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The ageing experience: loss, threat or challenge?

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What do you think it means to be old?

Six year old girl: *'Your face gets wrinkles, and your hair loses the colour, your feet hurt and you can't see very well. You can't do things as well when you get older. I can't do cart-wheels as well this year as last year!'*

69 year old woman: *'If you have a youthful approach to life you are never old. You don't feel old. It's only your body that changes. I got rid of the grey in my hair recently. My grand-daughter said I wasn't really old any more — just a little bit old!'*

70 year old man: *'Being old is wearing out, like an old car. You go slower even if you don't want to, sometimes you need rest, sometimes you need to be repaired, and then eventually, that's it. You have to realize you can't do things as well as you used to. To find peace of mind you accept that and do the best you can.'*

What age do you have to be before you are old?

Six year old girl: *'49.'*

69 year old woman: *'I don't feel old yet.'*

70 year old man: *'It varies depending on your outlook and health — around 70 for me.'*

INTRODUCTION

In our youth oriented society ageing carries connotations of loss. Texts on ageing invariably reinforce this point of view as they document age related changes: loss of hair, the skin's loss of elasticity and ability to regulate temperature, the sluggishness and inefficiency of body organs and systems, losses of strength, speed and energy, losses in the acquisition of new information and recall of the old, slowness in decision making and ultimately, the most feared of all, loss of independence and control (Birren & Schaie 1990; Kermis 1984; Woodruff-Pak 1988). This chapter, however, is not concerned with the rates at which we lose that which we spend our childhood years gaining: Instead the focus is on the new experiences that life has to offer in later years. There is no assumption that such experiences are better or worse than those of the past, though society may well construe them as being less desirable. We are all familiar with birthday greetings for the middle-aged which suggest that they may soon be 'past it', 'over the hill', or 'past their prime'. Such humour presupposes that the later years make similar demands and require similar skills to former years for satisfactory functioning. Such an assumption is unjustified. In cross-cultural psychology we have come to realise that the adaptive skills of white Australians are not the same as the skills which Aborigines need to survive in their communities. In developmental psychology, we have yet to seriously scrutinise the assumption that the adaptive skills of the young are the same as those of older members of our society. This sentiment is well captured by one somewhat disconcerting grey power slogan: 'Old age and treachery will overcome youth and skill'.

Our preoccupation with loss in relation to ageing is both understandable and excusable. First and foremost, old age signifies that our life is drawing to a close. Less compelling reasons also have a powerful impact on our attitudes to old age. Advertising constantly bombards us with 'stay forever young' messages through cosmetics, fashion and even breakfast cereals. Modern western society also has taught us to value efficiency and achievement. Both are touted as keys to success in life. Neither translates well into old age since both suffer as a consequence of the ageing process. Time taken to make decisions and complete tasks is greater as we age

(Kausler 1990; Salthouse 1985; Woodruff-Pak 1988) and the value which older adults place on their own achievement is less than that of middle aged adults (Rokeach 1973). Much of the anguish of younger generations when they consider being old stems from concerns about being slow, dithery, dependent and not doing things as well as they used to. Negative stereotypes of this kind about elderly people have been well documented and oftentimes widely refuted (Braithwaite 1986; Butler 1969; Green 1981; Luszcz & Fitzgerald 1986; Naylor & Harwood 1970; Radford 1987; Riley & Riley 1989). Some stereotypes have no factual basis, some exaggerate known losses and all involve unjustified overgeneralisation. But even when these losses occur, we should not assume that young and old approach the loss and deal with it in the same way. This point can be illustrated most poignantly through the views expressed by older people (Berman 1989; Grotjahn 1982; Liffman 1988). Dr Grotjahn shared his experiences of ageing in this way:

> I began work with the aged . . . a long time ago. Other people grew old, but not I. I could walk as well and as far as ever. I could work out clinical problems better than ever. I reached 60, 65, and even 70, without feeling any change. I decided, however, to work less: I would have more time for contemplation, more time for doing nothing . . . . Yet there was always another essay to write, a lecture to give, or another book to think about. (p.441)

After his 75th birthday, Dr Grotjahn suffered a heart attack. He still didn't feel old or sick — until his second coronary:

> But now I feel old. I do not work any more, nor do I walk. Strangely enough, I do not mind. Suddenly, 50 years of work is enough. I no longer worry about my patients, nor feel guilty because I do not understand them sufficiently or know how to help them . . . .
> I sit in the sun watching the falling leaves slowly sail across the water of the swimming pool. I think, I dream, I draw, and I sit . . . . How could I have known that I would be happy just sitting here, reading a little, writing a little, and enjoying life in a quiet and modest way; or that a walk across the street to the corner of the park would satisfy me more than the long walks I took a year ago when I used to find that four hours were not enough? (p.442)

Ageing presents us with new scenery, new experiences and new challenges. The purpose of this chapter is to review the major life changes that occur in our later years, the ways in which individuals have adapted successfully to these changes, and the ways in which our youth oriented society can ease the transitions.

DEFINITION OF TERMS AND THEORETICAL PERSPECTIVE

In the studies which are to be discussed the critical outcome variables relate to subjective well-being. Included are concepts such as mental health, psychological adjustment, morale, happiness and life satisfaction. No assumption is made that these concepts are interchangeable. Indeed research has shown that they are not (Andrews & McKennell 1980; George 1981; Grouble 1990; Headey et al. 1984; Watson & Tellegen 1985). Nevertheless, the concepts have a common theme. First, the phenomena assessed lie within the experiences of the individual (Campbell et al. 1976). Objective indicators of well-being such as health, wealth and social status are excluded from this definition. Also excluded are social aspects of adjustment such as adequacy of role performance (Scott & Stumpf 1984). Most definitions of satisfactory role performance have been from the perspective of those who are not elderly themselves and therefore are inconsistent with the present emphasis on elderly people's perceptions of the quality of their lives. Both objective indicators and successful performance of social roles are relegated to the role of independent variables which may predict life satisfaction.

In the 1960s and 1970s, much debate was generated by two competing theories of successful ageing, disengagement theory (Cumming & Henry 1961) and activity theory (Lemon et al. 1972). Disengagement theorists argued that affective and behavioural withdrawal from major social roles contributed to life satisfaction in later years. Activity theorists, on the other hand, maintained that subjective well-being was more likely if elderly people remained involved and socially integrated. Although both theories have since been discredited (George 1990), the concept of social roles has remained central to research aimed at understanding the process of successful adjustment in later years. The negative impact of loss of social roles, particularly on social networks, and the desirability of continuity of social roles, have been major themes in the literature (Rosow 1974; Rosow 1985). More recently, losses of social roles in later life have been conceptualised as life stage transitions which need not adversely affect quality of life in the long term (George 1990; Murrell et al. 1988).

The stress research of Lazarus and his colleagues (Folkman 1984; Lazarus et al. 1985; Lazarus & Folkman 1984) has had a major impact on how researchers have gone about analysing the adaptation of elderly people to major changes in their lives. They have argued that the occurrence of a life event is less important to understanding adaptation than how the life event is perceived. A particular life event may be perceived as a loss to one person, a threat to another and a challenge in the life of someone else. With recognition of the importance of how life events are appraised has come interest in the psychological and social resources

that influence the appraisal process and affect the way in which the individual responds to these events.

Perceptions of events are not completely idiosyncratic and can be influenced systematically by the social context. Researchers working from a life span development perspective distinguish between events which serve as markers of transition between life stages and events which are 'out of synch' with the way the life span normally develops (Murrell et al. 1988). The distinction rests on what happens to most people at a certain age, or rather on societal expectations of what is normal. Thus, in later years, retirement, caregiving, bereavement, ill health and relocation are changes which are considered normal and which are to be expected. At earlier stages of life, some of these events would not be considered normal. Researchers argue that unexpected events have a stronger impact on well-being (Danish et al. 1980). Because they are not anticipated, no time is allowed for preparation. Furthermore, the unusualness of the event denies the person the support of age peers who have had the same experience.

This chapter focuses on the life transitions which are normal in later life — retirement, caregiving, bereavement, ill health and relocation. Individual differences in adapting to change are analysed in terms of two types of variables, *psychological resources* and *social resources*. *Psychological resources* refer to the characteristics of the individual such as one's sense of mastery and coping strategies, while *social resources* refer to the size and quality of the social network, relations with family and so on. The extent to which resource variables have been examined in relation to each transition varies, but conclusions will be drawn regarding their effects where sufficient data are available. Finally, attention will focus on a sense of control and social support as two quality of life issues for elderly people. In order to provide a context for these discussions, some basic information will first be provided on levels of life satisfaction among those who are over 60 years of age and on the frequency of events in their lives.

