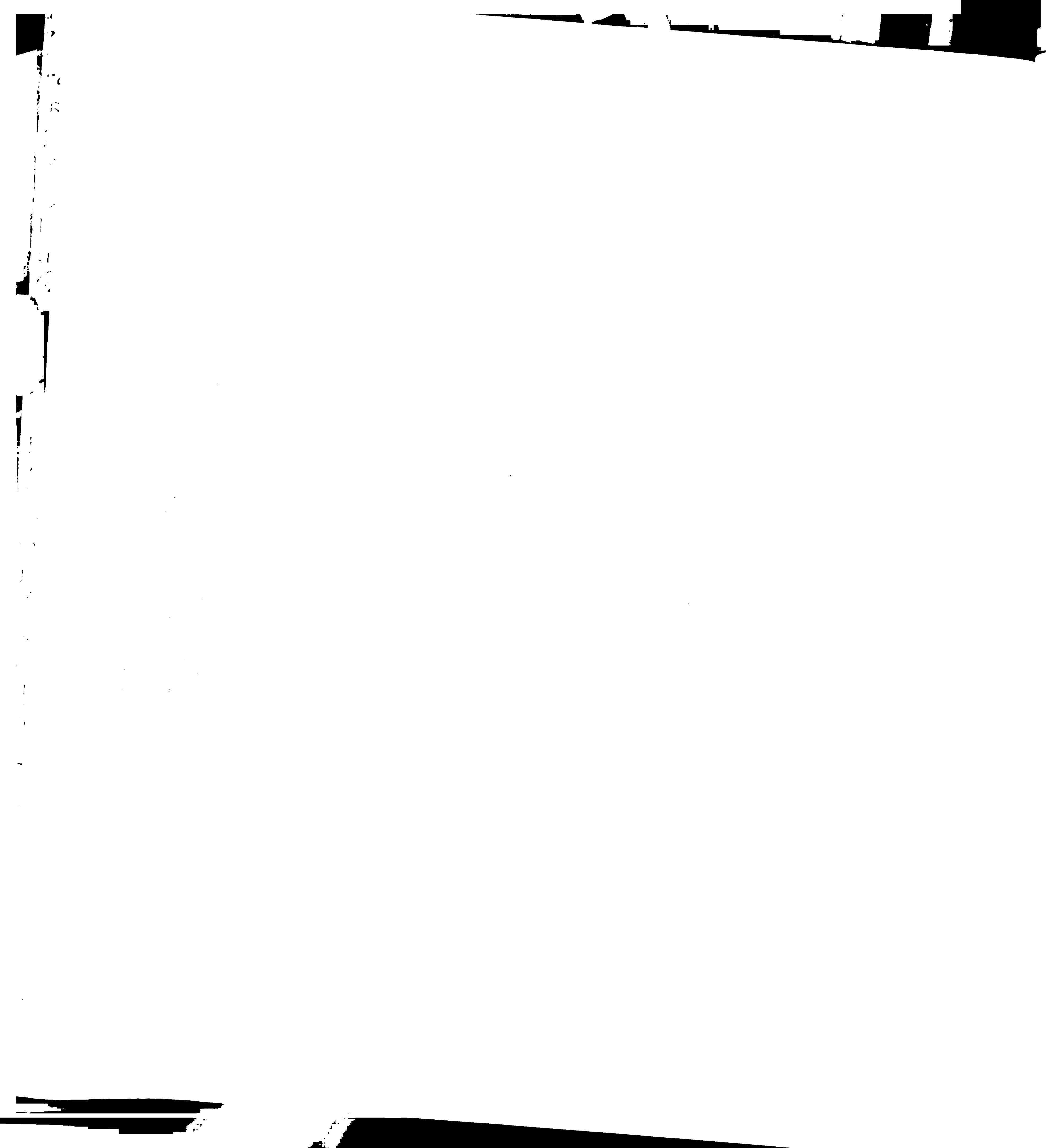
Joe (69) sums up what other participants say about how to manage stressful interpersonal relationships. One key is in learning what you can change and what you cannot. He says,

I came to the conclusion that some things you have to let go or you don't survive. As an example, my oldest daughter got married. I may not have been totally happy with her choice...I realize that I couldn't worry about things that there was nothing I could about it. I just had to put it out of my mind or I wouldn't be able to enjoy myself and survive.

If wisdom is managing one's emotions using knowledge gained by living, Joe has wisdom about being in relation to his wife. It is apparent that older adults are not static in how they manage their interpersonal relationships. They are continually using past experience to shape their present actions.

Adapting to Change

Contrary to the common belief that older adults are inflexible, aging is accompanied by constant changes: physiological changes, fluctuations in health, geographical relocation, and changes in social relationships. Ellen (67) warns against becoming set in one's ways when she says,



> We each have our own little something ...So I think if you aren't flexible in life you age faster. Not willing to accept, not willing to adopt a new lifestyle, aside from just in aging that you have to go through, whether it's on the job or whether it's with your family or whether it's in a community or whatever it is. If you're not willing to give and take then I think you are an unhappy person. An unhappy person will age faster.

Relationships must adapt to variations in health and situation. Margery (72) tells about her boyfriend who is becoming progressively weaker. Formerly dance partners, their relationship evolved as he has become more disabled. She says,

> I'm losing friends now and then. But we all kind of cling together and our activities have changed of course through the years because as I say this friend of mine who can't dance anymore, but he still likes to play bridge and we still keep in touch with all our friends and keep each one of us in touch with what everyone else is doing.

Regulating relationships requires many skills, one of which is knowing what one can change and what is out of one's hands. Contrary to young adults, older adults do not expect everything to go as planned. They have found that there are some things that one cannot change.

Accepting Life as it Is

Relationships transform as a person grows older and accepting life is antecedent to adapting to change. While in youth one is challenged to change the world, the older adults in this study seem ready to accept life as it is. Donna (81) accepts her life with its imperfections, saying,

> I've had a marvelous life. I can't say it was all perfect. But you wouldn't want it to be cause then there would be no contrast. You have to have contrasts. I wouldn't

> change anything. I'm sorry my first husband died young. He was really a veteran of World War II so it kind of delayed so he lasted until the middle 60's. I might have been able to be a better mother but all my kids turned out great so--. They are all fine, well adjusted. No prisoners. No criminals. Lucky actually. My grandkids are all coming up wonderfully. Everyone is bright and happy.

Widowhood is common in later adulthood and the loss of a long time partner is especially difficult. Yet, the participants in this study were amazingly accepting of death as a part of life. What Mary (76) says about the death of her husband was a common reaction in the data. Although she is unhappy that he died, she does not place the blame on anyone. She relays resignation that life is not always the way you want it. She says,

> There are some things in your life you cannot control. My husband's death. He went in as an out-patient and 16 days later in intensive care he died and I thought nobody is to blame. It just happened. There are things you cannot control.

Simon (82) was 68 when his wife died suddenly. Although he loved her a great deal, he could not see her being saved so that she could live the rest of her life severely disabled. He allowed her to die with minimal suffering and dealt with it with the help of his sons. He puts it like this,

> She ended up having a stroke. They took me and my sons down there and showed us the scan. They told us she will be an invalid the rest of her life, can't repair the damage. We told them to skip all that. Within 24 hours she was gone. But they could have kept her alive for months, but we voted against it...I have my boys --we made it together.

Accepting the inevitability of death is another way that elders adapt and accept life as it is. Simon adjusted by pulling together with his sons. Although others can be supportive, facing death is a primary task of later adulthood.

Accepting Death

Older adults are constantly facing death— their own deaths, the death of peers, and the loss of spouses. Some data suggests that elders accept the inevitability of an end to life better than their offspring. Consider Beatrice (93), whose children are most likely in their late 60s or 70s. A generation gap seems to exist that suggests that even later in life, children and parents are not on equal footing. This elder is more ready to accept death than are her children. Beatrice (93) describes this issue between her and her children, saying,

> Oh, I know one of the signs that I did like, there was a poet, Edna St. Vincent Millay or something, who said the grave is such a lonely place and I think it sounds so lovely. I put it on the little sign in the kitchen. And my kids hate it. I said well isn't it consoling that you can feel that way about-- supposed you went around and said Oh what am I going to do in that dark place! And so I said it is supposed to be lonely and that means to be dead and that's fine. That's how it is to be dead. And they just can't get that, I don't know why.

Beatrice models a comfort with death, illustrating that she sees it as part of life and not necessarily depressing. Perhaps her children cannot imagine being without her, yet she is ready to leave them when her time comes. She goes on to say,

> I have one sign down in the kitchen. My son-in-law doesn't like it. What does it say now --It is better to be above ground than under ground. Better to be over the hill than under the hill...it gives me the feeling that death is nothing to be afraid of. When I am dying it is because I need to die. Just like I needed to live. Just like a baby needs those things. And to this day I have no fear of the process of dying.

The thought of one's own death certainly could be different for a 93-year-old than it is for younger adults. It is evident that older adults still grow and change psychologically. Because older adults are constantly developing, there will always be a generation gap between an older adult and his or her child, even after the parent accepts the offspring as an adult. This gap is another indication that although they have forged an adult-adult relationship, the adult child and elder parent are not truly peers. In addition, these normal developmental changes in later life prompt shifts in the social network.

Shifting Social Networks

The SST conjecture that older adults purposefully narrow their social network to fewer but more meaningful contacts is supported in many interviews. For example, Leo (76) does not feel that he needs new friends and denies feeling lonely. Leo talks about how his relationships changed through retirement. He says,

> I had a lot of relationships at work and connection with my career although I continued as a consultant for several years and maintained those relationships, my consulting work kind of faded out and so there are a number of people that I associated with in my career but I no longer see except for perhaps on quite rare occasions. They still invite me to a Christmas party and that kind of thing, but I don't have regular contact with most of those people. I do with some who were especially close friends that I do keep in touch with but by in large that group of people have dropped out of my life and I have picked up a few new friends, not many. Most of the people I now see more of I knew before I retired.

Consistent with SST, these co-worker relationships, visualized as the outer circle in the convoy model, are easily replaced. Consistent with Bosse et al.'s (1993) study of retirees, Leo makes new acquaintances to replace those co-workers who are no longer in his life. He says,

> I retired at 57 1/2 and started going seasonal full time [doing taxes]...Well, I did it because I enjoyed the people I was working with. I enjoyed the clients that I developed and there are a number of things I could say about how they were developed...Anyway, I think that is, how would I say, a very empowering, something that keeps you going somehow.

So, while Leo was satisfied with a smaller group of social contacts, he did not shirk new social connections. In contrast to being reticent, some older adults embrace aging as a new adventure and an opportunity for new relationships, Margery (72) sees her life expanding through her children and grandchildren. She says,

> Well of course as you get older your life expands and becomes ever more complex and is never-- I can't imagine anyone saying they are bored. There's more things to do all the time as your network of friends increase and family increase and grandchildren increase and your horizons keep broadening. There is just no end! I enjoy keeping in touch with all my grandchildren.

Margery seems to enjoy the new relationships this later stage of life brings her. She may be an exception; perhaps she has a particularly expansive personality and enjoys making new friends and having novel experiences. In fact, since temperament and personality are stable, perhaps her method for handling aging is no different from how she has handled new situations throughout her life. Personal history also influences how a person manages their shifting social network of late life.

Dan (77) was a radioman in the Navy during WWII. He maintains association with other men with similar backgrounds by talking with "the guys" on the radio every morning. This is also a source of new friends for him and seems to be a viable source of emotional support. He says,

> We call it the Cracker Barrel Net, because it is all the fellows of my age or older, generally we are all about the same age. It is kind of comical, well it's not funny, but we got one guy who says well I've got to take my high blood pressure pills and another guy says I've got diabetes and I've got to do this. Another fellow says it's time for me to take my medication, go to the eye doctor. A lot of them have problems like that. I shouldn't say it's comical, because it isn't funny. But it should be called, instead of Cracker Barrel Net, it should be called the Sick Call Net or something like that because so many of my friends are suffering. In fact in the last two years I lost two real good friends on the air that I talked to for 10 or 15 years and all of the sudden they get serious ailment and pass on.

This excerpt describes elderly men who support each other via the radio. Dan mentions concerns about health, which are raised repeatedly in the interviews. He also speaks of radio friends who have passed on. This mechanism of support is interesting because these men apply skills they learned earlier in life and adapt them to maintain social contact in old age. One can use the radio without leaving the house, so the men were able to communicate this way even when they were ill. It is using personal experiences from earlier in life to adapt to normal stresses of aging.

In this study, it was sometimes difficult for the participants to figure out where they fit in socially because they did not experience "aging." Consistent with Kaufman's concept of the ageless self (Kaufman, 1986), Shirley says, "But in my mind I always think I'm about 30" Ernie (73) talks about trying to find things to do when retired. He did not identify with other retirees. He says,

> I've got to several places -- AC Transit has a retirees association. They have lunches once a month. I went to two of those. I looked around. Jesus Christ these people are old and I left. It's awful.

In addition to not identifying with "peers," sometimes the social relations at work are not good, so complete change in social contacts could improve one's life. Juan (72) does not talk much about co-workers, however, being away from other social contacts at work improved his life. He says,

> I have a very good retirement from the police department, but that was a blue collar job. Nasty job. Deal with nasty people all day. And it affects you mainly in your out look - you get cynical. I use to, people would tell me there's good in everyone but that's not so. There's people who are inherently evil in this world. I know that, they don't know that. It makes me angry. There's people [that are] just bad...That affects you to a degree.

For others, other contacts from the working world can add to one's life. Continued contact with the type of person one worked with in the past can be very rewarding. For Eileen (70) working as a teacher is something she enjoys, especially now when she can do it on her own terms. The continued contact with children enriches her life. Having the opportunity to mentor inexperienced teachers allows her to pass on what she learned through her career. She says,

> I still actually work. I am a retired teacher/counselor and so I still substitute teach at Juvenile Hall in the evening ...I grade would-be teachers on the part of their test that is essay and so I do that. But the nice thing about it is that if I want to do that, I do, and if I don't I just say 'I don't think so' and that's really wonderful. So I still have

some contacts with the kids which I like and an aspect of teaching, which is qualifying new teachers.

So, the social networks in later adulthood are dynamic. These elders do not seem to mourn the loss of peripheral social ties and do not shirk new relationships, at least those in the convoy models outer circle. Because one's social life is continually changing, continual adaptation is necessary. Making new social contacts is part of that adaptation. Making comparisons is a dynamic process that allows a sense of self that adapts to life's changes.

Identity through Comparisons

An integral part of the way people interact is by comparison. Contrary to the expected results, the elders in this study did not talk primarily about assistance exchanged, or instrumental support. Rather, they most frequently spoke of comparing themselves with the people in their lives. Ryff (1991) and Ryff, Lee, Essex and Schmutte (1994) identify comparison as a mechanism by which people situate themselves in their social environment and develop a sense of self.

First conceptualized by Festinger in 1954, social comparison theory refers to how a person develops a sense of self in relation to others and adapts that image as life situations dictate. Although there are several types of comparison, the basic premise is that comparison helps a person identify characteristics that are unique to him or her. Comparisons identify those who are alike or different as well as how one changes over time.

Comparison are made in several ways: upward or downward; identification or contrast. These terms facilitate describe how a person compares or distinguishes him or herself with others who are more (upward) or less (downward) fortunate. The type of comparison made is either an identification (noting similarities) or a contrast (noting

differences). In addition, there are four types of comparison that are named on the basis of the comparison target or attribute: physical, hypothetical, temporal, or social (Brown & Middendorf, 1996; Suls, Martin, & Wheeler, 2002).

For example, one can compare another's physical attributes, for example, Joe walks five miles every morning and once a week he walks 10. These walks are a major source of enjoyment in his life. He notes that his next-door neighbor must use a cane to walk and has the endurance to last one block. He compares his physical attributes as superior to his neighbor's. Since the walks make Joe happy, he might extrapolate that he is happier than his neighbor as a result. Hypothetical comparisons are with how things could be (Suls et al., 2002). For instance, an elder might say, "I could have had a stroke. Since I haven't, I must be aging successfully." Social and temporal will be discussed at length in the context of how they appear in the data. Although the participants in this study use all four types of comparison, this section will highlight social and temporal.

Social Comparison

Contrasts

According to Suls, et al. (2002), social comparison is assessing the self in relationship to others in order to evaluate or to enhance some aspects of self-concept. Social comparison allows a person to develop or maintain self-esteem. Self-esteem is a pathway to health and well-being in the SIHC (Berkman et al., 2000) (see Appendix 6 page 192).

In general, people are more likely to make comparisons that portray them in a positive light (Ryff, 1996). Downward contrast is the most common type of comparison in this sample. In this type of comparison, the elder compares some aspect of the self favorably to another who is less fortunate. While early studies showed that downward comparisons enhanced self-esteem, it is now accepted that the direction of the comparison

alone is not a factor in how the comparison affects self-esteem. The qualities of the comparison are more influential (Brown & Middendorf, 1996; Suls et al., 2002). For the older adults in this study, many of the comparisons are seem to reveal values. Karen (78) makes a common downward contrast when she says, "I'm very appreciative that I can still live in my house and don't anybody coming in to care for me, like a lot of people here."

At the most basic level, downward contrast in this sample deals first with remaining independent. When independence is taken for granted, other skills come to the forefront. Mary (76) is active and prides herself on her healthy habits, one of which is swimming. Swimming is an activity that is fun, gets her out of the house, helps her maintain her health, and minimizes her pain from arthritis. She realizes that not everyone can swim and that she is more fortunate than those who never learned and therefore has more tools to keep herself healthy. Mary says,

> Three times a week. I love the water. Nothing hurts in the water. I don't know how you feel about swimming. But I feel you could do this forever. And it is true. You can swim long after other kinds of exercise. I was never athletic, but always felt comfortable in the water. And I realize it is a gift when I see adults learning to swim and overcoming their fear of water.

She did not consider aging easy, but believes her plight is much better than others who have illnesses and difficult situations. She speaks of comparing her ailments to friends who cope with cancer and Alzheimer's disease; by comparison she is blessed.

> And in my case, I keep thinking Mary, keep it in perspective. Think of the people you know who have cancer. That has not happened to me...I don't have cancer, but I'm increasingly aware of the people who have it. Alzheimer's is another one.

A contrast is not necessarily favorable. Donna (81) does not feel that she is aging successfully, but she sees other people who are. She describes her feelings about a friend who is the same age as she, but more physically active, saying,

> My dearest friend...is one of the people who I always envied because she could do all kinds of things that I wasn't able to do...She is a different mix genetically and she is very athletic and she never did get bad shoulders. She never did get anything like sciatica. She even to this day she can go skiing and she is my age. Our birthdays are just within a couple of week of each other. She can still go on skiing.

Comparisons can be between self and another or observed between other people. While trying to comfort a friend who is feeling lonely, Ruth (74) compares one friend to another. This peer-to-peer comparison is an attempt to show her friend that she has more support than she realizes. She relays her conversation with her friend,

> Well, she was saying that she was lonely. But she is not lonely. She has a son-in-law, and then I called her last night, and I think we talked awhile and in that short period of time she had two other calls come in. This other lady is just her. She has no children. She has no brother or sister. That is a different lonely. She's has to call friends for, whereas . . .She has the son-in-law. He calls her up. She just has lots of friends!

This is a case of a friend making an assessment of another. While there is no research determining this type of comparison has on self-esteem, Ruth most likely

communicates this perspective to her friend when offering appraisal support. So the act of comparison affects the degree of empathy or compassion one person has for another.

Identification

Identification is placing the self in the place of someone who is less fortunate. Jim (67) makes this observation about his wife's mother.

> C has a mom who is 93 and lives in a retirement home in [city] right now and is just totally out of it. And it's no kind of life. My mom was that way. She died about six, seven years ago . . . When I think about being that way myself I would hate to be that sort of a drag on anybody.

Jim's quote is a downward identification, or associating the self with someone who is less fortunate. The next two examples are of older women who make comparisons between themselves and two older women whom they admire. Mildred (71) compares her life span to that of her mother. For her, this is an upward comparison, but one that is reassuring ("my mother lived a long time, so should I"). She speaks of her mother as a role model when she says,

> I'm 71 years old, I don't feel old. But my mother lived to be 97 years old. That means I've got 20 more years. Now I have even greater respect for my mother. For her to have lived to 97. By the time she died, her heart gave out, but she lives to be 97 years old. My father died when he was 58 years old. My mother lived 40 years more after my father died and she never got married again. That in itself was remarkable too.

Bonnie (83) compares her attitude toward life favorably to a woman older than she. She describes an acquaintance whom she admires, saying,

> This little lady was 100 years old. She is as cute as a bug's ear. She manages an apartment. She drives her car. She plays bridge three times a week. She has two highballs at night and she doesn't go to the doctor, because she is like I am: if it isn't broke don't fix it.

In this comparison, it is almost as if Bonnie says that she will also live to 100 because she does not believe in fixing things that are not broken. Upward identification tends to be an optimistic view, whereas the upward contrast identifies how others are doing better than is the participant (Suls et al., 2002). In addition to longevity, independence is another area where the participants identified others who had done things to which they could aspire. Consider how Geraldine (72) views this acquaintance from the pool. She says,

> Yeah, there is somebody up at the pool now I don't know how old he is exactly. I think he is about my husband and my age. His wife and he go bicycling in different countries every summer. They just came back from Belgium on a bicycle trip. I thought I want to do that. It's through Elder Hostel...And I thought well why not. Why not try it. Go bicycling and try that. I like to make things happen.

She identifies with this couple because they seem to be the same age as she and her husband. If they can do it, why could not she do the same? This type of comparison tends to be motivating. If a person can identify with someone who does something better than he or she, then they can strive to that same accomplishment. Conversely, if a person makes an upward contrast, the person may recognize another's strengths and not feel that she can live up to the other person's accomplishments.

Lateral Comparison

Comparison with peers can also verify normality. Ruth (74) notes changes in her memory, but this was all right since she perceived that her friends were going through the same thing. She says,

> And I've got more nervousness and forgetfulness than I had, but most of my friends say the same things. One says she forgets but she seems to remember a lot of things. . . I almost need one of my kids who remembers the names or the conversations, so. . .That kind of bothers me...I can't remember when I had my lunch. . . Yes it is getting worse, but it doesn't bother me too much because my friends are the same way.

Ruth normalizes her experience with memory loss by comparing herself to her peers and determining she is the same as they are. She sees herself as normal and the changes do not seem as alarming as they would should she be the only one in her cohort with memory difficulties.

Temporal Comparisons

Temporal comparisons are integral to social interaction because they help a person construct an enduring sense of self over time (Brown & Middendorf, 1996). In this sample of older adults, comparisons with the self earlier in life dominated. Jim (67) compares his sense of entitlement when he was younger with his perspective today. Because he now can see the perspective of another person more clearly, this change has altered his relationships with women. Earlier in life he felt that he was entitled to have whatever he wanted, without regard for how his actions might affect others. He says,

> Because it was something about I should get all from life that there is and if there is an experience for -- I should exploit every opportunity for gratification. One can

> always find things that are not perfect about a relationship. So when I was out of town on a trip or when my previous wife was gone I'd say well you know there are things really missing from this relationship.

And with this justification, he would go out to meet women. Being able to weigh his options caused Jim to stop having affairs. Reflecting on his past three marriages, he feels that at least one of his marriages could have worked, had he the wisdom he now possesses.

> I think that what I've learned is that working on the relationship rather than just letting it happen is so important. Wanting to give myself, to give more than 50%, not that I need to keep score. But I can remember walking into a house in one of these marriages, seeing something that needed cleaning up that I could easily do if I would take 10 minutes and put something up and I would say to myself well she can do that. And now when I see something like that I move to do it without even thinking about it because the ball game has changed for me. I don't feel selfish about those things. I don't keep score.

He has also noticed a difference in how he approaches peripheral social ties. It is as if he has gained social skills as he has reflected on his life.

> I can reject chasing say a relationship with a person that I would like to be a friend, a male person that I would like to be a friend of, and it becomes apparent that that person is not that interested and I can just -- It's not a big deal.

Jim attributes these changes to experience and without them he is unclear that he would have learned the lessons he did that made him the person he is today. He says,

> I've made some horrible mistakes in my life, so it was really . . .I certainly would have done it differently...Because as I look back, take a few steps back and look at it from a distance, which I hadn't done, it's always been just a big tangle of events. You did

> this thing which took some action in your life, but you made some decision and you just went on from it. I never stopped to think how it might have been different…A lot of it was really thoughtless and selfish. I mean what I did was thoughtless and selfish. But so it is with human kind.

Jim describes growth throughout his life in the way he manages his interpersonal relationships. It is unclear whether he truly learned from his experiences or whether this is a maturational change independent of experience. In either case, he acts differently now than he did when younger. Or, at least, his perception is that he now behaved differently.

This sentiment is reflected in other interviews. Many participants mention that they do not take life as seriously as they did in the past. Nancy (73) says,

> Probably a more relaxed person. I mean you would have to ask other people. I don't see myself as being too different except that I'm sure that I take life more easy. I mean I'm more relaxed about what happens.

Not reacting to everything and being selective about what is communicated can shift potentially contentious situations to positive interactions. This change has an effect on relationships, as seen with Jim's comments on how he no longer "keeps score" whether it is he or his wife who does more work around the house. Fran (69) gives us another example. Here she is talking about being more kind in her interactions with her husband. She says,

> Just an example: I'd say to my husband 'Go to the store and get so and so and so and so,' and he'd come back and have everything right but one thing was wrong. I'd immediately say, 'Well you didn't get this right,' and go on about one thing instead of saying I really appreciate your going to the store and you did really great. It's too bad you didn't get that one. And his reaction back isn't one of anger or making me feel bad. He feels better about himself.

So, by changing the way she reacts to her husband, she also changes the reaction he has to her words. Multiply this by several times everyday and one can see how the entire relationship can be more amicable than earlier in life. In fact, research does verify that as emotional reaction dampens with age, satisfaction with marriage tends to increase (Levenson, 1997).

Gender Differences

Even when women worked outside the home, most described freedom from having to provide meals for others at specific times and to care for children rather than being free from work. While the feeling of freedom for women predominately centered on release from home chores, women and men alike expressed feeling free. Both men and women cite family as very important if not the central thing in their lives, yet women talked about family much more than did men. Men talked about their wives taking care of them; however, husbands taking care of wives was not reflected in the data.

Women's Work

As noted earlier, women were more likely to mention freedom from family responsibilities while men were more likely to report freedom from work at a job outside the home. This was not a hard and fast rule, as many women talked about being constrained

earlier in life by both a job and family responsibilities. However, men did not describe a release from family responsibilities other than being the breadwinner.

Although statistics for which women worked while children were at home are not available for this sample, a significant number of them did. Of the entire sample, three women indicated that they never worked outside the home. While a woman devoting their entire adult lives to homemaking was normative when this cohort was young, this norm shifted during their adult lives. Eileen (70) observed that working outside the home was the norm for the women in her social circle. So, children leaving home and retirement were both releases she experienced in old age. She says, "Now I don't know anybody, well I only know one woman who never worked. Everybody else I've known has worked."

Women also talked about balancing family with work, whereas the men spoke of the pressure of having to support a family. Ruth (74) describes this here when she says,

> When you are younger you have to go to work and come home to your take care of kids. All those things are rush, rush, rush. This way it's just my husband and myself and one son that stays here sometimes. It's not bad, use to get up early in the morning about five o'clock, now I get up eight or nine, (laughs), sleep in for three hours, go to bed late.

Although work usually adds stress, a woman who felt captive in a homemaker role might welcome a role outside the home. However, balancing work and family is always challenging. Geraldine (72) says,

> I don't know how I had time to go to work or do anything else...I liked working. It was enjoyable, but sometimes I think about when I work. I like my work. There were times when I thought going to work meant getting away from what was going

> on at home. There was so much going on here that it was just kind of a place for me to get away to, you know, in that respect.

Sometimes working was a necessity. Women without job skills were forced to take whatever work they could find, whether they enjoyed it or whether it was a job they could be proud of. When her husband left her, Marta (80) took on domestic work in her neighborhood to support her children. Later, when a position opened at a local tavern, she took it because it was steady work and paid more than her other opportunities. The fact that she worked in a bar was embarrassing for her children and perhaps not the healthiest environment for her. She says,

> I took care of some little children. Little B and D from next door and then when they moved I had three houses, that's all I knew was housework. I did three houses. I cleaned up. And then a lady told me one day I know you need work she said. There is a bar down the street that they need somebody to come in two hours a day while the lady went home to take a nap.

She goes on to talk about how some neighbors ostracized her and her children because of where she worked. She talks about how being ostracized caused her children to become very close to her.

Some women found that knowing you could get and maintain a job gave them a feeling of security they could get in no other way. Mildred (71) talks about working as a means to freedom. She knows she can take care of herself.

> I think that when you have children and then work and have a career and retirement, that you don't have to depend on somebody else, it makes you in control of yourself. I could have never been one of these women that never worked and took care of herself. After my first marriage and divorce I said I will never depend on anybody

> but me. I think women should always be able to be in control of themselves. I think about a woman having a career and a life in case something would happen to her husband or anything. Then she could take care of herself and it would be OK.

Mildred found strength in the knowledge that she could support herself if needed. However, female participants of this study often spoke of stress in both spheres of responsibility—home and work. Pearl (67) talked about first working with a psychiatrist, but ultimately got her life together by working with a minister from Japan. She talks about the time earlier in life when she had a problem with prescription drug abuse.

> I took tranquilizers for 25 years. I had a slight nervous breakdown at age 24. I became a supervisor at work and that was more than I could handle. But I was married, I had a family, I was a supervisor at work and I think all that pressure -- So I had a slight nervous breakdown.

All of the men in this sample worked; however few talked about child rearing. None discussed balancing caring for a household and working. Nevertheless, they described being accountable for supporting a family as very stressful (see Work and Retirement, page 94).

Women as Advocates for Health

As noted in Chapters 1 and 2, many studies associate close social contacts with health and longevity. Health, specifically function, is essential to social competence (the ability to make social contacts). In this sample, a few men attribute their health to wives. This was especially true when wives supported their husband's health habits. For example, Robert (72), despite having several serious chronic diseases, denies problems with illness because his wife manages it. Here is how he describes this aspect of their relationship:

> I think if you have good health, then your relationship will be as healthy as you... The reason that I look as healthy as I do I go up to the hospital and take my medicine. My wife make me take my medicine all the time...We are close...I think I would have a very difficult time without her.

While the data for this health promotion function are not strong in this study, only husbands reported it. No women spoke of how their husbands helped them managing health or illness. Shye, et al. (1995) found that being married was related to longevity in men but not in women. While they surmised that this was an indirect effect of network size (married men having a larger social network than unmarried), their results were not conclusive. They did not look at wives' health promotion practices.

In summary, this section discussed the themes common to most of the participants in this study; however, none of these themes completely describes any one of the participants. For example, some participants did not have children and some raised children as a single parent. In the case of elders from a marginalized group, few of these themes apply.

The themes presented here reflect the theoretical foundations presented in Chapter 2 (see page 45). The next chapter will discuss the themes in the context of the theories presented in Chapter 2.

Chapter 5 Discussion

Although few participants attributed successful aging to relationships with others, most participants spoke of the importance of family relationships. Contrary to the concept of the empty nest, freedom from family responsibilities was often cited as the best part about aging. The participants had developed different relationships with their children. The transition that began in mid-life gave way to a comfort in their new role. In addition, the role of social and temporal comparison was striking because the participants judged their ability to age well by comparing themselves to peers or to themselves in the past.

This chapter will discuss the findings and relate them to the theoretical foundation. First, in concert with life course theory, the socio-political history is described as the environment or context. Second, there is an exploration of the apparent contradiction of being glad that home responsibilities are over, yet valuing time with children. Third, the role of social comparison is discussed. The fourth major topic is gender differences. Last, the case of the gay elder is contrasted to the predominant themes.

Preconceived notions

Beginning this project, I thought that I was going to find that interpersonal relationships were the most important thing in the lives of elders and that they directly contributed to SWB. While analyzing the interviews, I had to confront the fact that this was a stereotype on my part. Relationships were most important to some, but to others it was being a role model, or pursuing hobbies, or keeping up with friends.

Rather than being set in their ways, these older participants were flexible and adapted to a myriad of changes. It stands to reason that there would be little uniformity in descriptions of successful aging. Other researchers have noted that older adults, because of divergent personal histories, are more different than they are alike (Carey, Walter, Lindquist,

& Covinsky, 2004; Hayflick, 1998a; Hayflick, 1998b; Hazzard, 1997). This holds true for physiological as well as psychosocial parameters.

Another insight was that the participants did not discuss receiving much instrumental support. I expected that they would talk about having family to help them out and that would be a factor that contributed to well-being. This was another stereotype I held that shattered as I analyzed the interviews. There is very little discussion about receiving help from others and frequent mention of how the participants assist family members.

In addition, the historical context seemed to be more important than I imagined. Many participants mention the Great Depression or World War II as pivotal events in their lives. This historical context was the backdrop for their perception of their roles as parents and for how they viewed themselves.

Life Course Perspective

Life course perspective implies that older adults are viewed in the context of their lives, including personal and historical experiences. A brief review of US history during their lifetimes provides the background that the members of this age cohort share.

Historical Context for Study Participants

The participants in this study were born in the years 1907-1934 and lived through a time of rapid scientific advancement. Born in the industrial era, they are now coping with the information age. Their older siblings and fathers fought in World War I (US involvement 1917-1918). As children, they survived the great flu pandemic of 1918. Women gained the right to vote in 1920. The 1920s were a time of expanding economy and prosperity that was marked by high employment and wages (Zinn, 1999). The Great Depression started with the market crash of 1929 and by 1933 one-fourth to one-third of

eligible workers were unemployed. Impoverished farmers headed west to California, hopeful for a better life. Then came World War II (WWII; US involvement 1942-1945); the nation rallied in support and both men and women supported the effort by joining the military or industry (Zinn, 1999). People of Japanese ancestry were interred in California ostensibly to protect us from enemies living within Asian communities. WWII ended with detonation of the first nuclear bombs, inaugurating the nuclear age; mankind first had the tools of its own obliteration at hand. After WWII came the Korean Conflict (1950-1953) (Evanhoe, 2005).

Since the military action in Korea was not a declared war, these veterans came home to far less celebration that did the WWII veteran. However, both received veteran's benefits, the most influential of which were those provided under Serviceman's Readjustment Act of 1944 (GI Bill). The services included payment for college, employment assistance, and mortgage support (Administration, The GI Bill). This provided a significant number of men and women with job skills and a start on family life. Thus began another era of prosperity, which catapulted the US into position as the world economic powerhouse. The baby boom (1946-1964), or the largest rate of increase in the US population ever, followed.

As young adults, most in this cohort married and lived in nuclear families in which most husbands are the breadwinners and the wives homemakers. Middle-class society scorned women working outside the home, divorce, single adults, and anyone else with an alternative life-style. The Cold War was in full swing and nuclear holocaust was perceived as an ever present danger. Homes had bomb shelters and children practiced "duck and cover" drills under the illusion that these measures would save them from nuclear explosion. The Space Race began in the 50s with the Soviet's launch of Sputnik. The US and the Soviet

Union competed to put the first man in space, then the first man on the moon, ultimately accomplished by the US in 1969. John Fitzgerald Kennedy was assassinated in 1963, ending the American age of innocence and the illusion that "it can't happen here."

Their children grew up and became veterans of the Vietnam War (1964-1972). In Alameda County, the University of California at Berkeley was the epicenter of the Free Speech Movement (1964-1965). The Health and Ways of Living study was initiated (1965). The Black Panthers organized social programs in Oakland beginning in 1966 (LeBlanc-Ernest, 1999). This was an age of returning to roots and ethnic identification was the rage.

They lived through an era of great scientific, technological, and social change. Because they were residents of Alameda County in the 1960s, they were at the epicenter of the cultural revolution. Because they all experienced these changes at about the same phase of their lives, this unique history ties them together but separates them from older and younger generations. The perspective of this cohort is unique owing to the history they share. However, social history shaped their lives tempered by personal factors and normal development.