LEVELS OF SUBJECTIVE WELL-BEING

Survey research indicates that the life satisfaction and happiness of elderly people is at least equal to that of younger age groups (Costa et al. 1987; Diener 1984; Palmore 1981). Australian data from the National Social Science Survey show satisfaction rising a little with age (Headey 1988). Similar results have been reported in the United States (Gove & Ortega 1984). Rodgers (1982) examined the findings of different U.S. surveys over some 20 years, and concluded that the gap in the 50s which showed older people to be substantially less happy than the young had disappeared by the late 70s. The trend has continued in more recent studies (Gove 1985).

These data are cross-sectional so that the findings may reflect either changes which occur with age or differences in the experiences of people who belong to different age cohorts and have lived through different times. To control for cohort effects, longitudinal studies have been conducted to follow individuals as they age. The Duke Longitudinal Studies have provided data on a sample of noninstitutionalised elderly Americans over 60 years of age over a 20 year period and on a second sample of middle aged and older people over a six year period (Palmore 1981). Both studies found little or no change in life satisfaction with age.

In Australia, the first longitudinal study of elderly people has involved following up 503 of the 1050 interviewed in Sydney in 1981 as part of the Ageing and the Family Project (Kendig et al. 1983). The second wave of data was collected in 1988 (McCallum 1990a). After seven years, the 503 survivors who agreed to be interviewed were, on average, no less happy with their lives than they had been on the occasion of the first interview. For 59% there was no change, 14% were less happy, and 37% were more happy (McCallum 1991).

One of the most recent and methodologically sophisticated studies of the relationship between age and psychological well-being has been undertaken by Costa and his colleagues. Costa et al. (1987) followed up 4,942 Americans who, at the time of the first interview 9 years earlier, were aged between 25 and 74. A further 4,986 were administered the well-being measures for the first time during the follow-up study. This design allowed the investigators to examine not only age and cohort effects, but also the effects of the timing of data collection and of testing on an earlier occasion. Costa and McCrae (1982) have proposed a series of comparisons for disentangling age, cohort, period and measurement effects based on the work of Schaie (1977). On the basis of cross-sectional, longitudinal, time-sequential and cross-sequential analyses (see Appendix I), Costa et al. (1987) concluded that psychological well-being was stable through adulthood.

The fact that age appears to be unrelated to life satisfaction has met with varied interpretations. Explanations can be broadly divided into those which emphasise the psychological make-up of individuals and those which emphasise life experiences. The first approach is favoured by Costa et al. (1987) who adopt the position that enduring personality dispositions are critical in understanding subjective well-being. Those who are satisfied when they are young are also likely to be satisfied when they are old — because of the type of person they are.

Campbell and his colleagues (Campbell 1981; Campbell et al. 1976) emphasised the importance of finding one's niche, a problem more likely to confront the young than the old. They argue that age brings more realistic expectations and an increased knowledge of self and the world. This enhances the capacity of elderly people to be happy. McCrae (1982), in a study of the coping strategies of young and old, noted that older people were less likely to adopt the 'immature' tactics of hostility or attempting to escape from the reality of loss or threat. Similar differences

have been reported by Irion and Blanchard-Fields (1987). These findings sit comfortably with Campbell's interpretations of age bringing a sense of security about one's place in the world.

It should be noted, however, that in a recent follow-up study, McCrae (1989) was unable to confirm his earlier findings longitudinally. He concluded that age did not affect ways of coping. Such a conclusion may be premature at this stage. McCrae's findings are based on a 7 year testing interval with respondents ranging in age from 21 to 91 years at the time of initial data collection. If coping strategies change as a result of life stages or experiences (Folkman et al. 1987), a more sensitive design may be necessary to detect these developments.

Turning from psychological to social explanations, Campbell's niche-finding argument again warrants attention. Campbell (1981) introduces the social component in this way: 'The early years of adult life are characterised by strong affective experience; many pleasant and unpleasant events punctuate the lives of adult people. As people grow older, these events are less common and less intense; life is more bland' (p. 202).

Evidence from life events research tends to support Campbell's assertion. After reviewing this literature, Murrell et al. (1988) concluded that the life events of older adults differ in both quantity and quality from those of young adults. Chiriboga (1984) reported that younger groups have more events in their lives of both a positive and negative kind than older groups. Comparing types of events, Hughes et al. (1988) found that those 60 and over were less likely to move, to have job changes, to have legal troubles, to marry, separate or divorce. They were more likely to experience a new illness, hospitalisation, retirement or widowhood. By the same token, Murrell et al. (1988) have emphasised that many of the more frequent life events of later life are neither dramatic nor upsetting. In a study of almost 3,000 Kentucky residents aged 55 or over, Murrell et al. (1984) found that the most frequent event experienced was a desirable one — taking a trip out of town.

In the follow-up to the Australian Ageing and the Family Project, McCallum (1990a) has presented preliminary findings which put the salience of the most frequent undesirable life events, that is, health events, into perspective. Of the original respondents who were 60 years of age or over, 79% were still alive 7 years later. When the young-old and the old-old were compared, the results were striking: 90% of those between 60 and 66 years of age at the time of the first interview had survived. Of those aged 81 years or more in 1981, 50% were alive 7 years later. Cardiac illness was the major primary cause of death (37%), followed by cancer (14%), stroke (13%) and respiratory illnesses (10%). The 1981 respondents were classified into three categories according to their functional health. Those who were unable to use public transport, or walk half a mile, or go out of doors, or get around the house comprised the *functionally limited group*. Those who were dependent on another for shopping, or housework, or meal preparation comprised the *intermediate group*, and those who could

meet all requirements were regarded as *independent*. Of those who were independent in 1981, 44% remained independent in 1988, 30% had moved to the intermediate group, 8% had become functionally limited, 2% were institutionalised, and 16% had died. For the intermediate group, 25% were classified in the same way in 1988 as in 1981, 20% had become functionally limited, and a surprising 16% had improved, regaining independence. Of the intermediate group, 3% were institutionalised and 36% had died. For those who were functionally impaired in 1981 the outcome was more negative, but still not completely gloomy. Although 45% had died and 4% were institutionalised, 24% had not changed their functional status and 27% had improved over the 7 years. To complete the picture of stability, McCallum (McCallum 1990a) has reported that two out of three of those who had survived until follow-up had retained the same marital status and the same living arrangements over the 7 year period.

A sense of control and social support are two quality of life issues

The data show that age is not accompanied by decreases in life satisfaction, that older people's lives are affected by fewer life events and when problems do occur, they adopt coping responses that are just as adaptive, if not more so, than those of younger age groups. Nevertheless, older

people do have to face some major life transitions and some individuals deal with change more successfully than others.

ADJUSTMENT TO RETIREMENT

Many myths have been associated with retirement, the more colourful involving dire predictions of loneliness, poverty, illness and death. Such expectations rest on the assumption that paid work is central to a person's identity, sense of worth, and general well-being in industrialised societies (Barron et al. 1952). With the emergence of considerable research showing that retirees are as satisfied with their lives as workers (Atchley 1976; Friedmann & Orbach 1974; Palmore et al. 1984), new perceptions of retirement have emerged. Occupation is not seen necessarily as a major source of self-identification and retirement is accepted as a legitimate role in itself, giving the individual the freedom to continue or expand other roles.

In a recent U.S. study, Bossé et al. (1991) assessed the stressfulness of retirement in two ways. First, 200 men who had retired in the past year were asked to complete the Elders Life Stress Inventory (Aldwin 1990). Retirement had the second lowest mean stress rating of the 31 events which may have been experienced in the past 12 months. The lowest was the retirement of their wives from paid work! Second, Bossé et al. asked 703 men to identify work or retirement problems which they had had in the last 3 months and to indicate how much they were troubled by these problems. The mean stress rating of workers reporting work problems was significantly greater than the stress rating of retirees reporting retirement problems. The age of the respondents was controlled, since workers, on average, were younger than retirees.

Although retirement does not have adverse consequences for retirees as a group, researchers have consistently identified a minority who find adjustment to retirement difficult. Studies from the United States, Australia, Britain, Israel, and France show about one third of retirees reporting problems (see Braithwaite & Gibson 1987 for a review of these studies).