Freedom from Family Responsibilities

Contrary to the notion of the empty nest, where parents grieve the loss of their nuclear family as children leave home, many adults in this sample expressed relief that they no longer had family responsibilities. This sentiment is overwhelming in the data and the reasons for this deserve consideration.

These older adults no longer have the responsibility of raising children and maintaining a family home. Most participants spoke of finally being free to do what they want and denied feeling lonely and without purpose. Transitioning to a new, less stressful role may explain this sense of release. Maintaining a career, raising children, and nurturing a

spousal relationship are potential sources of ambient stress. Eliminating or reducing that stress enhances well being (Cohen & McKay, 1984). The two major roles in which the participants described stress level change were those of parent and employee. In both arenas, older adults experience major transition.

Free from Stress

Parenting in midlife is antecedent to late life parenting. Generally midlife parenting refers to parents whose children are old enough to be out of the house and have children of their own rather than the age of the parent (Bleisner, Mancini, & Marck, 1996). In this study, the focus is on the parent rather than the child, as is traditional in parenting studies (Ryff & Seltzer, 1996). This perspective acknowledges that adults are part of family systems throughout their lives (Fingerman & Bermann, 2000). Even though older adults appear delighted to be released from their families, interpersonal relationships between adult and child are continuous and can be rewarding throughout the life span.

The primary task of midlife parenting is concern about the child getting a start in his or her life. In late life, this concern abates and parents accept their children as adults. They no longer rely on children as a source of identity and activity; however, the parent's perception of a child's success affects the elder's well-being (Ryff & Seltzer, 1996). Bleisner et al. (1999) define the following areas of interest in defining late life parenting: role expectations, significance of the parental role, interaction patterns, and quality of relationship. This data set did not focus on parent-offspring interaction patterns, so this section focuses on role expectations, the significance of the parental role, and on relationship quality. In this data set, role expectation and significance are highly intertwined and will be discussed together. Quality is not illustrated in these data, but can be inferred from how the participants talk about their relationships.

Role Related Stress

Children leaving the home when the parent is middle-aged are normative, or expected, events. While these are generally less stressful than are non-normative events (Hagestad, 1986), a certain amount of stress is inherent to all major life transitions. Chronic strains, however, can be more harmful than acute stressful events because they persist over time. Parenting minor children in the home (over a period of years) would cause more stress than would a normative midlife role transition. Pearlin (1989) identifies six types of chronic strains (see page 52): role overload (demands exceed capacity); inter-role, such as work-family; role restructuring, as it occurs through life transitions; role captivity (restriction to an unwanted role, such as housewife or retiree; interpersonal conflict; and ambient strains, such as living in poverty or having a chronic illness.

While conflict and ambient strains were not examined in this study, the first four stressors involve social roles that pertain to mid and late life parenting and its relationship to work. A working parent lives with many stressors for the entire period of time the children are at home. Pearlin's (1989) theory explains why these older adults are so happy to retire and have their children independent. It is a consequence of being released from the stress of maintaining a home and a nuclear family. While older adults with children are still parenting, the strains are entirely different from those encountered earlier in life. This section illustrates how the release from role stressors could be the source of the feeling of release these elders experience.

Role Overload and Inter-role

In this context, role overload and inter-role strains are related, so these first two stresses are presented together. The primary sources of role overload are the pressure of supporting a family (more commonly an issue for men) and balancing work and

homemaking (primarily for women). If both the family situation and the work situation were stable, there was less stress. However, consider Pearl (67; page 153) who says that being promoted to supervisor at work caused her to have a "nervous breakdown." Had Pearl not had children, she might have handled the responsibility that accompanied her promotion. Having large challenges at both home and at work were simply too much. Nancy (73) identified the stress of role overload when she says,

> I think maybe after retirement when there weren't as many stresses, not having as many stresses in your life, deadlines and things I had to do.

Many participants spoke of the relief of giving up a role, or sometimes many roles when their children left home. Some could retire; others took up hobbies or traveled. Those who continued to work past retirement did so on their own terms---they did the type of work they wanted in the context they preferred. They managed the number of hours worked. This degree of control tempered the stress. Looking back at their lives, many were unable to comprehend how they were able to manage family and work at the same time earlier in life.

Role Restructuring

The third role-related stress is role restructuring. Role restructuring occurs as the parents build a new relationship with their children. The parents in this study did not seem particularly stressed over their parenting roles, yet their roles had clearly been transformed from that of caregiver to almost a peer connection. It is likely that the actual transition happens in midlife so that by later adulthood, the new roles are established. If so, the parents would be past the major stress of role restructuring and reaping the rewards of a new relationship with their children.

Although they express a feeling and freedom and release, the participants in this study made few references in the data to receiving assistance and many references to the type of help they provide for others. Although contrary to the societal image of the "Greedy Geezer," who saps up financial resources at the expense of others in the family (Williamson, Watts-Roy, & Kingson, 1999), this is consistent with the principles of reciprocity as an essential feature of any adult relationship (Hegyvary, 2004). Recall that Bromberg (1983) showed that adult daughters gave more instrumental support to their elderly mothers, whereas the mothers provided their daughters with more emotional support. Attias-Donfut (2001)found that while children often provided more instrumental support for their parents, elderly parents provided significant financial support for their adult children. However, if the need for caregiving reoccurred (child to parent or parent to child) or estranged family members were reunited, the relationship would again require renegotiation.

With role restructuring based on a non-normative event, the stress level would most likely increase. An example of this would be Juan (see Adults but Still Kids, page 104) who took both adult daughters back into his home when they experienced life crises. Another example is Constance, who took care of her five grandchildren after her daughter died (see page 116). While the stress of role restructuring was not a focus of this study, other researchers have documented increased stress in grandparents who are primary caregivers for grandchildren (Burnette, 1999; Emick & Hayslip, 1999; Kelley, Yorker, & Whitley, 1997). Nevertheless, role restructuring normally occurs throughout adulthood, including the role of grandparent in reference to grandchildren (Roberto et al., 1999).

Role Captivity

The fourth role-related stress is role captivity. This was not very prominent in the data; however, it was present. A person could feel captive in the role of homemaker, as

Geraldine (72) says on page 144. She saw her work as a refuge from the stresses of staying home and caring for children. Margery (72) disliked being financially dependent upon someone else. She tells us, "I could have been much more independent instead of being a stay at home housewife…I had to ask my husband for enough money to buy a dress. That was very demeaning." In contrast, men in this sample expressed feeling trapped in a job.

Often men wanted to do a different type of work but were unable to change because they were obligated to support their families. Women in this sample rarely expressed work role captivity; nevertheless, most women spoke of their primary focus on the home and family, even if they worked outside the home. Since they no longer have to keep a home and support a family, older adults may have fewer roles to fulfill. Some roles are now optional rather than obligatory, such as continuing to work after retirement without the financial need to do so.

Life satisfaction in late adulthood presupposes that one has enough financial and social resources to maintain their lives (Pinquart, 2001). The effect of socioeconomic status, ethnicity, or culture on roles was not explored in this study; however, it is a area with potential for future study.

Role Significance and Expectations—Does Culture Make a Difference?

Culture may be a source of role expectations. Although this study was not designed to identify ethnic or cultural differences in parenting style, an observation was made during analysis that hints that perhaps such a difference exists. This would support the idea that stages of parenting are culturally bound and that culture is a factor that defines the nature of relationships throughout life.

During analysis, the researcher questioned whether parenting styles were determined by culture, ethnicity, or socioeconomic status. The participants highlighted here

are examples of role significance because they valued taking care of their adult children. Perhaps they expected the caregiving component of the parenting role to continue through the child's adulthood. Mildred (71; African American), Juan (72; Latino), Robert (72; African American), Amparo (72; Latina), and Constance (78; African American) (see Adults but Still Kids, page 104) are examples of older adults who spoke of retaining tight ties with their children and grandchildren.

Mildred mourned the emptiness of her house when her youngest child left home and moved about 50 miles from her long time home to be near her son. She still cooked dinner for him frequently. Juan supported both adults daughters when their lives were in crisis—one because of divorce and the other due to her alcoholism. Robert felt a serious obligation to be a role model for his family and did not feel a release from constraints when his children left the home. He felt the same pressure to role model for his children and grandchildren as he did when they lived at home. Amparo, who is Latina, did not continue to provide care for her widowed daughter, but described an unusually close relationship with her that resembled that of peers. Finally, Constance cheerfully took care of her five grandchildren when her daughter died. In the interview, she does not complain about being robbed of leisure in her old age.

Beyene, Becker, and Mayen (2002), in their interviews with 83 Latino elders, found that well-being was highly correlated with fulfilling cultural expectations and not feeling lonely. The participants in that study noted that family was of primary importance and that self-esteem was a family-based quality rather than an individual trait. Principles from the SIHC help explain this. Recall Durkheim's contention that behavior is the result of tempering attachment with regulation. The initial parent-child relationship is the source of attachment. Regulation takes the form of cultural mores. The degree of closeness and the

seriousness with which these parents perform their roles are regulated by cultural norms. It is possible that the stages of parenting are culturally bound or that culture defined the nature of their relationships throughout life.

Although this project is not designed to prove correlations, these interviews were noticeably different from the bulk of the others. The European Americans in the sample seemed to talk about doing things with their children. For example, Margery (72; page 101) spoke of traveling with her grandchildren to assure that they had fond memories of her. She also spoke of her children and grandchildren exposing her to new relationships and experiences (page 119). This dutiful provision of support was in stark contrast to the more usual description of completely changing parenting roles.

In mainstream US, one marker for how successful parents are is their ability to launch their children from the home. Middle-age parenting is marked by concern over whether the child will become independent. What the child is doing (college, military, or work) is interpreted in terms of how successful this will make the child. In later life, the *perception* of how the well the child is doing is associated with well-being (Ryff & Seltzer, 1996). Parental-value expectations are key in this perception.

Culture undoubtedly influences how the parents perceives their role in reference to their children. While this observation could be a matter of coincidence, perhaps Juan, Mildred, Beatrice, and Amparo have a different expectation of parenthood as older adults than to mainstream European American US families because of their ethnic backgrounds. This study was not designed to answer this question; however, this would be an interesting line of inquiry to pursue. In doing so, teasing away the effects of SES would be essential in identifying cultural or ethnic factors. In any case, a study designed to look at the relationship

between macro level factors and support provided in a parenting relationship would be illuminating.

Interaction Patterns

This study did not look at interaction patterns. Although one could attempt to extrapolate from what the participants say in the interviews, it is important to remember that the participants report their *perceptions* of the interactions. A better way to explore interaction patterns qualitatively would be to interview the older parent and middle-aged child as a dyad. In addition to obtaining the perceptions of both members of the dyad, interviewing the pair together would be an opportunity to observe their interaction. Another modality for study might be to videotape and code the dyad interacting around a conflict. Levenson (1997) and others use a similar technique to study interaction patterns of married couples.

Peek and O'Neill (2001) compared network characteristics of older African Americans (AA) with European Americans (EA). While there was no difference in the size of social networks between the two groups, AAs had more interactions with family members than did EAs. While this study does not confirm Peek and O'Neill's findings, the interviews with Mildred, Robert, and Constance (see page 99) are consistent with their finding. Mildred and Constance were active caregivers for family members and Robert describes a life focused around his children and grandchildren. Further study could reveal if having more family than non-related network members contributes to a difference in SWB.

New Horizons—Learning, Development, and Change

Donna (81; Accepting Life as it Is, page 124) says that older people who are not flexible are not as happy as those who are. As discussed previously, later adulthood requires many adaptations, including those in the social realm. While close relationships are often life-long, the character of interactions changes according to life stage, circumstance, and

experience. Emotional development (Carstensen, 1992; Carstensen et al., 2000; Carstensen & Turk-Charles, 1994; Lang, 2001) and social comparison (Keyes & Ryff, 1999) are two factors that affect how an older adult views interpersonal relationships.

Emotional Development

Research into the psyche of older adults shows that emotional development continues throughout adulthood (Birditt & Fingerman, 2003; Carstensen, 1992; Carstensen et al., 2000; Carstensen & Turk-Charles, 1994; Friedman & King, 1994; Gross et al., 1997; Levenson, 1997; Patterson, 1995). Older adults feel emotions just as deeply as do younger, however they are also able to control them better. They feel negative emotions for a shorter period of time and experience positive emotions more frequently. This increased ability to manage emotion has a powerful effect on interpersonal relationships (Carstensen, 1992; Carstensen et al., 2000; Carstensen & Turk-Charles, 1994; Lang & Carstensen, 1994).

Ellen, Dan, and Joji speak about reuniting with their spouses as a happy occasion. They attribute this to having the time to focus on their spousal relationship. In some cases, participants refer to the long period of time being married as a comfort because they know each other very well.

Fran (page 127) remarks that whereas in the past she looked for happiness in material possessions, relationships have now come to the forefront. Consider Jim (67; see Learning to be In Relation, page 121) who was married four times. He states,

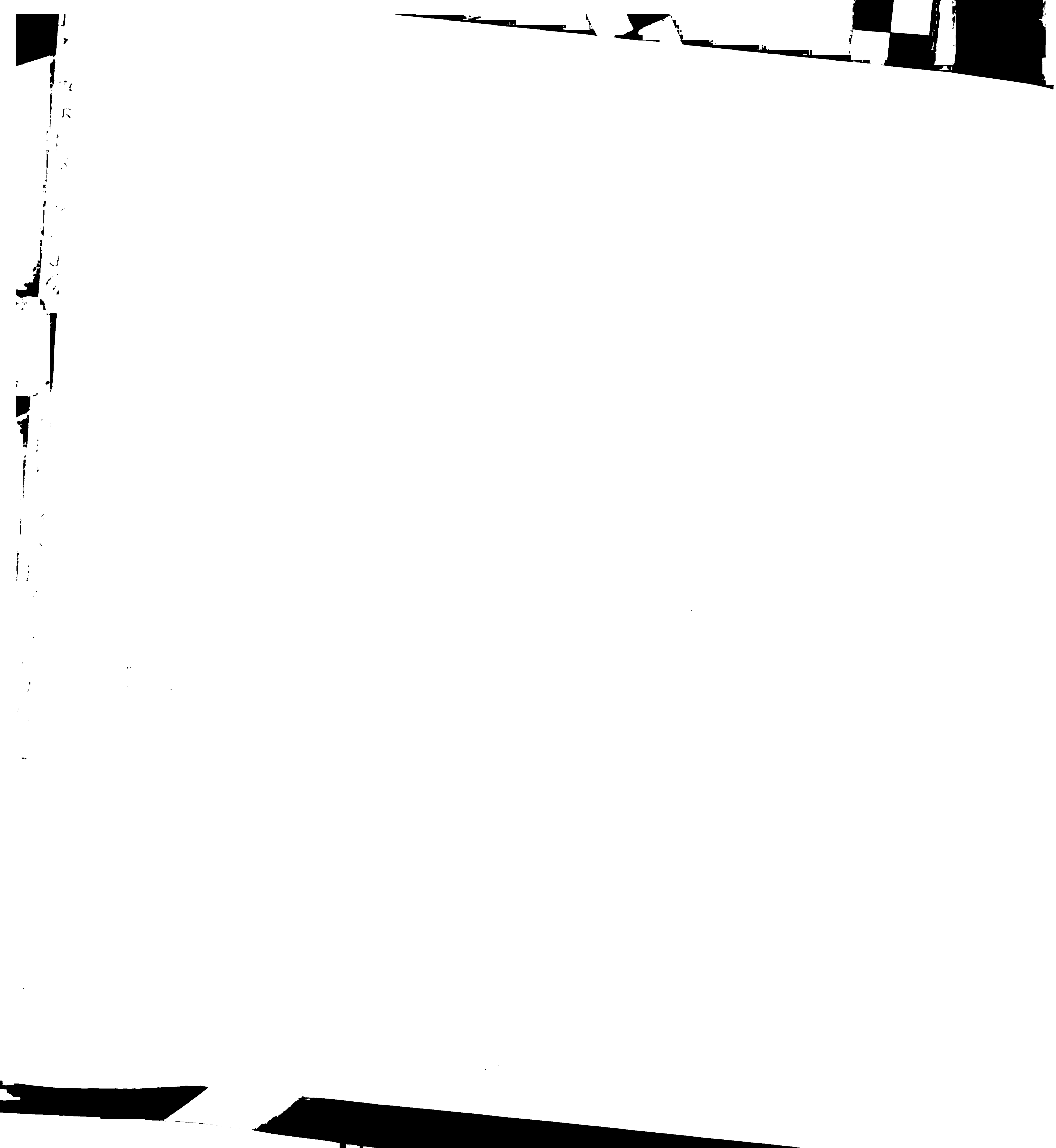
> A lot of other things that have seemed important to me during my middle age...are not important...the major change for me [with aging] is just being able to look at two competing things I need to be doing and decide to do that which is going to really bring me happiness, satisfaction.

Jim attributes this change to learning through his failed marriages. However, his ability to "choose his battles" may be the result of maturation rather than learning per se. It seems to be a theme common to many of the interviews, and no other participant speaks of having four marriages. Rodney (page 128), who has been married once, notices that he is more tolerant than he was in the past. He considers himself more likely to try to work out problems with his wife rather than "heading straight for a divorce." When Joe talks of his daughter marrying someone he does not care for, he declares, "I came to the conclusion that some things you have to let go or you don't survive." While this could be the result of learning, there could be an entirely different mechanism. Data support the fact that several cognitive processes change with age. An extended thinking process might enable a person to consider consequences more thoroughly before reacting to a situation.

In addition, the participants who speak of being more accepting of what life brings are also illustrating the ability to manage emotions and to hold negative emotions for a shorter period of time. Emotional maturation (Carstensen et al., 2000; Gross et al., 1997; Lang & Carstensen, 1994; Levenson, 1997) might affect adjustment to old age.

Social and Temporal Comparison

Keyes and Ryff (1999) define social comparison as a mechanism by which people evaluate and understand themselves by comparing themselves to each other (p. 175). In these interviews, making social comparisons was an important way that older adults used their relationships with other people to mark their progress through time. Aging is a



frontier, discovering each age as you reach it. Having others around you with whom to compare yourself is one way to evaluate your progress.

Temporal comparisons provide an enduring sense of self by comparing a single person at different points in time (Brown & Middendorf, 1996). It is a process by which a person adapts self image to perceived changes that occur over time (Brown & Middendorf).