Those who have difficulty adjusting to retirement are more likely to have health problems, to have inadequate income and to be negatively disposed to retirement (Bossé et al. 1991; Braithwaite & Gibson 1987; Matthews & Brown 1987). Poor health limits activity so that retirement becomes a time of restrictions, frustrations, and perhaps even suffering; a time which contrasts strongly with past memories of physical well-being and work (Shanas 1970). Chronic financial strain has been linked with depression in older adults (Krause 1987a). Loss of income is a consequence of loss of work, so that it is not surprising to find inadequate income explaining discontent among retirees. The importance of pre-retirement disposition has emerged from a number of studies which have linked willingness to retire, positive attitudes to retirement, voluntary and anticipated retire-

ment, and retirement planning, with successful adaptation (see Braithwaite & Gibson 1987). At the same time, Thompson and Streib (1958) and Barfield and Morgan's (1974) warning should be noted: Being positive before retirement may only be advantageous if you have a realistic view of what is ahead.

Atchley (1976) has proposed that retirement adjustment fluctuates over time. First retirees enter a honeymoon phase, followed by disenchantment, re-orientation, stability and termination phases consecutively. The model has not had a significant impact on empirical research except to alert researchers to the possibility that adjustment may depend on time since retirement. In a study of 70 male university retirees, Levy (1979) pointed out that the prognosis for retirees experiencing adjustment difficulties depended on the circumstances of their retirement. Retirees who were reluctant but healthy were eventually as satisfied with life as willing healthy retirees. Unhealthy retirees, on the other hand, not only experienced difficulties initially, but also later on.

Braithwaite et al. (1986) used data from 487 male and female retirees who participated in the Australian Ageing and the Family Project, to identify distinct styles of poor adjustment among the third of retirees traditionally grouped together as the non-coping minority. Four poor adjustment styles were delineated. The first two, poor health and negativism, had long term adverse consequences for adjustment. Poor adjusters with continuing health problems were likely to have retired for health reasons, to have inadequate income, to have lower morale, and be less active and involved with others. Negativism was a style reflecting mental attitude which could not be explained by health problems or involuntary retirement. These poor adjusters saw nothing good about retirement, considered life boring, and had low morale in general. One interpretation is that these retirees were disappointed with what the new role had to offer and despaired at what the future held. The remaining two styles were characterised by short term difficulties which were unrelated to later adjustment. The reluctant retiree fell into this category as did the retiree who disliked change.

The recent abolition of mandatory retirement for men at 65 and women at 60 is likely to have an impact on the likelihood of poor retirement adjustment. Choosing the time at which one retires can be expected to increase retirement satisfaction. The importance of control in our lives as we age is discussed later in this chapter. Nevertheless, some older people will still be forced to retire for health reasons or because of age prejudices.

Just as worthy of consideration is the downside of the abolition of mandatory retirement. This policy initiative may not be beneficial if pension entitlements are restricted. McCallum (1990b) has pointed out that increasing life expectancy and early retirement means an increase in the numbers of people expecting and needing government support through pensions and benefits. This increase combined with the lower birth rates in

the latter part of this century can be expected to affect the dependency ratio (the number who are economically nonproductive to the number who are economically productive). Once the dependency ratio reaches unmanageable proportions, some Australians may be forced to continue working in the future because government support is inadequate. Gains in freedom to work may be accompanied by the loss of the freedom to retire.

When retirement is experienced by married couples, the question of coordination and the impact on the retiree's partner must be considered. Two findings are noteworthy. Lee and Shehan (1989) found that wives experienced dissatisfaction when their husbands retired but they continued to work. The explanation offered by Lee and Shehan was that women resented the fact that their husbands did little around the house. Rexroat and Shehan (1987) found that men spent less than 8 hours per week on domestic labour while their wives did almost an extra 20 hours, even when they were employed outside the home.

Data from the Ageing and the Family Project (McCallum 1986) revealed that reactions to a spouse's retirement were generally positive (72% found their spouse's retirement 'not at all difficult'). Nevertheless, interesting sex differences emerged. While 88% of men reported having no difficulty adjusting to their wife's retirement, only 65% of women felt this way. Although women were more likely to mention companionship as one of the best things about their husband retiring, they were also likely to mention 'the spouse always being there' as one of the worst things (29%). Interestingly enough, men did not mention this as a problem at all. McCallum interprets these findings as reflecting the intrusion of men into women's traditional domain of responsibility, the home. Dempsey (1989), on the basis of a study of retiring couples in a small town in Victoria, offers an alternative interpretation. She concluded that retired men help rather than share responsibility, and they do the kinds of things that take less time, are not servant-like and do not seriously interfere with personal autonomy. In the meantime, their wives wait on them 'hand and foot'.