Social Comparison

In general, people make comparisons that cast them in a favorable light (Suls, Martin & Wheeler, 2002). A recent study confirmed this finding in older adults. Frieswijk, Buunk, Steverink and Slaets (2004) examined the relationship between upward and downward social comparison to life satisfaction in 444 community dwelling older adults who had varying degrees of physical ability. In frail elders, upward comparison and downward contrast related positively to life satisfaction; whereas, upward contrast and downward identification related negatively.

The results of this study seem to support a relationship between life satisfaction and comparisons or contrasts in frail elderly. So, it did not distinguish whether the direction of the comparison increased life satisfaction or whether/how elders make comparisons or contrasts to adjust to changes of increasing disability. However, that people tend to make comparisons that portray themselves in a positive light is well accepted (Suls et al., 2002)

Making comparisons with someone who is much more accomplished tends to be demoralizing (Kwan, Love, Ryff, & Essex, 2003), so most comparisons show the subject in a favorable light. Comparisons made to someone close in ability are more likely to be motivating because a person can more easily identify with them. Consider Geraldine's (72) description of the interaction she had with an acquaintance at the pool (page 144). He and his wife had taken a bicycle trip to Belgium with Elderhostel. This interests Geraldine and

she assesses his similarities to her. He is about the same age and they both swim for exercise. Geraldine is a widow whereas her friend traveled with his wife. However, since this trip was with Elderhostel, she would have travel companions. She makes the assessment that she is capable of this. Geraldine explored a bicycle trip abroad with Elderhostel and one can imagine that she might ultimately go on such a trip.

However, if Geraldine found out that Lance Armstrong was leading bicycle trips to France, she might not be as enthusiastic about joining him. As a profession cyclist with unprecedented accomplishments, few young people can aspire to keep up with him, let alone a 72-year-old woman. It is easy to see that Geraldine would not be motivated to pursue such a trip.

Ideally, eliciting an upward comparison will induce the self-improvement motive, which can provide hope and inspiration (Suls et al., 2002). This principle operates providing the target sees the goal as achievable (Suls, et al.). A person whose abilities are close but slightly less than the comparison target is likely to strive to achieve the competence of the more capable model.

This principle could be used to motivate people to exercise, to learn new skills, or to accomplish a desired goal. Alternatively, this principle can serve to simply reaffirm an older person's normality by finding others with similar goals.

Temporal Comparison

Whereas some psychologists explain transitions in life as distinct phases (Erikson et al., 1986), others recognize that concepts of the self occur in the form of a narrative (Rosenberg, Rosenberg, & Farrell, 1999). The narrative explanation means that a person develops a story that accounts for change over time. Memory takes random events and

organizes them into a story around the themes they represent. This strategy renders a linear account that makes sense of transformation in thinking as an adult ages.

Rosenberg, Rosenberg and Farrell (1999) explored what they termed the "myth" of the midlife crisis. Although abundant research fails to document the existence of a distinct crisis in mid-adulthood, the concept persists in our culture. They surmised that the reason is that change, or human development, does not happen in a linear fashion. So, Rosenberg et al. hypothesize that the mid-life crisis is a strategy people use to make sense of and explain transformation over time.

These data reflect an abundance of temporal comparison between the self now as compared to earlier in life. Perhaps older adults use this same strategy to explain why their behavior changes as they age. A story puts a seemingly indefinable change into linear terms that we can explain and that others can comprehend. It could be that another factor, such as genetics or physiology, stimulates this change and that learning is the result rather than the cause. The story of learning from experience is an attempt to explain change; however, perhaps behavior changes in spite of experience.

In these data, Jim states that he has learned

Human psychological development has been well-studied in children and less so in later adulthood. While early studies focused on how parents affected children, later researchers look also at how children affect the parent's development. It is now generally accepted that adults continue to develop psychologically throughout the lifespan (Baltes et al., 1980).

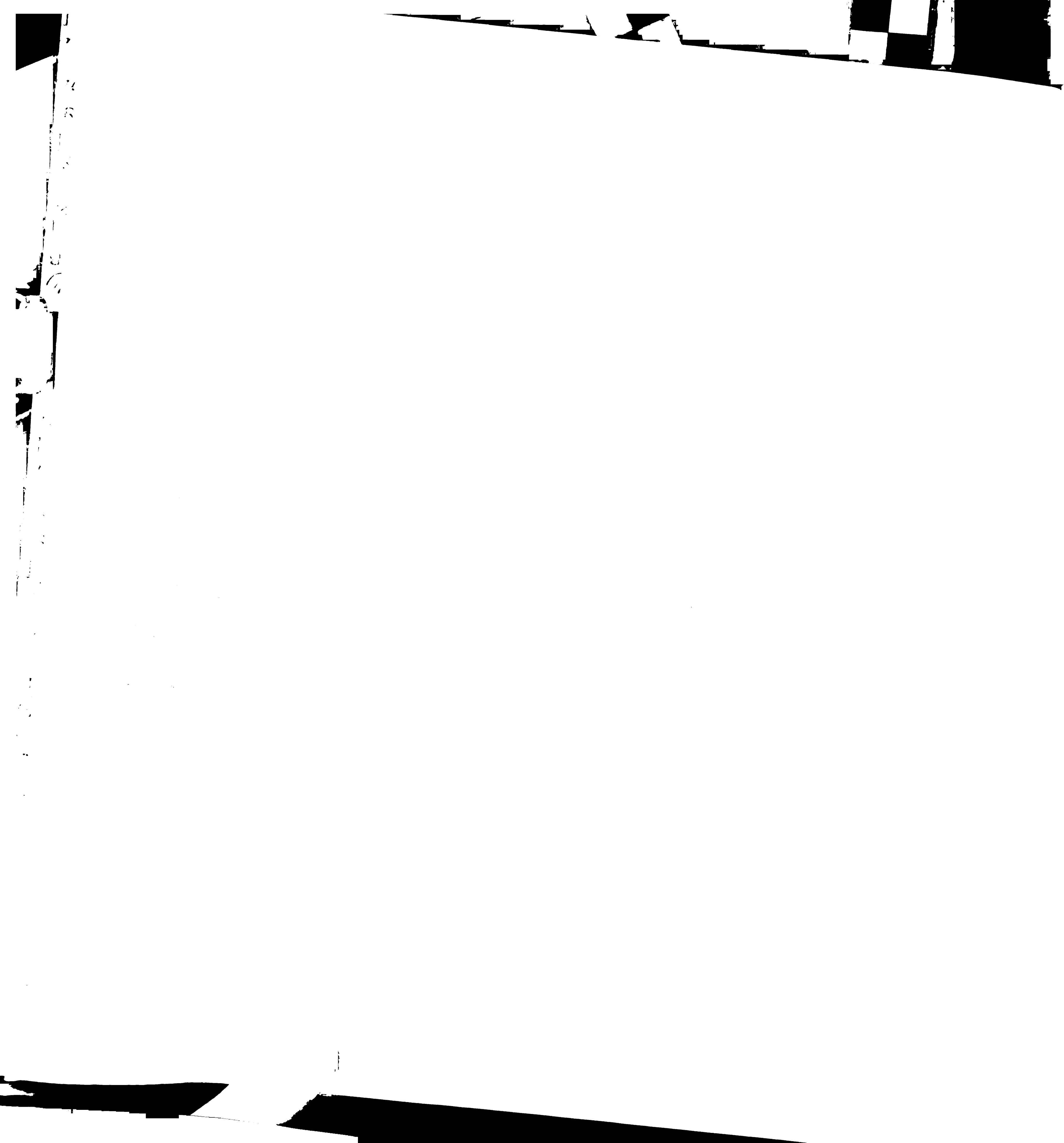
Gender Differences

The most obvious difference between men and women in later life is the discrepancy in their numbers. Gender and age are inversely related so that while the ratio of

men to women is 82.4 to 100 for those between the ages of 65-74, this ratio drops to 41 to 100 for those over age 85. As a consequence, a higher proportion of men are married than women (75% compared to 43%), leaving an excess of unmarried women. In addition, 45% of women over 65 are widowed, compared to 14% of men. Marriage is an important element of social environment; less than 5% of all those over age 65 have never been married (US Census Bureau, 2004). Both marriage status and being a widow affect both social relationships and well-being (Larson, 1978).

Gender role differences also are macro level factors. Traditionally, women are the primary care givers – for children, for older adults, and for spouses (Mercer, Nichols, & Doyle, 1989). This remained true through 2000, even as more women have entered the labor force. Young adults are creating family roles as the result of women's workforce participation. For example, the 2000 census showed that approximately 45,000 men or 2.3% of the male workforce, provided caregiving at home as a primary occupation as compared to 67,000 women, or 3.0% of the female workforce (United States Census Bureau, 2004). In 1950 this phenomenon was virtually non-existent. The women who are now over 60 have lived through a transformation in women's employment trajectory; in the next generation we may see the results of this change.

Workforce participation patterns for women born between 1926 and 1945 changed dramatically over the 30 years between 1950 and 1980. In the 1950s, women typically worked until the first child was born. Most remained out of the workforce while raising their children and some returned to paid employment once the children left home. In 1950, when the women in this study were aged 16-43, the work force participation rate for women between the ages of 16-24 was 43.9%. At age 25, the rate fell to 34%, and rose to 39% for ages 35-44 (Fullerton, 1999). By 1980, when the women in the ACS cohort were



aged 46-73, the rate of growth slowed. Between 1950 and 1980, percentages of employed women increased to 62% for 16-24 year olds, 65.5% for women 25-44, and then decreased to 60% for women 45-54.

This represents a growth rate of approximately 2.6% per year in workforce participation for women for the years between 1950 and 2000 (Toosii, 2002). In 2000, women represented 47% of the workforce, a growth rate of 0.7%. If projected to the year 2050, women will constitute approximately 48% (Toosii, 2002). So the rapid rate of change in workforce participation has slowed; however, this rapid flux of women into the workforce heralded shifts in home responsibilities, self-identity, roles, and household income (United States Census Bureau, 1995). The increase in women's workforce participation echoed other social changes, such as a decline in birth rates, an increase in the number of single women, later age of first marriage, and increased divorce rate (Toosii, 2002). Undoubtedly, these shifts in home responsibilities most likely affected SWB.

Working outside the home is associated with increased social integration in women. Moen, Dempster-McClain and Williams (1992) found that higher social integration in 1956, as measured by multiple roles, was related to higher self-rated health and better functional abilities in 1986. Furthermore, the women with more roles earlier in life had higher social integration late in life. This is significant because, in a meta-analysis of 286 studies on social support and SWB, Pinquart and Sorenson (2000) found that social integration was more closely linked to life satisfaction and happiness for women than for men ($p < .001$ for both). SES was strongly related to life satisfaction and happiness in men ($p < .001$ for both). Also, income was positively related to life satisfaction ($p < .05$) and happiness ($p < .001$) for men but was not a significant factor for women. Yet, overall, SWB is lower in older women than in older men (Pinquart & Sorensen, 2001).

The older women in this cohort typically worked before they got married, then quit to stay home with the children. However, within their young to middle-aged parenting years, the norm switched and most women worked outside the home. Consider these two quotes from Eileen (70). She relays a story about a woman she knew shortly after she was married. She says,

> There was a woman, a husband and wife, and they had a son who was a real problem, and we women would look at each other and say, 'well of course she was working' and 'what do you expect? She's not there to raise her child.' We really condemned her for being a working mother. It was very, very rare.

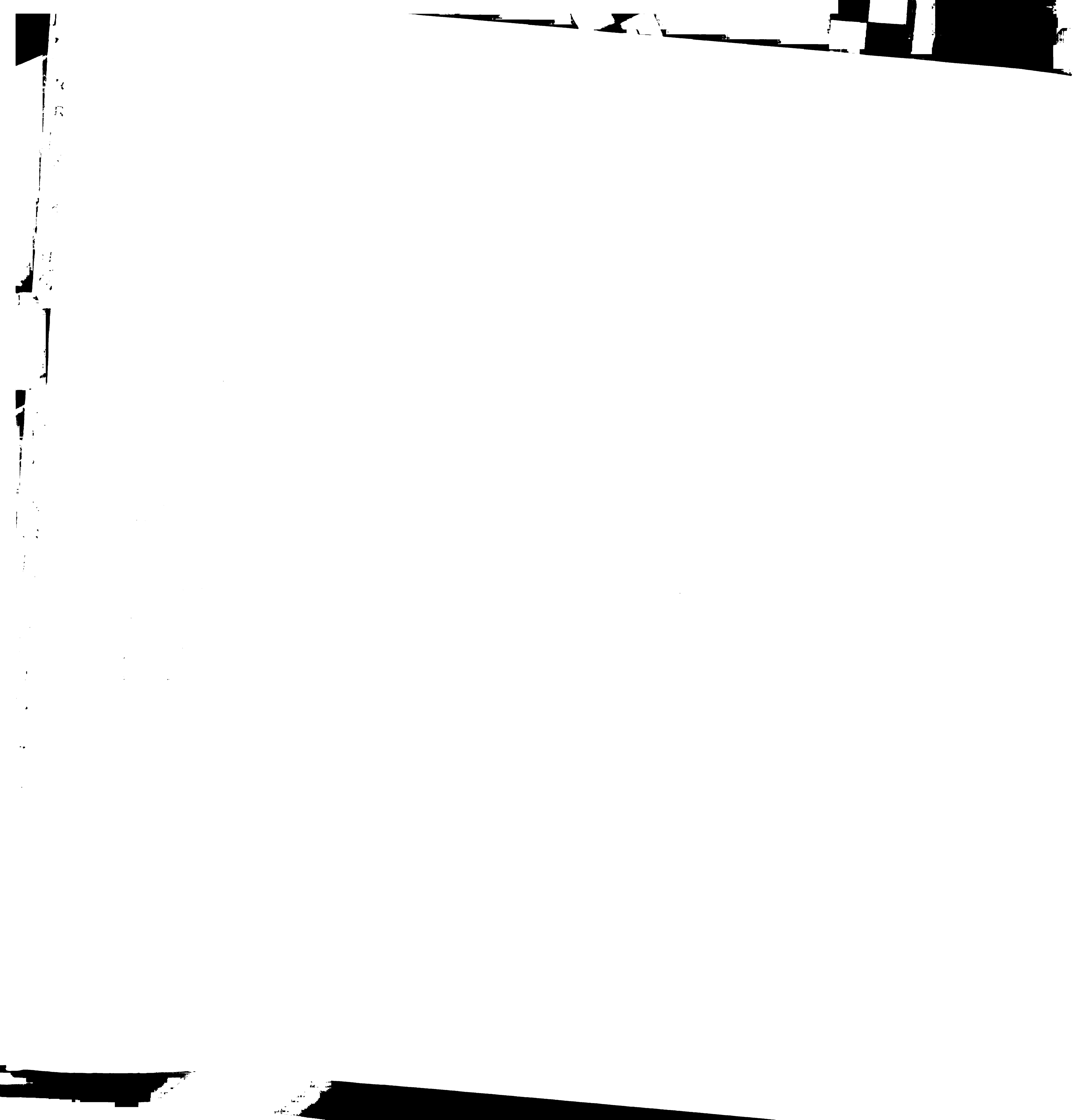
Eileen graduated from college around 1950 and immediately got married; children soon followed. She returned to graduate school 15 years later and became a teacher in 1969. By this time more women had entered the workforce and a career outside the home became normative in her social circle. She balanced homemaking with her career and so did all her friends. On page 147 Eileen remarks, "Now I don't know anybody, well I only know one woman who never worked." Later in the interview, she said this about her employment: "I had a very successful teaching career and it was wonderful. I had a great time." She is still teaching on a volunteer basis.

In some of the interviews, wives were mentioned as organizing their husband's medications and reminding them to go to the doctor. These functions can be defined as caregiving or instrumental (tangible) and emotional support. Literature shows that women are more often social network members than are men (Antonucci & Akiyama, 1987) and women are more often family caregivers (Christensen, Stephens, & Townsend, 1998; Hooyman & Gonyea, 1999; Sheehan & Donorfio, 1999; Walker, Pratt, & Eddy, 1995). Caregiving for adult family members and for grandchildren are roles know to be stressful

and to affect health and well-being (Baillie et al., 1988; Burnette, 1999; Christensen et al., 1998; Hooyman & Gonyea, 1999; Kelley et al., 1997; Walker et al., 1995). Another social change that is currently occurring is that men are beginning to take more responsibility for family caregiving (United States Census Bureau, 2004). A gender (female)-sensitive theory of aging well should include both women's work patterns and caregiving activities.

Recall that marriage is associated with longevity, but more strongly associated in men than in women (Berkman & Syme, 1979; Seeman et al., 1987). However, women bear the brunt of balancing work and home roles and have more inter-role generated stress. Since more women are working throughout their adult lives than in the past while more men are caring for home and family, one wonders how these shifting roles will affect health and well-being in the older adults of the future. Of note, the women in the sample who worked generally did not complain about working other than inter-role stress. Studies have shown working outside the home is related to better health and well-being in women (Giele, 1998; Moen et al., 1992).

Women's roles at home and work affect stress levels as well as the availability of social support. As previously discussed (page__), literature shows that women are more often social network members than are men (Antonucci & Akiyama, 1987). While one might surmise that a higher number of social contacts would temper stress, women are often family caregivers (Christensen et al., 1998; Hooyman & Gonyea, 1999; Sheehan & Donorfio, 1999; Walker et al., 1995). Caregiving for adult family members and for children are roles known to be stressful and to affect health and well-being (Baillie et al., 1988; Burnette, 1999; Christensen et al., 1998; Hooyman & Gonyea, 1999; Kelley et al., 1997; Walker et al., 1995). Who does the caregiving is another area of U.S. social life that is evolving because men are taking more responsibility for family caregiving (United States Census Bureau, 2004).



A Gender-Sensitive Theory of Aging Well

Im and Meleis (2001) propose six features of a gender-sensitive theory that considers women's health. Recall these six criteria from page 80:

- Has gender as a basic feature and a central agenda;
- Composed of women's own voices and experiences;
- Includes the diversity of women's experiences;
- Reflects on theorists' own androcentric, ethnocentric, and ageist assumptions;
- Considers the sociopolitical context; and
- Includes empowerment guidelines for raising consciousness and to guide activism.

None of the current theories of successful aging or aging well meets these criteria. In view of the data here reflecting that family connections are central to how women organize their lives, a truly representative theory of aging well would include features of social relationships. In particular, it would address issues of balancing family life with outside activities and the caregiving role of women. It is likely that caregiving will significantly impact men's SWB in the future as men broaden their domestic roles.

Cohen and McKay (1984) postulate that social support alters stress either by decreasing the experience of the stress or changing the response to stress. Among middle aged and elder adults in the U.S. today, men tend to have lower levels of well-being if they feel dependent upon their wives (Huyck, 1999). However, as the normality of women working outside the home becomes inculcated in U.S. society, perhaps this will change and it will become normative for men and women to share caregiving and earning a living.

Perhaps the support they give each other will temper the stress and increase well-being for both.

Discussion Summary

The purpose this dissertation was to explore what characteristics of social relationships in older adults promote or hinder well-being. Specifically, the research questions were the following:

- What are the qualities of social relationships that older adults describe (in the context of interviews on successful aging)?
    - What types of relationships are described?
    - How do older adults describe their relationships with others, such as kin, peers, neighbors, friends, and paid helpers?
    - How do they describe the characteristics of relationships that promote or hinder well-being?
- Is there a gender difference in the description of relationships?
    - Do older women describe different qualities in relationships than do older men?

To summarize the findings, older adults in this sample describe relationships with children and their spouses, especially the characteristics of family relationships in late life. They are still actively parenting, although the form of that parenting has changed from earlier in life. They recognize their children as adults, although generational differences remain. Parenting is a source of satisfaction for most of the participants. The freedom from maintaining a family that came with retirement and/or children leaving home was generally a

welcomed release and contributed to life satisfaction. Being relatively free from day to day pressures allowed couples to rekindle their relationship.

In addition, older adults use people in their social networks as a point of comparison by which they measure themselves. Comparisons allow self-image to adjust with changes over time. These participants, as is typical, tend to utilize comparisons that portray themselves in a positive light. Comparison is a potential source of identity, self-esteem, motivation, self-efficacy, and coping. These mechanisms correspond to the *pathways to health* in the SIHC (Figure4 Appendix 6 page 239). Because comparison is used in this manner, the strength of these pathways is somewhat dependent upon the social network. Social network affect SWB because the nature of available comparisons.

As this sample reflects, this generation of women was the first to combine employment with homemaking in significant numbers. Even when employed outside the home, the women's primary focus was on their families. Many of the men fought in World War II and returned to be the major source of financial support for a nuclear family. Some women monitored their husband's health, whereas the women in this sample did not mention their spouses doing the same for them. The men commented more often than the women that they enjoyed their relationships with their wives after retirement. These data shed some light on the subjective experience of aging in the context of social relationships. They lead to some implications for how social connections can be optimized for the benefit of older adults.

Limitations

Because these interviews were collected for a different project, the questions did not focus on interpersonal relationships nor did the interviewers necessarily follow-up when participants volunteered information on interpersonal relationships. These were individual

interviews, so the content of the responses are the participant's perception of interpersonal relationships. There was no observation in this investigation, other than the field notes collected by the interviewer.

The participants for these interviews are volunteers. As such, they may be more physically or cognitively fit than those who did not volunteer. They may also have more extroverted and gregarious personalities than those who did not volunteer. In addition to volunteering for the interview, they have participated in the ACS for four decades. It is impossible to know how this sample may differ from one that would be selected from the current population of Alameda County.

Although the participants of the ACS reflected the ethnic mixture of Alameda County in 1965 when the study began, the sample consists mainly of EAs. The sample is not reflective of the diversity in Alameda County today. In the sample interviewed, there were not enough participants of any ethnic group other than EAs to have a representative sample. In addition, because data on socioeconomic status is not available, conclusions cannot be drawn regarding the effect of SES on respondents' responses to the questions. SES could have a profound effect on how older adults view aging.

This study did not consider the role of physiology in regulating social relationships or behavior. This is a blossoming area of inquiry that lends an entirely different perspective to interpersonal relationships and affective states. For example, Bloor, Uchino, Hicks and Smith (2004) found that women showed greater cardiovascular reactivity while discussing negative relationships that did men. This line of inquiry will undoubtedly uncover more associations between physiology and social interaction in the future.

The age range of participants is from 65 to 93. There were not sufficient numbers of any members of specific age groups to draw conclusions about the differences

between someone aged 65 compared to a person in his or her 90s. Since most of the participants are in their 70s, the results primarily describe this decade. Despite these limitations, this study provides some interesting insights that have implications to consider as the population ages.

Implications

In concert with the social integration and health continuum (SIHC), there are implications of this study at both the contextual and the personal levels. The types and frequency of social interactions depend upon resources available in the environment, such as neighborhood characteristics, history, culture, gender identity, and physical barriers to social interaction. The resources in the environment determine the social network, which influences the personal level factors. Personal level factors include expectations, personal history, personality, motivation, and self-esteem. Health is a major factor cited by the participants that influences this ability. Interventions at any level can enhance social interaction and influence SWB in elders.

Environmental

Social competence or the ability to get out and make social contacts, was a recurrent theme in both the interviews and the literature. However, there are also environmental barriers. For example, the availability of transportation is critical to making person-to-person contact. Types of community resources available limits or expands opportunities. An understanding of the diverse nature of older adults can stimulate creation of programs for seniors that meet the needs of many rather than a few. Knowledge and acceptance of marginalized groups increases the freedom of more individuals to seek social contact. Aside from enhancing the health of the individuals, the inclusion of greater

diversity increases the diversity of the network and results in more resources being available to everyone (Cattell, 2002).

Ideally, each community would have an affordable, effective system of transportation available to well and disabled seniors because being able to get out and make social contacts is an element of social competence. When health or geography precludes direct interaction, technology such as the telephone, computers with Internet connection, radio, and new modalities the future will bring are areas that deserve attention as critical to physical and mental health. Recall that the emotional support is cited as essential to SWB by many authors and some feel is the most important type of support (Ryff & Seltzer, 1996; Weiss, 1974). Emotional support can be offered through many modalities other than personal contact, such as telephone, Internet, and shortwave radio.

In addition, the seniors in this study did not portray themselves as passively receiving, but as being engaged with active social exchange. It is imperative that elders have a mechanism for contributing to others. One role many older adults enjoy is that of mentor. One must be long lived in order to amass extensive experiences and passing on this knowledge is a unique gift elders can give to younger adults and children. Mentoring gives them the opportunity to pass on what they have learned over a long life to others who can carry the knowledge to the future. Additionally, the elders will perhaps benefit because intergenerational activities will temper some of the stress of losing peers.

The participants in this study have a variety of interests and express the desire to remain engaged with life. Many spoke of being with people of different ages. As Ernie states on page 139, he no longer wanted to attend the retirement group through his former profession because, "there are too many old people here." In developing senior centers and residences, we place elders with each other with the best of intentions—that they will find a

place where they can meet peers and have activities geared toward the interests of "old people." The problem with this is that although John may have the body and physical skill of an 80-year-old, he may have the interests and analytic skills of a 20-year-old. Older people are more diverse than are younger and have a variety of interests fed by a rich social environment.

Personal Level Implications

Contrary to the common belief that older adults are set in their ways, the third age is a dynamic developmental stage requiring constant adaptation. Elders must adapt to a changing society, losing peers, leaving a profession, creating a new relationship with their spouse and children, and births and marriages resulting in a growing family in addition to changing health and physical function. Some older adults relish the challenge.

It is important to recognize that as much as an elder they might look like he or she needs assistance, most value their independence. A mechanism for reciprocation should be an integral part of any assistance program for the elderly. The elder might give the caregiver an item, share a story, teach a skill, or provide emotional support. Generous younger adults who assist seniors need to recognize that altruism can reap feelings of dependency on part of the receiver and lead to psychological distress.

Research Implications

This was an exploratory, descriptive secondary analysis of a set of interviews with older adults designed to extract what they say about interpersonal relationships in the context of talking about aging well. It introduced many questions about transitions, family relationships, and how aging affects them. This section will discuss some possible areas of research for the future.

Future Areas of Research

This research opens the door to further study in many aspects of social ties in later adulthood. Possible areas of inquiry include sense of self, marriage, intergenerational relations, transitions, perception and acceptance of death, support in single elders, childless elders, support in chronic disease, and especially minority and LGBT elders.

One interesting observation about the overall interviews is that the participants described the best parts of aging differently from the indicators that a person is aging successfully. This may be that the participants did not think of the word "successful" when they considered what they wanted from life as an older adult.

Transition from Middle Age to Late Life Parenting

Another striking characteristic is how much the participants talk about their children. This emphasizes that parenting is never completed. Beginning with the concept of self, one of the more compelling issues is how the older adult transitions from the middle age parent to the older adult parent to the very old parent.

Another area of study would be to identify and describe further the parenting styles of older adults and identify cultural and ethnic differences. Consider Robert (72) who stated that he did not feel a release from the constraints of what others think as he ages. He felt a responsibility to be a role model for his children and grandchildren. Yet, Robert did not feel he was aging successfully. Are his close ties to his family and the continuing concern about what they think of him a sign of inadequate separation from his children? Or is it a cultural difference?

Other Close Relationships

Discussing the characteristics of parenting in late life stimulates interest in close relationships in those without children. Investigating the relationships childless older adults

is an important line of study as the number of people choosing not to have children increases.

Being close to others has its advantages, but closer relationships also foster conflict. There is generally more tension between two people who are close than there are between those with more loose ties (Fingerman, 1996). This does not imply that relationships that have a degree of tension are inherently harmful. Although Robert does not exemplify tensions in his interview, he describes an intense need to act as a role model. It is possible that these tensions exist. Studying tensions in family bonds and the association to SWB deserves further study.

Support After Stroke

Stroke is a major medical illness, often with life-long consequences. Social support is an important element in recovery. The results of this study can be applied to a support group for stroke survivors, both as a clinical application and as a potential area of research.

Because permanent disability is not uncommon, a person who sustains a major stroke must go through a reassessment of the self.. One observation this researcher has made is that people who have had a stroke compare their progress with their functionally ability prior to the stroke rather than noticing improvement day by day. Benchmarking is a technique that has been used to assist stroke victims to monitor progress (Gubrium, Rittman, Williams, Young, & Boylstein, 2003).

These data indicated that family ties are very important to elders. Older adults fill valuable roles and are likely to give as well as receive. A research project could be designed to measure the benefit (less depression, higher function) of teaching family to assist the

stroke survivor benchmarking as a way to direct comparisons in a way that will improve self-esteem and enhance motivation.

Conclusion

The older adult participants in this study belie the image of old age as a period of decline and death. Rather than being mournful that the children have left the home, they rejoice in their freedom to use their time as they wish and to discover new frontiers. However, their children still occupy a central place in their lives.

Rather than being set in their ways, older adults must adapt to more changes than perhaps at any other time in their lives. They have to reinvent parenting and rejuvenate spousal and other close relationships. They need to set new goals for career or hobbies and implement a plan. They must adjust to the loss of many loved ones and life-long associates.

Interpersonal relationships in later adulthood hold much potential. While emotions are felt just as deeply as they are earlier in life, they are easier to manage. Other people's actions are seen more in perspective of their importance (or lack thereof) in a broader view of the relationship. Rather than taking action based on expectations or ego, older adults have learned to pick their battles to maximize the benefit from the relationship.

Sometimes old skills are applied to a new situation, such as using WWII radio skills to create a "Cracker Barrel Net." A long life means time to amass experience to apply to the current life situation and to pass on to future generations to make their lives better. Older adults contribute to the betterment of society.

Old age is the only time in life when a person can reap the benefits of long-lived relationships. Growing older is moving into a vibrant phase in which any aspect of interpersonal relationships can be recreated into a new adventure. Later adulthood is an era to anticipate, a time of potential. The last phase of life can be what we make of it.

Glossary

Appraisal support occurs in situations in which a person turns to others to determine if a threat exists. Appraisal support alters one's assessment of thereat on one's ability to cope (Cohen & McKay, 1984) p. 256-257.

Cohort – a group of people within a population who have experienced the same significant event within a specified period of time (Tootsie, 2002). In this study, the cohort is those born between the years 1907 and 1934 and living in Alameda County, California in 1965.

Competence the skills needed to manage everyday life (Pinquart and Sorenson, 2000, p. 188). Social competence refers to the skills necessary to acquire and maintain interpersonal relationships.

The Convoy Model Many of the studies use the convoy model to collect data and discuss findings. The convoy model heuristic consists of three concentric circles surrounding a target individual. Each person is thought to be moving through life surrounded by a group of people with whom he or she is related through the exchange of social support (Kahn & Antonucci, 1980). Each successive circle represents social connections that are progressively close to the individual. The term convoy is used rather than network to capture both the protective and dynamic nature of the social network as it accompanies the individual over the life span. A convoy travels with a person throughout her life, modulating in size and character based on attachment needs and role fluctuations throughout the life span. The convoy encompasses the context of a person's life and ties childhood with adulthood because the character of adult life, including stressors, is dependent upon personal history as well as social context (Kahn & Antonucci, 1980; Levitt, 2000).

Embeddedness—"The connections that individuals have to significant others in their social environments." (Barrera, 1986, p.415) Social embeddedness refers to the quality, including the depth and the strength, of relational ties people have with significant others within their social network (Lansford et al., 1998)

Happiness –one indicator of emotional health (Pinquart & Sorenson, 2000, 2001a,b).

Life satisfaction – a positive evaluation of one's life situation (Piquart & Sorenson, 2000)

Older Adult--Any designation of an age at which old age begins is arbitrary. There is precedence in the literature for defining older adulthood as early as age 50 (Friedman & King, 1994; Levitt, Antonucci, Clark, Rotton, & Finley, 1985b) and as late as age 75 (Hazzard, 1997). This project will use the term older adult or later adulthood as that period in life after the age of 60. The term old-old means those aged 80 and greater.

Qualitative Description – Sandelowski (2000)

Self-esteem – a cognitive evaluation of the self (Pinquart and Sorenson, 2000).

Social capital is defined as "resources produced when people cooperate for mutual benefit" (Cattell, 2001, p. 1502).

Social climate -- Social climate is defined as the nature of the environment, including the experience of helpfulness and protection. Social climate grows out of one's network and embeddedness and results in social competence (Langford et al., 1997).

Social Comparison states that people understand experiences and evaluate themselves by comparing themselves to others (Keyes & Ryff, 1999) p. 175.

Social competence includes social skills required to develop and maintain relationships (Bedford et al., 2000) as well as the physical ability to make social contact (Pinquart & Sorensen, 2000). Social isolation is the result of inadequate social competence.

Social connections Social connections are relationships, meaning any interaction between one person and another. That interaction may be a brief, chance encounter or weak tie (as when two strangers chat while waiting for a bus) or an intimate, long-term affiliation, sometimes called strong ties (such as marriage; Norbeck, 2002, personal communication).

Social Control theory posits that behavior is managed in a social environment by pressures placed on the subject by others in the network (Rook, Thuras,& Lewis, 1990, p.). Social control in the health domain refers to regulatory attempts by others (direct), and feelings of obligation and responsibility to others (indirect), that encourage engagement in a healthy lifestyle (Tucker, 2002, p. 59)

Social exchange – "the reciprocal dimension of social support networks, by which one may assess not only perceived support from others but also the extent to which an individual perceives him or herself as giving assistance, advice and emotional and other forms of support to other persons." (Minkler, Satariano, & Langhauser, 1983, p.213)

Social Influence the way members of a social network obtain normative guidance about health-relevant behavior, such as smoking (Kawachi & Berkman, 2001) p. 459.

Social Integration – The degree to which a person has access to interpersonal interaction and other social resources.

Social support The phrase social support connotes that the connections are positive and perhaps a more precise term would better explain the phenomenon. However, social support is the conventional term in the literature. Social support, relationships, and social connection will be used interchangeably in this discussion. There is no assumption made that these encounters are wholly positive or negative; most relationships include both support and conflict. Social Support

Social support signifies the reciprocal exchange of assistance and protection—both tangible and intangible positively related to psychological well-being (Berkman & Syme, 1979; Langford et al., 1997; Pinquart & Sorensen, 2000). There is ample evidence that not all social connections are beneficial (Fingerman, 1995, 1996; Rook, Thuras & Lewis, 1990).

Medline defines social support as; "Support systems that provide assistance and encouragement to individuals with physical or emotional disabilities in order that they may better cope"(Medline as accessed through PubMed, November 28th, 2002). This definition assumes that social support exists only when there is a stressor that the individual is unable to manage on his own, but the proposition of this chapter is that social support exists within a network and exerts main effects and buffering effects on stress to create well-being throughout life.

Social network "Social networks are the collection of interpersonal ties that people of all ages maintain in varying contexts." (Litwin, 2001, p. 516) Support network and social network will be used synonymously, although this is not meant to imply that all aspects of the social network are supportive.

Well-being Psychological well-being has three primary domains: positive affect, absence of negative affect and life satisfaction: taken together, these factors comprise subjective well-being (SWB; Diener, 1984). Positive affect and negative affect may at first glance seem mutually exclusive. Studies show that although positive and negative affect cannot exist in the same person concurrently, the frequency and intensity of these emotions over time have an independent influence on well-being (Diener, 1984).