CAREGIVING

Traditionally, caregiving has not been recognised as a stressor in the life event literature. One explanation is that it is not 'an event' with a clear beginning and end, although the more recent concepts of 'life strain' and 'daily hassles' can readily incorporate the experience. The more likely reason for omission is that caregiving has been assumed as a normal part of everyday life. Indeed, the *cessation* of caregiving was the life event which was first addressed in the literature. Texts often refer to the 'empty nest' syndrome as the middle age life event likely to threaten women's well-being. Having the last child leave home, however, is not stressful for most women and is seen as an opportunity to devote more time to other interests, particularly paid work or a new career (Lowenthal & Chiriboga

1975; Neugarten 1968; Palmore 1981). In the light of these findings, it will be interesting to gauge women's reactions to the increasing trend for 18 to 29 year olds to live at home with their parents (Shehan & Dwyer 1989). This trend appears to be more established in the United States, Britain and Germany than in Australia. In Australia, Young (1987) has observed the trend for young people to leave home at a slightly earlier age, but to return home one or more times before making a final departure. The stress impact of episodes of leaving and returning has yet to be fully assessed.

As the refilling of the empty nest continues, pressure is mounting for families to assume increasing responsibility for their frail aged relatives. This is not to suggest that caring for the aged is a new phenomenon. The myth of children abandoning their aged parents has been demolished for some time, first by Shanas (1979a; 1979b) and later by others (Brody 1981; Brody 1985; Cicirelli 1983). Families have always cared for their frail aged, but the pressures to do so to an advanced stage of disability are now increasing (Rowland 1991). Increases in the proportion of the population who are elderly has led to aged care policies in Australia and elsewhere which restrict access to nursing homes and encourage community care (House of Representatives Standing Committee on Expenditure 1982; Howe 1990). When the community care which is required becomes intensive, the responsibility invariably falls on the shoulders of one member of the family — a spouse or a child (Kinnear & Graycar 1982; Tennstedt & McKinlay 1989). The demands that are made on them are neither normal nor reasonable (McCallum & Gelfand 1990) and previous experiences of caregiving in the parenting years are turned on their head (Braithwaite 1990).

Estimates vary, but most studies report that between 70 and 80% of caregivers are women (Australian Council on the Ageing and Australian Department of Community Services 1985; Braithwaite 1990; Jones & Vetter 1984; Stone et al. 1987). Where care is provided to a parent, this percentage increases dramatically, but when care involves a spouse, the gender difference is less marked. Caregiving for parents or spouses is not restricted to the latter part of life, but studies typically report more than 40% of carers as being 60 years of age or over, with the median age hovering around the mid-50s.

Since Grad and Sainsbury's (Grad & Sainsbury 1968) pioneering work linking caregiving to mental illness, many studies have documented the burden of family caregiving and have demonstrated high rates of anxiety and depression and low levels of morale and life satisfaction among primary caregivers (Braithwaite 1990; George & Gwyther 1986; Schulz et al. 1990; Tennestedt & McKinlay 1989). Although these studies have met with methodological criticisms associated with the problem of defining the population of caregivers and of obtaining representative and adequate control samples (Morris et al. 1988; Schulz et al. 1990), there is little disagreement that caregiving poses serious problems for some families.

After a decade of intensive research on caregiving, insights into the causes of caregiver stress are confusing and conflicting (see the reviews of Braithwaite 1990; George & Gwyther 1986; Morris et al. 1988; Raveis et al. 1990; Schulz et al. 1990; Tennstedt & McKinlay 1989). The key concept of burden has been inadequately defined and it has taken some time for researchers to adopt a common research paradigm (Pearlin et al. 1990; Stephens & Zarit 1989).

Increasingly, researchers are coming to the view that the stress of caregiving does not lie in the workload that is entailed nor in the disabilities of the person needing care (George & Gwyther 1986; Kinney & Stephens 1989b; Morris et al. 1988; Novak & Guest 1989). Difficult and disruptive behaviour in the person receiving care, however, does seem to be associated with greater stress, as does strain in the caregiver-carereceiver relationship (Kinney & Stephens 1989a; Kinney & Stephens 1989b; Morris et al. 1988; Young & Kahana 1989). Braithwaite (1990) has incorporated these findings into a model explaining caregiving burden and stress.