Appendix 1

Table 2
Sample Demographics

Pseudonym	Sex	Age	Race	Marital Status	Children	Education	Employment
Eileen	F	70	W	D	2	17	1
Gregory	M	76	W	M	2	17	1
Ellen	F	67	W	M	5	12	2
Mary	F	76	W	W	2	17	2
George	M	66	W	N	0	14	2
Ruth	F	74	B	M	5	16	2
Margery	F	72	W	W	7	16	3
Robert	M	72	B	M	3	17	2
Geraldine	F	72	W	M	6	16	2
Jim	M	67	W	M	3	17	1
Bonnie	F	83	W	W	2	15	2
Sarah	F	80	B	M	4	13	2
Catherine	F	80	B	D	9	03	2
Randall	M	80	W	M	2	17	2
Bradford	M	72	W	M	0	17	2
Beatrice	F	93	W	W	2	13	3
Nancy	F	73	W	M	5	13	2
Fran	F	69	W	M	0	12	2

Pseudonym	Sex	Age	Race	Marital Status	Children	Education	Employment
Rodney	M	76	W	M	3	12	2
Pearl	F	67	A	W	1	10	2
Marta	F	82	W	W	6	07	2
Bernice	F	73	B	D	7	12	2
Perfecta	F	79	H	W	2	07	2
Martin	M	90	W	W	2	12	2
Milton	M	92	W	M	0	13	2
Mildred	F	71	B	M	3	12	2
Shirley	F	67	W	M	1	14	2
Kevin	M	86	W	W	0	12	2
Thomas	M	80	B	M	3	06	2
Ethan	M	80	B	W	3	14	2
Charles	M	75	B	W	3	12	2
Theresa	M	66	W	M	2	16	1
Constance	F	78	B	W	1	04	2
Barbara	F	77	B	M	0	14	2
Simon	M	82	W	W	2	12	2
Grace	F	71	W	W	5	12	2
Ernie	M	73	W	M	2	12	2
Emily	F	85	W	M	2	12	2
Dan	M	77	A	M	3	12	2

Pseudonym	Sex	Age	Race	Marital Status	Children	Education	Employment
Karen	F	78	W	W	2	12	2
Juan	M	72	H	M	3	13	2
Sam	M	76	W	M	3	12	2
Amparo	F	72	H	W	4	08	2
Donna	F	81	W	M	4	17	2
Louise	F	78	W	W	2	08	3
Timothy	M	73	W	D	3	12	2
Joe	M	69	W	M	3	12	2
Joji	M	71	A	M	4	17	2
Murray	M	68	NA	M	2	12	2

Marital Status	Employment
M-Married S-Separated D-Divorced W-Widowed	1-Currently employed 2-Not now, but formerly employed 3-Never been employed
	.
Educational Level	Children
Last grade completed	Total natural and adopted

Appendix 2

Interview Questions

1. (Best) When you wrote about what you thought was the best part about getting older you mentioned _______________. Can you tell me more about this? How did you come to this answer?

- Are there other "bests" you could add?
- Some people have said that one good thing about getting older is being released from some of the constraint and judgments that they experienced when they were younger. How do you feel about this?

2. (No best parts) In the question that asked about the most difficult part of getting older, you said there were no best parts. Can you tell me more about this?

- Some people have said that one good thing about getting older is being released from some of the constraints and judgments they experienced when they were younger. How do you feel about this?

3. What is it about getting to the age ____ that allows one to give up the need to meet the expectations of other people?

4. When you wrote about what you thought was/were the most difficult part of getting older, you mentioned ____. Can you tell me about this? How did you come to this answer?

- Are there other aspects you feel are difficult?

5. When some people write or talk about aging, they use the words "successful aging." If you read or heard this, what would it mean to you?

- What would someone be like if they were aging successfully?
- What would successful aging involve for you?

6, (With Chronic Illness) You mentioned that you had the chronic condition(s) of

_________. How does this condition affect how you perceive successful aging?

7. (WITHOUT CHRONIC ILLNESS) how do you think that having a chronic condition such as heart disease or diabetes would influence how you currently experience aging?

- Would having a chronic condition influence how you currently think about aging successfully?

8. Sometimes when people are asked how things are going they say things are "in control." What is it that allows you to have the sense that things are in control?

- Can you tell me the difference between the sense of control and being in control?
- Some people say that having a sense of control and things being manageable mean the same thing. How are they the same of different for you?

9. The last question on the survey asked about changes you would make if you had your life to live over. You mentioned that you _____. Tell me more about your answer.

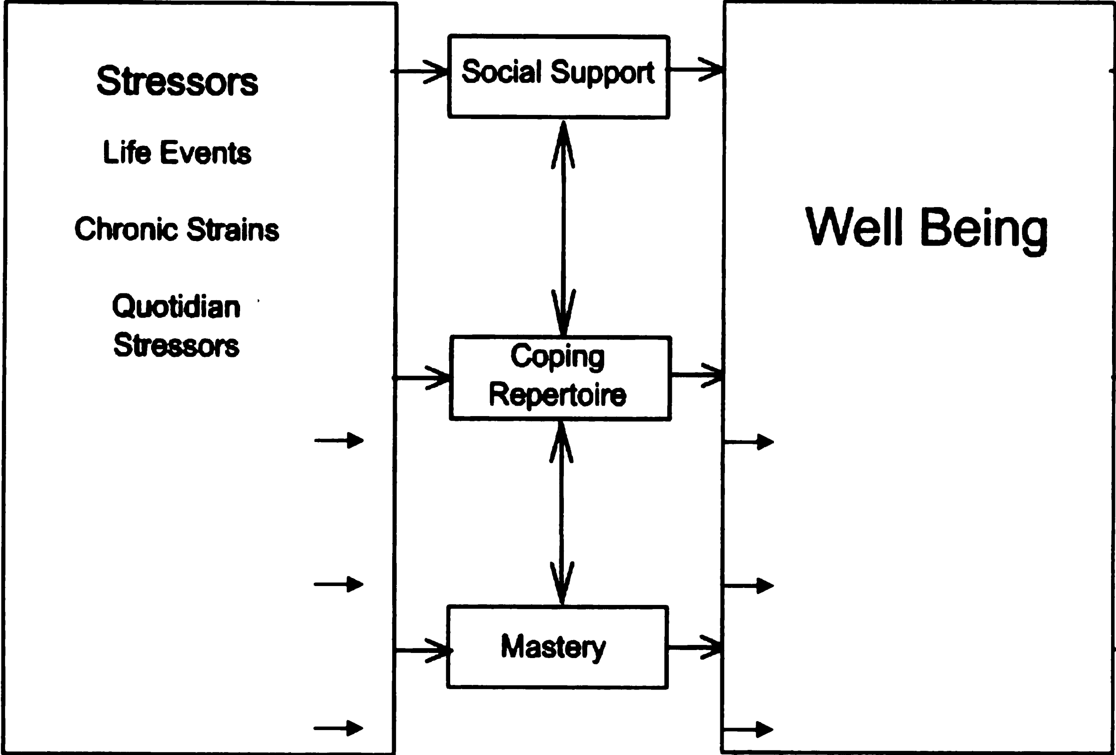
- What kind of feeling do you get when you think about this question and your response?
- How does this currently affect how you feel about aging?

10. If you were conducting this interview, what other questions would you ask?

Thank-you.

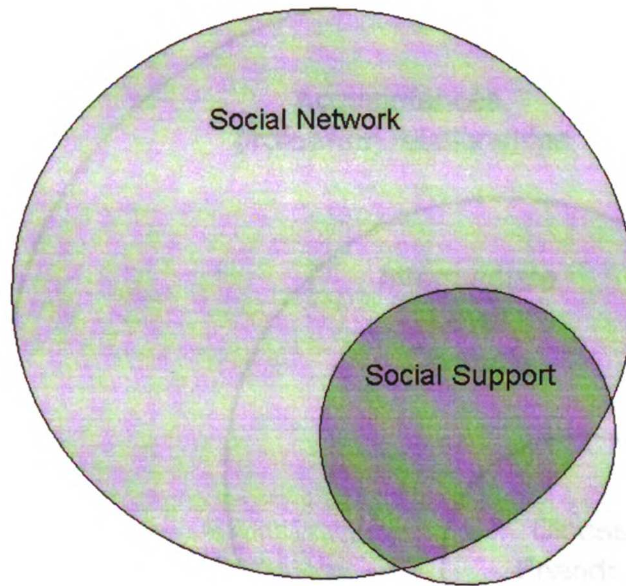
Appendix 3

A Sociological Model of Stress
Adapted from Pearlin LI (1989)



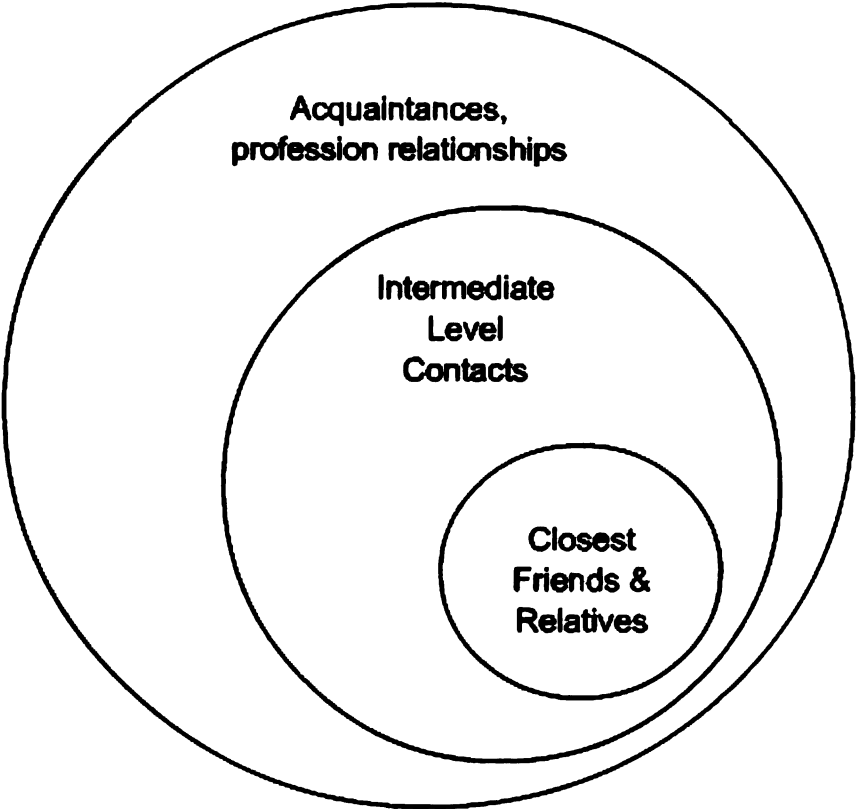
Appendix 4

Social Network and Social Support



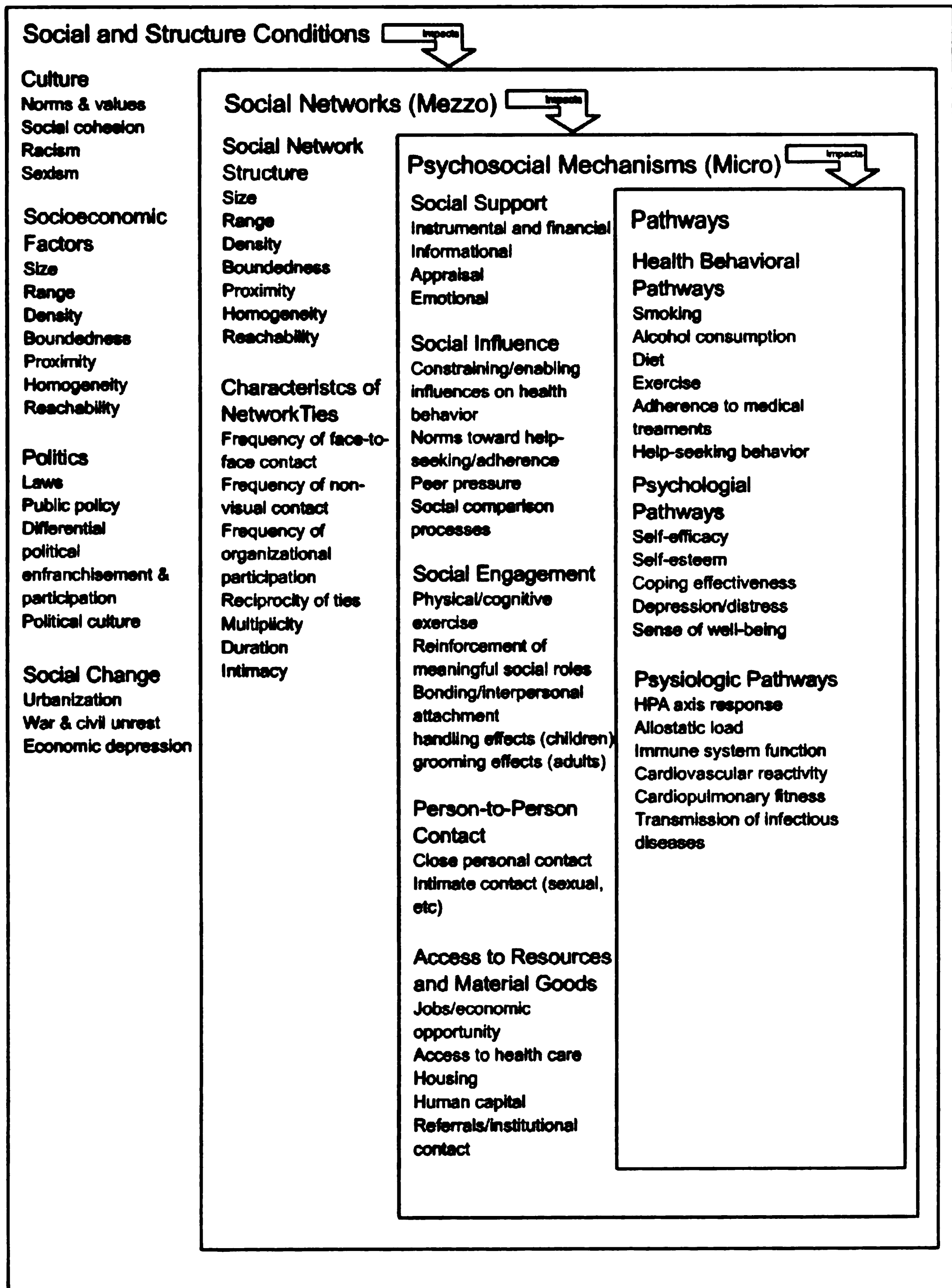
Appendix 5

The Convoy Model



Appendix 6

The Social Integration and Health Continuum



References

Adelman, M. (1990). Stigma, gay lifestyles, and adjustment to aging: a study of later-life gay men and lesbians. *Journal of Homosexuality, 20*(3-4), 7-32.

Administration on Aging. (2003). A Profile of Older Americans: 2003. Retrieved May 8, 2003, from www.aoa.dhhs.gov/aoa/STATS/statpage.html

Akiyama, H., Antonucci, T., Takahashi, K., & Langfahl, E. S. (2003). Negative interactions in close relationships across the life span. *Journal of Gerontology B Psychological Science and Social Science, 58*(2), P70-79.

Antonucci, T. C., & Akiyama, H. (1987). Social networks in adult life and a preliminary examination of the convoy model. *Journal of Gerontology, 42*(5), 519-527.

Attias-Donfut, C. (2001). The Dynamics of Elderly Support: The transmission of solidarity patterns between generations. *Zeitschrift fur Gerontologie und Geriatrie, 34*(1), 9-15.

Baillie, V., Norbeck, J. S., & Barnes, L. E. (1988). Stress, social support, and psychological distress of family caregivers of the elderly. *Nursing Research, 37*(4), 217-222.

Balfour, J. L., & Kaplan, G. A. (2002). Neighborhood environment and loss of physical function in older adults: evidence from the Alameda County Study. *American Journal of Epidemiology, 155*(6), 507-515.

Baltes, P. B., & Baltes, M. M. (1990). Psychological perspectives on successful aging: The model of selective optimization with compensation. In P. B. Baltes & M. M. Baltes (Eds.), *Successful aging: Perspectives from the Behavioral Sciences* (Vol. 4). Cambridge: Cambridge University Press.

Baltes, P. B., Reese, H. W., & Lipsitt, L. P. (1980). Life-span developmental psychology. *Annual Review of Psychology, 31*, 65-110.

Barnett, R. C., Kibria, N., Baruch, G. K., & Pleck, J. H. (1991). Adult Daughter-Parent Relationships and Their Associations with Daughters' Subjective Well-Being and Psychological Distress. *Journal of Marriage and the Family, 53*(February 1991), 29-42.

Barrera, J. M. (1986). Distinctions between social support concepts, measures and models. *American Journal of Community Psychology, 14*, 413-445.

Bassuk, S. S., Berkman, L. F., & Amick, B. C., 3rd. (2002). Socioeconomic status and mortality among the elderly: findings from four US communities. *American Journal of Epidemiology, 155*(6), 520-533.

Bearon, L. B. (1996). Successful aging: What does the good life look like. Summer 1996 Volume 1 Number 3. Retrieved May 18, 2002, from www.ces.ncsu.edu/depts/fcs/pub/aging.html

Bedford, V. H., Volling, B. L., & Avioli, P. S. (2000). Positive consequences of sibling conflict in childhood and adulthood. *International Journal of Aging and Human Development, 51*(1), 53-69.

Bengtson, V. L. (1973). *The Social Psychology of Aging.* New York: The Bobbs-Merrill Company, Inc.

Bengtson, V. L., & Allen, K. R. (1993). The Life Course Perspective Applied to Families Over Time. In P. G. Boss, W. J. Doherty, R. LaRossa, W. R. Schumm & S. K. Steinmetz (Eds.), *Sourcebook of Family Theories and Methods: A Contextual Approach* (pp. 469-498). New York: Plenum Press.

Bengtson, V. L., Burgess, E. O., & Parrott, T. M. (1997). Theory, explanation, and a third generation of theoretical development in social gerontology. *Journal of Gerontology Social Sciences, 52b*(2), S72-S88.

Berkman, L. F., & Breslow, L. (1983). *Health and Ways of Living: The Alameda County Study.* New York: Oxford University Press.

Berkman, L. F., & Glass, T. (2000). Social Integration, Social Network, Social Support, and Health. In L. F. Berkman & I. Kawachi (Eds.), *Social Epidemiology* (pp. 137-173). New York: Oxford University Press.

Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. (2000). From Social Integration to health: Durkheim in the new millennium. *Social Science & Medicine, 51*, 243-257.

Berkman, L. F., & Kawachi, I. (2000a). A Historical Framework for Social Epidemiology. In L. F. Berkman & I. Kawachi (Eds.), *Social Epidemiology* (pp. 3-12). New York: Oxford University Press.

Berkman, L. F., & Kawachi, I. (Eds.). (2000b). *Social Epidemiology.* New York: Oxford University Press.

Berkman, L. F., & Syme, S. L. (1979). Social networks, host resistance, and mortality: a nine-year follow-up study of Alameda County residents. *American Journal of Epidemiology, 109*(2), 186-204.

Beyene, Y., Becker, G., & Mayen, N. (2002). Perception of aging and sense of well-being among Latino elderly. *Journal of Cross Cultural Gerontology, 17*(2), 155-172.

Birditt, K. S., & Fingerman, K. L. (2003). Age and gender differences in adults' descriptions of emotional reactions to interpersonal problems. *Journal of Gerontology B Psychological Science and Social Science, 58*(4), P237-245.

Bleisner, R., Mancini, J. A., & Marck, L. I. (1996). Looking Back and Looking Ahead: Life-course Unfolding of Parenting. In C. D. Ryff & M. M. Seltzer (Eds.), *The Parental Experience in Mid-Life* (pp. 607-637). Chicago: University of Chicago Press.

Bloor, L. E., Uchino, B. N., Hicks, A., Smith, T. W. (2004). Social relationships and physiological function: The effects of recalling social relationships on cardiovascular reactivity. *Annals of Behavioral Medicine*, 28 (1), 29-38.

Boey, K. W. (2003). Religiosity and psychological well-being of older women in Hong Kong. *International Journal of Psychiatric Nursing Research, 8*(2), 921-935.

Bosse, R., Aldwin, C. M., Levenson, M. R., Spiro, A., 3rd, & Mroczek, D. K. (1993). Change in social support after retirement: longitudinal findings from the Normative Aging Study. *Journal of Gerontology: Psychological Sciences, 48*(4), P210-217.

Bowlby, J. (1969). *Attachment and Loss Volume I: Attachment.* New York: Basic Books, Inc.

Bowlby, J. (1973). *Attachment and Loss Volume II: Separation Anxiety and Anger.* New York: Basic Books, Inc.

Bromberg, E. M. (1983). Mother-Daughter Relationships in Later Life: The effect of quality of relationship upon mutual aid. *Journal of Gerontological Social Work, 6*(1), 75-92.

Brown, R., & Middendorf, J. (1996). The underestimated role of temporal comparison: a test of the life-span model. *Journal of Social Psychology, 136*(3), 325-331.

Bryant, L. L., Beck, A., & Fairclough, D. L. (2000). Factors that contribute to positive perceived health in an older population. *Journal of Aging and Health, 12*(2), 169-192.

Bryant, L. L., Corbett, K. K., & Kutner, J. S. (2001). In their own words: a model of healthy aging. *Social Science & Medicine, 53*(7), 927-941.

Burnette, D. (1999). Physical and emotional well-being of custodial grandparents in Latino families. *American Journal of Orthopsychiatry, 69*(3), 305-318.

Candib, L. M. (1994). Chapter 7 Self-in-Relation Theory: Implications for Women's Health. In A. J. Dan (Ed.), *Reframing Women's Health: Multidisciplinary Research and Practice* (pp. 67-78). Thousand Oaks: Sage.

Capsi, A., & Elder, G. H., Jr. (1986). Life satisfaction in old age: linking social psychology and history. *Psychology and Aging, 1*(1), 18-26.

Carey, E. C., Walter, L. C., Lindquist, K., & Covinsky, K. E. (2004). Development and validation of a functional morbidity index to predict mortality in community-dwelling elders. *Journal of General and Internal Medicine, 19*(10), 1027-1033.

Carstensen, L. L. (1992). Social and emotional patterns in adulthood: support for socioemotional selectivity theory. *Psychology and Aging, 7*(3), 331-338.

Carstensen, L. L., Isaacowitz, D. M., & Charles, S. T. (1999). Taking time seriously. A theory of socioemotional selectivity. *American Psychologist, 54*(3), 165-181.

Carstensen, L. L., Pasupathi, M., Mayr, U., & Nesselroade, J. R. (2000). Emotional experience in everyday life across the adult life span. *Journal of Personality and Social Psychology, 79*(4), 644-655.

Carstensen, L. L., & Turk-Charles, S. (1994). The salience of emotion across the adult life span. *Psychology and Aging, 9*(2), 259-264.

Cattell, V. (2001). Poor people, poor places and poor health: The mediating role of social networks and social capital. *Social Science & Medicine, 52*, 1501-1516.

Cavelli, S., Bickel, J. F., & Lalive D'epinay, C. J. (2002). *Relational Life and Social Activities in Very Old Age: The Impact of Three Life Events.* Paper presented at the Gerontological Society of America, Boston, Massachusetts.

Christensen, K. A., Stephens, M. A. P., & Townsend, A. L. (1998). Mastery in Women's Multiple Roles and Well-Being: Adult Daughters Providing Care to Impaired Parents. *Health Psychology, 17*(2), 163-171.

Cobb, S. (1976). Social Support as a Moderator of Life Stress. *Psychosomatic Medicine, 38*(5), 300-314.

Cohen, S. (1988). Psychosocial Models of the Role of social Support in the etiology of Physical Disease. *Health Psychology, 7*(3), 269-297.

Cohen, S., & Mc Kay, G. (1984). Social Support, Stress, and the Buffering Hypothesis: A Theoretical Analysis. In A. Baum, J. Singer & S. Taylor (Eds.), *Handbook of Psychology and Health* (Vol. 4, pp. 253-267). Hillsdale, New Jersy: Erlbaum.

Covey, H. (2000). Shakespeare on old age and disability. *International Journal of Aging and Health, 50*(3), 169-183.

Coyne, J. C., & Downey, G. (1991). Social Factors and Psychopathology: Stress, Social Support, and Coping Processes. *Annual Review in Psychology, 42*, 401-425.

Cumming, E., & Henry, W. E. (1961). *Growing Old: The Process of Disengagement.* New York: Basic Books.

Daltroy, L. H., Larson, M. G., Eaton, H. M., Phillips, C. B., & Liang, M. H. (1999). Discrepancies between self-reported and observed physical function in the elderly: the influence of response shift and other factors. *Social Science and Medicine, 48*(11), 1549-1561.

Diener, E. (1984). Subjective Well-Being. *Psychological Bulletin, 95*(3), 542-575.

Doblhammer, G., & Kytir, J. (2001). Compression or expansion of morbidity? Trends in healthy-life expectancy in the elderly Austrian population between 1978 and 1998. *Social Science and Medicine, 52*(3), 385-391.

Elder, G. H. (1974). *Children of the Great Depression: Social change in life experience.* Chicago: University of Chicago Press.

Elder, G. H., Jr., Shanahan, M. J., & Clipp, E. C. (1997). Linking combat and physical health: the legacy of World War II in men's lives. *American Journal of Psychiatry, 154*(3), 330-336.

Emick, M. A., & Hayslip, B., Jr. (1999). Custodial grandparenting: stresses, coping skills, and relationships with grandchildren. *International Journal of Aging and Human Development, 48*(1), 35-61.

Erikson, E., Erikson, J., & Kivnick, H. (1986). *Vital Involvement in Old Age.* New York: W. W. Norton & Company.

Ernster, V. L., Selvin, S., Sacks, S. T., Austin, D. F., Brown, S. M., & Winkelstein, W., Jr. (1978). Prostatic cancer: mortality and incidence rates by race and social class. *American Journal of Epidemiology, 107*(4), 311-320.

Estes, C. L., & Binney, E. A. (1989). The biomedicalization of aging: Dangers and dilemmas. *The Gerontologist, 29*(5), 587-896.

Evanhoe, E. (2005). The Korean War. from http://www.korean-war.com/TimeLine/KoreanWarOverview.html

Finfgeld-Connett, D. (2005). Clarification of social support. *Journal of Nursing Scholarship, 37*(1), 4-9.

Fingerman, K. L. (1995). Aging Mothers' and Their Adult Daughters' Perceptions of Conflict Behaviors. *Psychology and Aging, 10*(4), 639-649.

Fingerman, K. L. (1996). Sources of Tension in the Aging Mother and Adult Daughter Relationship. *Psychology and Aging, 11*(4), 591-606.

Fingerman, K. L. (2004). The consequential Stranger: Peripheral Relationships across the Life Span. In F. R. Lang & K. L. Fingerman (Eds.), *Growing Together: Personal Relationships across the Life Span* (pp. 183-209). New York: Cambridge University Press.

Fingerman, K. L., & Bermann, E. (2000). Applications of family systems theory to the study of adulthood. *International Journal of Aging and Human Development, 51*(1), 5-29.

Fingerman, K. L., & Birditt, K. S. (2003). Do age differences in close and problematic family ties reflect the pool of available relatives? *Journal of Gerontology B: Psychological Science and Social Science, 58*(2), P80-87.

Flyvbjerg, B. (2001). *Making Social Science Matter: Why Social Inquiry Fails and How It Can Succeed Again.* Cambridge, United Kingdom: Cambridge University Press.

Ford, A. B., Haug, M. R., Stange, K. C., Gaines, A. D., Noelker, L. S., & Jones, P. K. (2000). Sustained personal autonomy: a measure of successful aging. *Journal of Aging and Health, 12*(4), 470-489.

Frank, J. W., Cohen, R., Yen, I., Balfour, J., & Smith, M. (2003). Socioeconomic gradients in health status over 29 years of follow-up after midlife: the Alameda County Study. *Social Science and Medicine, 57*(12), 2305-2323.

Fredrickson, B. L., & Carstensen, L. L. (1990). Choosing social partners: how old age and anticipated endings make people more selective. *Psychology and Aging, 5*(3), 335-347.

Friedman, M. M. (1993). Social support sources and psychological well-being in older women with heart disease. *Research in Nursing and Health, 16*(6), 405-413.

Friedman, M. M. (1997). Social support sources among older women with heart failure: continuity versus loss over time. *Research in Nursing and Health, 20*(4), 319-327.

Friedman, M. M., & King, K. B. (1994). The relationship of emotional and tangible support to psychological well-being among older women with heart failure. *Research in Nursing and Health, 17*(6), 433-440.

Fries, J. (2000). Compression of Morbidity in the Elderly. *Vaccine, 18*, 1584-1589.

Fullerton, H. H. (1999). Labor force participation: 75 years of change, 1950-98 and 1998-2005. *Monthly Labor Review*, 3-12.

Fung, H. H. (2002). *Emotional Reactions in Hong Kong to 9/11.* Paper presented at the Meetings of the Gerontological Society of America, Boston, MA.

Fung, H. H., & Carstensen, L. L. (2004). Motivational changes in response to blocked goals and foreshortened time: testing alternatives to socioemotional selectivity theory. *Psychol Aging, 19*(1), 68-78.

Fung, H. H., Carstensen, L. L., & Lang, F. R. (2001). Age-related patterns in social networks among European Americans and African Americans: implications for socioemotional selectivity across the life span. *International Journal of Aging Human Development, 52*(3), 185-206.

Fung, H. H., Carstensen, L. L., & Lutz, A. M. (1999). Influence of time on social preferences: implications for life-span development. *Psychology and Aging, 14*(4), 595-604.

George, L. (1996). Missing Links: The Case for a Social Psychology of the Life Course. *The Gerontologist, 36*(2), 248-255.

Giele, J. Z. (1998). Chapter 10: Innovation in the Typical Life Course. In J. Z. G. a. G. H. Elder (Ed.), *Methods of Life Course Research: Quantitative and Qualitative Approaches* (First ed.). Thousand Oaks: Sage.

Gilligan, C. (1982). *In a Different Voice: Psychological Theory and Women's Development.* Cambridge, MA: Harvard University Press.

Gist, Y. J., & Hetzel, L. I. (2004). U. S. Census Bureau, Census 2000 Special Reports

We the People: Aging in the United States. *Census 2000 Special Reports* Retrieved May 8, 2005, from http://www.census.gov/prod/2004pubs/censr-19.pdf

Gross, J. J., Carstensen, L. L., Pasupathi, M., Tsai, J., Skorpen, C. G., & Hsu, A. Y. (1997). Emotion and aging: experience, expression, and control. *Psychology and Aging, 12*(4), 590-599.

Gubrium, J. F., Rittman, M. R., Williams, C., Young, M. E., & Boylstein, C. A. (2003). Benchmarking as everyday functional assessment in stroke recovery. *Journal of Gerontology B Psychological Science and Social Science, 58*(4), S203-211.

Guse, L. W., & Masesar, M. A. (1999). Quality of Life and Successful aging in Long-Term Care: Perceptions of Residents. *Issues in Mental Health Nursing, 20*, 527-539.

Haan, M., Kaplan, G. A., & Camacho, T. (1987). Poverty and health. Prospective evidence from the Alameda County Study. *American Journal of Epidemiology, 125*(6), 989-998.

Hagestad, G. O. (1986). The aging society as a context for family life. *Daedalus: Journal of the American Academy of Arts and Sciences*

The Aging Society, 115(1), 119-139.

Halpern, J., Shroder, M. A., & Citera, M. A. (1996). Perceptions by Adult Children of Elderly Parents Needs. *Psychological Reports, 78*, 571-577.

Hartel, U., Stieber, J., & Keil, U. (1988). Social relations and smoking behavior: results from the first MONICA Survey Augsburg. *Soz Praventivmed, 33*(1), 27-31.

Hayflick, L. (1998a). Aging is not a disease. *Aging and Clinical Experimental Research, 10*(2), 146.

Hayflick, L. (1998b). How and why we age. *Experimental Gerontology, 33*(7-8), 639-653.

Hazzard, W. R. (1997). Ways to make "usual" and "successful" aging synonymous. Preventive gerontology. *Western Journal of Medicine, 167*(4), 206-215.

Hegyvary, S. T. (2004). Clarifying Social Support. *Journal of Nursing Scholarship, 36*(4), 287.

Hobbs, F., & Stoops, N. (2002, November 2002). U. S. Census Bureau, Census 2000 Special Reports

Demographic Trends in the 20th Century. Retrieved January 31, 2002, 2002, from www.census.gov/prod/2002pubs/censr-4.pdf

Hooyman, N. R., & Gonyea, J. G. (1999). A Feminist Model of Family Care: Practice and Policy Directions. In J. D. Garner (Ed.), *Fundamentals of Feminist Gerontology* (pp. 149-169): Haworth Press.

House, J. S. (1981). The Nature of Social Support. In J. S. House (Ed.), *Work Stress and Social Support* (pp. 13-40). Reading MA: Addison-Wesley.

House, J. S., Landis, K. R., & Umberson, D. (1988). Social Relationships and Health. *Science, 241*, 540-545.

Huyck, M. H. (1999). Gender Roles and Gender Identity in Midlife. In S. Willis & J. Reid (Eds.), *Life in the Middle: Psychological and Social Development in Middle Age* (pp. 209-230). San Diego: Academic Press.

Im, E. O., & Meleis, A. I. (2001). An international imperative for gender-sensitive theories in women's health. *Journal of Nursing Scholarship, 33*(4), 309-314.

Jacobson, D. (1986). Types and Timing of Social Support. *Journal of Health and Social Behavior, 27*(September), 250-264.

Johnson, A. (2000). *The Blackwell Dictionary of Sociology.* Malden, Massachusetts: Blackwell Publishing, Inc.

Kahn, R. L., & Antonucci, T. C. (1980). Convoys over the life course: Attachment, roles and social support. In P. B. Baltes & J. O. G. Brim (Eds.), *Life-Span Development and Behavior* (Vol. 3, pp. 253-286). New York: Academic Press.

Kaplan, G. A. (1988). Social contacts and ischaemic heart disease. *Annals of Clinical Research, 20*(1-2), 131-136.

Kaplan, G. A. (1992). Maintenance of functioning in the elderly. *Annals of Epidemiology, 2*(6), 823-834.

Kaplan, G. A. (1996). People and places: contrasting perspectives on the association between social class and health. *International Journal of Health Services, 26*(3), 507-519.

Kaplan, G. A., Lazarus, N. B., Cohen, R. D., & Leu, D. J. (1991). Psychosocial factors in the natural history of physical activity. *American Journal of Preventive Medicine, 7*(1), 12-17.

Kaplan, G. A., Seeman, T. E., Cohen, R. D., Knudsen, L. P., & Guralnik, J. (1987). Mortality among the elderly in the Alameda County Study: behavioral and demographic risk factors. *American Journal of Public Health, 77*(3), 307-312.

Kaufman, S. R. (1986). *The Ageless Self.* Madison, WI: The University of Wisconsin Press.

Kawachi, I., & Berkman, L. F. (2001). Social ties and mental health. *Journal of Urban Health, 78*(3), 458-467.

Kayser-Jones, J. (1986). Distributive justice and the treatment of acute illness in nursing homes. *Social Science and Medicine, 23*(12), 1279-1286.

Kelley, S. J., Yorker, B. C., & Whitley, D. (1997). To grandmother's house we go. and stay. Children raised in intergenerational families. *Journal of Gerontological Nursing, 23*(9), 12-20.

Keyes, C. L., & Ryff, C. D. (1999). Psychological Well-Being in Midlife. In S. Willis & J. Reid (Eds.), *Life in the Middle: Psychological and Social Development in Middle Age* (pp. 161-178). San Diego: Academic Press.

Kotler, P., & Wingard, D. L. (1989). The effect of occupational, marital and parental roles on mortality: the Alameda County Study. *American Journal of Public Health, 79*(5), 607-612.

Krause, N., & Rook, K. S. (2003). Negative interaction in late life: issues in the stability and generalizability of conflict across relationships. *Journal of Gerontology B Psychological Science and Social Science, 58*(2), P88-99.

Kwan, C. M., Love, G. D., Ryff, C. D., & Essex, M. J. (2003). The role of self-enhancing evaluations in a successful life transition. *Psychology and Aging, 18*(1), 3-12.

Lachman, M. E. (2003). Negative interactions in close relationships: introduction to a special section. *Journal of Gerontolology B Psychological Science and Social Science, 58*(2), P69.

Lang, F. R. (2001). Regulation of social relationships in later adulthood. *Journal of Gerontology: Psychological Sciences, 56B*(6), P321-326.

Lang, F. R., & Carstensen, L. L. (1994). Close emotional relationships in late life: further support for proactive aging in the social domain. *Psychology and Aging, 9*(2), 315-324.

Langford, C. P., Bowsher, J., Maloney, J. P., & Lillis, P. P. (1997). Social support: a conceptual analysis. *Journal of Advanced Nursing, 25*(1), 95-100.

Lansford, J. E., Sherman, A. M., & Antonucci, T. C. (1998). Satisfaction with social networks: an examination of socioemotional selectivity theory across cohorts. *Psychology and Aging, 13*(4), 544-552.

Larson, R. (1978). Thirty years of research on the subjective well-being of older Americans. *Journal of Gerontology, 33*(1), 109-125.

Lazarus, R. S., & Folkman, S. (1984). *Stress, Appraisal, and Coping.* New York: Springer Publishing Company.

Leblanc-Ernest, A. D. (1999). The Black Panther Party Research Project. from www.stanford.edu/group/blackpanthers/index.shtml

Lefrancois, R., Leclerc, G., Hamel, S., & Gaulin, P. (2000). Stressful life events and psychological distress of the very old: does social support have a moderating effect? *Archives of Gerontology and Geriatrics, 31*(3), 243-255.

Lerner, S. (2002, October 22, 2002). Good and Bad Marriage, Boon and Bane to Health. *New York Times.*

Levenson, R. W. (1997, July 19, 1997). *Emotion in the Elderly and in Late-Life Marriages.* Paper presented at the Faculty Club, UC Berkeley.

Levenstein, S., Smith, M. W., & Kaplan, G. A. (2001). Psychosocial predictors of hypertension in men and women. *Archives of Internal Medicine, 161*(10), 1341-1346.

Levitt, M. J. (2000). Social Relations Across the Life Span: In Search of Unified Models. *International Journal of Aging and Health, 51*(1), 71-84.

Levitt, M. J., Antonucci, T. C., Clark, M. C., Rotton, J., & Finley, G. E. (1985a). Social support and well-being: Preliminary indicators based on two samples of the elderly. *International Journal of Aging and Human Development, 21*(1), 61-76.

Levitt, M. J., Antonucci, T. C., Clark, M. C., Rotton, J., & Finley, G. E. (1985b). Social support and well-being: preliminary indicators based on two samples of the elderly. *International Journal of Aging and Human Development, 21*(1), 61-77.

Levitt, M. J., Weber, R. A., & Guacci, N. (1993). Convoys of social support: An intergenerational analysis. *Psychology and Aging, 8*(3), 323-326.

Liang, J., Krause, N. M., & Bennett, J. M. (2001). Social exchange and well-being: is giving better than receiving? *Psychology and Aging, 16*(3), 511-523.

Litwin, H. (2001). Social Network Type and Morale in Old Age. *The Gerontologist, 41*(4), 516-524.

Litwin, H., & Shiovitz, S. (2002). *Activities or relationships: Which matter more in later-life?* Paper presented at the Fifty-fifth Scientific Meeting of the Gerontological Society of America, Boston, MA.

Lynch, J. W., Kaplan, G. A., & Shema, S. J. (1997). Cumulative impact of sustained economic hardship on physical, cognitive, psychological, and social functioning. *New England Journal of Medicine, 337*(26), 1889-1895.

Marmot, M., & Brunner, E. (2005). Cohort Profile: The Whitehall II study. *International Journal of Epidemiology, 34*(2), 251-256.

Marmot, M. G., Smith, G. D., Stansfeld, S., Patel, C., North, F., Head, J., White, I., Brunner, E., & Feeney, A. (1991). Health inequalities among British civil servants: the Whitehall II study. *Lancet, 337*(8754), 1387-1393.

Marshall, C., & Rossman, G. B. (1999). *Designing Qualitative Research* (Third ed.). Thousand Oaks, CA: Sage Publications.

Mcauley, E., Blissmer, B., Marquez, D. X., Jerome, G. J., Kramer, A. F., & Katula, J. (2000). Social Relations, Physical Activity and Well-Being in Older Adults. *Preventive Medicine, 31*, 608-617.

Mercer, R., Nichols, E., & Doyle, G. (1989). *Transitions in a Woman's Life: Major events in developmental context* (Vol. 12). New York: Springer.

Minkler, M. A., Satariano, W. A., & Langhauser, C. (1983). Supportive exchange: an exploration of the relationship between social contacts and perceived health status in the elderly. *Archives of Gerontology and Geriatrics, 2*(3), 211-220.

Moen, P., Dempster-Mcclain, D., & Williams Jr., R. M. (1992). Successful aging: A life-course perspective on women's multiple roles and health. *American Journal of Sociology, 97*(6), 1612-1638.

Norbeck, J. S. (1988a). *Challenges in social support research.* San Francisco: School of Nursing University of California San Francisco.

Norbeck, J. S. (1988b). Social support. *Annual Review of Nursing Research, 6*, 85-109.

Ostir, G. V., Markides, K. S., Black, S. A., & Goodwin, J. S. (2000). Emotional well-being predicts subsequent functional independence and survival. *Journal of the American Geriatrics Society, 48*, 473-478.

Ostir, G. V., Markides, K. S., Peek, M. K., & Goodwin, J. S. (2001). The association between emotional well-being and the incidence of stroke in older adults. *Psychosomatic Medicine, 63*, 210-215.

Patterson, B. J. (1995). The process of social support: adjusting to life in a nursing home. *Journal of Advanced Nursing, 21*(4), 682-689.

Pearlin, L. I. (1989). The sociological study of stress. *Journal of Health and Social Behavior, 30*(September), 241-256.

Pearlin, L. I., & Skaff, M. M. (1996). Stress and the life course: a paradigmatic alliance. *Gerontologist, 36*(2), 239-247.

Peek, M. K., & Lin, N. (1999). Age differences in the effects of network composition on psychological distress. *Social Sciences and Medicine, 49*(5), 621-636.

Peek, M. K., & O' Neill, G. S. (2001). Networks in later life: an examination of race differences in social support networks. *International Journal of Aging and Human Development, 52*(3), 207-229.

Peters, A., & Liefbroer, A. C. (1997). Beyond martial status: Partner history and well-being in old age. *Journal of Marriage and the Family, 59*(August 1997), 687-699.

Pinquart, M. (2001). Correlates of subjective health in older adults: a meta-analysis. *Psychology and Aging, 16*(3), 414-426.

Pinquart, M., & Sorensen, S. (2000). Influences of socioeconomic status, social network, and competence on subjective well-being in later life: a meta-analysis. *Psychology and Aging, 15*(2), 187-224.

Pinquart, M., & Sorensen, S. (2001). Gender differences in self-concept and psychological well-being in old age: a meta-analysis. *Journal of Gerontology B Psychological Science and Social Sciences, 56*(4), P195-213.

Pohl, J. M., Boyd, C., Liang, J., & Given, C. W. (1995). Analysis of the Impact of the Mother-Daughter Relationships on the Commitment to Caregiving. *Nursing Research, 44*(2), 68-75.

Pyett, P. M. (2003). Validation of qualitative research in the "real world". *Qualitative Health Research, 13*(8), 1170-1179.

Racher, F. E. (2002). Synergism of frail rural elderly couples: influencing interdependent independence. *Journal of Gerontological Nursing, 28*(6), 32-39; quiz 52-33.

Rankin, S. H. (1995). Going it alone: Women managing recovery from myocardial infarction. *Family and Community Health, 17*(4), 50-62.

Rankin, S. H. (2000). Life-span development: refreshing a theoretical and practice perspective. *Scholarly Inquiry for Nursing Practice: An International Journal, 14*(4), 379-388.

Rankin, S. H., De Leon, J. F., Chen, J. L., Butzlaff, A., & Carroll, D. L. (2002). Recovery trajectory of unpartnered elders after myocardial infarction: an analysis of daily diaries. *Rehabilitation Nursing, 27*(3), 95-102; discussion 103.

Reynolds, P., & Kaplan, G. A. (1990). Social connections and risk for cancer: prospective evidence from the Alameda County Study. *Behavioral Medicine, 16*(3), 101-110.

Riley, M. W., Foner, A., & Riley, J. W. (1999). The Aging and Society Paradigm. In *Handbook of Theories of Aging* (pp. 516). New York: Springer Publishing Company.

Roberto, K. A., Allen, K. R., & Blieszner, R. (1999). Older women, their children, and grandchildren: a feminist perspective on family relationships. *Journal of Women and Aging, 11*(2-3), 67-84.

Roberts, R. E., Kaplan, G. A., & Camacho, T. C. (1990). Psychological distress and mortality: evidence from the Alameda County Study. *Social Science and Medicine, 31*(5), 527-536.

Roberts, R. E., Kaplan, G. A., Shema, S. J., & Strawbridge, W. J. (1997). Does growing old increase the risk for depression? *American Journal of Psychiatry, 154*(10), 1384-1390.

Rook, K. S. (1984). The negative side of social interaction: impact on psychological well-being. *Journal of Personality and Social Psychology, 46*(5), 1097-1108.

Rook, K. S., Thuras, P. D., & Lewis, M. A. (1990). Social control, health risk taking, and psychological distress among the elderly. *Psychology and Aging, 5*(3), 327-334.

Rosenberg, S., Rosenberg, H., & Farrell, M. (1999). The Midlife Crisis Revisited. In S. Willis & J. Reid (Eds.), *Life in the Middle; Psychological and Social Development in Middle Age* (pp. 47-73). San Diego: Academic Press.

Roszak, T. (2001). *Longevity Revolution: As Boomers Become Elders.* Berkeley, California: Berkeley Hills Books.

Rowe, J., & Kahn, R. (1998a). Successful aging. *Aging Clinical Experimental Research, 10*(2), 142-144.

Rowe, J. W., & Kahn, R. L. (1987). Human Aging: Usual and Successful. *Science, 237*, 143-149.

Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist, 37*(4), 433-440.

Rowe, J. W., & Kahn, R. L. (1998b). *Successful Aging.* New York: Pantheon.

Rowe, J. W., & Kahn, R. L. (1999). the Future of Aging. *Contemporary Long Term Care*, 36-44.

Ryff, C. D., & Seltzer, M. M. (1996). The uncharted years of midlife parenting. In C. D. Ryff & M. M. Seltzer (Eds.), *The Parental Experience in Midlife* (pp. 3-28). Chicago: The University of Chicago Press.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23*(4), 334-340.

Schoenbach, V. J., Kaplan, B. H., Fredman, L., & Kleinbaum, D. G. (1986). Social ties and mortality in Evans County, Georgia. *American Journal of Epidemiology, 123*(4), 577-591.

Schwartz, C., Meisenhelder, J. B., Ma, Y., & Reed, G. (2003). Altruistic social interest behaviors are associated with better mental health. *Psychosomatic Medicine, 65*(5), 778-785.

Seeman, T. E., Kaplan, G. A., Knudsen, L., Cohen, R., & Guralnik, J. (1987). Social network ties and mortality among the elderly in the Alameda County Study. *American Journal of Epidemiology, 126*(4), 714-723.

Selye, H. (1956). *The Stress of Life*. New York: Mc Graw-Hill.

Selye, H. (1976). *Stress in Health and Disease*. Boston: Butterworths.

Sheehan, N. W., & Donorfio, L. M. (1999). Efforts to create meaning in relationship between aging mothers and their caregiving daughters: A qualitative study of caregiving. *Journal of Aging Studies, 13*(2), 161-176.

Shye, D., Mullooly, J. P., Freeborn, D. K., & Pope, C. R. (1995). Gender differences in the relationship between social network support and mortality: a longitudinal study of an elderly cohort. *Social Science and Medicine, 41*(7), 935-947.

Sidani, S., & Sechrest, L. (1996). Analysis and use of qualitative data. *NIDA Research Monograph, 166*, 292-309.

Siriphant, P., & Drury, T. F. (2005). Healthy practices, social relationships and dental perceptions among US dentate adults. *Journal of Public Health Dentistry, 65*(1), 36-42.

Slater, C., & Carlton, B. (1985). Behavior, lifestyle, and socioeconomic variables as determinants of health status: implications for health policy development. *American Journal of Preventive Medicine, 1*(5), 25-33.

Slater, C. H., Lorimor, R. J., & Lairson, D. R. (1985). The independent contributions of socioeconomic status and health practices to health status. *Preventive Medicine, 14*(3), 372-378.

Snowden, L. R. (2001). Social embeddedness and psychological well-being among African Americans and whites. *American Journal of Community Psychology, 29*(4), 519-536.

Stewart, A. L., Ware, J. J. E., Sherbourne, C. D., & Wells, K. B. (1992). Psychological Distress/Well-Being and Cognitive Functioning Measures. In A. L. Stewart & J. J. E. Ware (Eds.), *Measuring Functioning and Well-Being: The Medical Outcomes Study Approach* (pp. 102-142). Durham: Duke University Press.

Stewart, M., Craig, D., Mac Pherson, K., & Alexander, S. (2001). Promoting positive affect and diminishing loneliness of widowed seniors through a support intervention. *Public Health Nursing, 18*(1), 54-63.

Strawbridge, W. J., Cohen, R. D., & Shema, S. J. (2000). Comparative strength of association between religious attendance and survival. *International Journal Psychiatry Medicine, 30*(4), 299-308.

Strawbridge, W. J., Cohen, R. D., Shema, S. J., & Kaplan, G. A. (1996). Successful aging: predictors and associated activities. *American Journal of Epidemiology, 144*(2), 135-141.

Strawbridge, W. J., Shema, S. J., Cohen, R. D., & Kaplan, G. A. (2001). Religious attendance increases survival by improving and maintaining good health behaviors, mental health, and social relationships. *Annals of Behavioral Medicine, 23*(1), 68-74.

Strawbridge, W. J., Wallhagen, M. I., & Cohen, R. D. (2002). Successful aging and well-being: self-rated compared with Rowe and Kahn. *Gerontologist, 42*(6), 727-733.

Suls, J., Martin, R., & Wheeler, L. (2002). Social comparison: Why, with whom and with what effect? *Current Directions in Psychological Science, 11*(5), 159-163.

Susser, M. (1973). *Causal thinking in the health sciences: concepts and strategies in epidemiology.* New York: Oxford Press.

Target, M. (2005). Attachment Theory and Research. In E. S. Person, A. M. Cooper & G. O. Gabbard (Eds.), *The American Psychiatric Publishing Textbook of Psychoanalysis* (pp. 159-172). Washington, D. C.: American Psychiatric Publishing, Inc.

Thoits, P. A. (1982). Life stress, social support, and psychological vulnerability: epidemiological considerations. *Journal of Community Psychology, 10*(4), 341-362.

Thomas, J. C., & Weber, D. J. (Eds.). (2001). *Epidemiologic Methods for the Study of Infectious Disease.* New York: Oxford University Press.

Thorne, S. (1994). Secondary Analysis in Qualitative Research: Issues and Implications. In J. M. Morse (Ed.), *Critical Issues in Qualitative Research Methods* (pp. 263-279). Thousand Oaks: Sage.

Toosii, M. (2002). A century of change: the US labor force, 1950-2050. *Monthly Labor Review*(May), 15-28.

Tucker, J. S. (2002). Health-related social control within older adults' relationships. *Journal of Gerontology B Psychological Science and Social Science, 57*(5), P387-395.

United States Census Bureau. (1995, September 13, 2000). Sixty-five plus in the United States. Retrieved November 11, 2000, 2000, from www.census.gov/apsd/www/statbrief/sb95_8.pfd

United States Census Bureau. (2004, October 20, 2004). Selected characteristics of workers who worked at home by sex: 2000. Retrieved August 7, 2005, from http://www.census.gov/population/cen2000

United States Census Bureau. (2004-2005). Statistical Abstract of the United States Section 2: Vital Statistics (Vol. 2005). Washington DC: US Census Bureau.

United States Veteran's Association. (2005). The GI Bill, US Department of Veteran's Affairs. Retrieved June 3, 2005 from www.gibill.va.gov/education/GI_Bill.htm

Valanis, B. (1999). *Epidemiology in Health Care, Third Edition.* Stamford, Connecticut: Appleton & Lange.

Virmani, J., Schneiderman, L. J., & Kaplan, R. M. (1994). Relationship of advanced directives to physician-patient communication. *Archives of Internal Medicine, 154*, 909-913.

Von Faber, M., Bootsma-Van Der Wiel, A., Van Exel, E., Gussekloo, J., Lagaay, A. M., Van Dongen, E., Knook, D. L., Van Der Geest, S., & Westendorp, R. G. (2001). Successful aging in the oldest old: Who can be characterized as successfully aged? *Archives of Internal Medicine, 161*(22), 2694-2700.

Walker, A. J., Pratt, C. C., & Eddy, L. (1995). Informal Caregiving to Aging Family Members: A Critical Review. *Family Relations, 44*, 402-411.

Weiss, R. S. (1974). The Provisions of Social Relationship. In Z. Rubin (Ed.), *Doing Unto Others.* Englewood Cliffs, NJ: Pretice-Hall.

Wenger, G. C. (1991). A network typology: From theory to practice. *Journal of Aging Studies, 5*, 147-162.

Wenger, G. C., & Tucker, I. (2002). Using network variation in practice: Identification of support network type. *Health and Social Care in the Community, 10*(1), 28-35.

Williamson, J. B., Watts-Roy, D. M., & Kingson, E. R. (Eds.). (1999). *The Generational Equity Debate.* New York: Columbia University Press.

Wingard, D. L. (1982). The sex differential in mortality rates: demographic and behavioral factors. *American Journal of Epidemiology, 115*(2), 205-216.

Wingard, D. L., Berkman, L. F., & Brand, R. J. (1982). A multivariate analysis of health-related practices: a nine-year mortality follow-up of the Alameda County Study. *American Journal of Epidemiology, 116*(5), 765-775.

Yen, I. H., & Kaplan, G. A. (1998). Poverty area residence and changes in physical activity level: evidence from the Alameda County Study. *American Journal of Public Health, 88*(11), 1709-1712.

Yen, I. H., & Kaplan, G. A. (1999a). Neighborhood social environment and risk of death: multilevel evidence from the Alameda County Study. *American Journal of Epidemiology, 149*(10), 898-907.

Yen, I. H., & Kaplan, G. A. (1999b). Poverty area residence and changes in depression and perceived health status: evidence from the Alameda County Study. *International Journal of Epidemiology, 28*(1), 90-94.

Yen, I. H., & Syme, S. L. (1999). The social environment and health: a discussion of the epidemiologic literature. *Annual Review of Public Health, 20*, 287-308.

Zinn, H. (1999). *A People's History of the United States: 1492-Present.* New York: Harper Perennial.

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