The starting point for the model was the impressive body of literature which had accumulated documenting the so called burden of caring for an aged relative; losses in employment, money, friends, social activities, leisure, freedom, privacy and sleep; disruption of household routine and family life; change of roles; and responding to demands for assistance from another. Yet these experiences are an integral part of caring in other areas of life as well. New born babies present their parents with all these losses, changes, dependencies and annoyances; but parents respond with pride, affection and tolerance, and rarely call their new infant a burden. The central thesis of the model is that burden does not lie in what the caregiver does nor in what the carereceiver asks, but is rather a product of any kind of caregiving which is unable to prevent deterioration of a physiological, psychological or social kind.

In dealing with increasing dependency, five 'crises of decline' are encountered which contrast sharply with the demands typically made during child rearing: awareness of degeneration, unpredictability, time constraints, renegotiating the caregiver–carereceiver relationship and lack of choice. Using cross-sectional data from 144 caregivers in Canberra, support was found for the 'crises of decline' model. Caregivers who were most likely to be stressed (a) were dealing with more emotional disturbance and cognitive impairment: (b) had much to learn about caregiving; (c) felt pressured by time; (d) had been dominated by the recipient of care; (e) had a difficult relationship with this person; and (f) wanted nursing home care for their relative. Carers who were female and who felt solely responsible for care were also at risk. In examining the relationship between burden and minor psychiatrist symptoms, both coping strategies and family characteristics seemed to assist in preventing a difficult situation from getting worse. Caregivers who were burdened, in the sense that their basic needs were not being met, were less likely to have impaired

mental health if they adopted problem-focused coping (e.g. developed plans of action, sought advice), if they got away from the situation to re-charge their batteries and if they had a close-knit and supportive social network.

While stress is characteristic of this kind of caregiving, it is important to recognise that carers do experience satisfaction in this role and often report that they are pleased they have provided care themselves (Motenko 1989). It is interesting to note, however, that such carers would often also add 'I would never wish this on my own children' (Braithwaite 1990).

The later years provide opportunity for caregiving of another kind. Rowland (1986) has drawn attention to another life transition, becoming a grandparent or a great-grandparent. Research suggests that most find this role significant and emotionally fulfilling, providing a sense of familial renewal and a diversion to their lives (Doka & Mertz 1988; Kivnick 1982; Neugarten & Weinstein 1964). At this stage, insufficient data are available to fully understand the relationships between grandparenting and well-being (Miller & Cavanaugh 1990; Thomas 1986; Troll 1980).

BEREAVEMENT

Death of a significant other consistently emerges as the most stressful life event (Bossé et al. 1991; Holmes & Rahe 1967). Furthermore, its impact is no less among the elderly than the young (Bossé et al. 1991; Bourque & Back 1977), although Palmore (1981) suggests that adjustment may be more difficult in middle age than old. Bereavement in later life commonly involves widowhood. Women are the most likely to be affected because of their greater longevity and because they have traditionally married men older than themselves. Of Australians aged 65 and over, 48% of women are widowed compared with only 14% of men (Rowland 1991). Studies have repeatedly linked bereavement with depression (Clayton 1979; Maddison & Viola 1968; McCallum 1986; Pearlin & Lieberman 1979; Raphael 1983), but they have also concluded that as psychologically stressful as the experience is, the effects are not long lasting (Murrell et al. 1988; Palmore 1981). Clayton concluded that within a year, men and women were handling the event with minimal morbidity and mortality. Using Ageing and the Family Project data, McCallum found that 2–4 years after the event, only 40% reported having bouts of severe depression compared with 60% in the first year.

In seeking to understand the factors which may explain differences in adjustment among the bereaved, researchers have examined the nature of the death. One hypothesis has been that adjustment would be easier if it were expected and if the bereaved could prepare themselves through anticipatory grief (Glick et al. 1974). For elderly persons, however, this does not appear to be the case. Both Norris and Murrell (1987) and Hill (1988) found that psychological distress was just as great for those who expected the death as for those who did not.

Part of the difficulty in interpreting these results is that anticipated death may have been accompanied by a stressful caregiving experience. Some suggest that death brings a sense of relief (George & Gwyther 1986), while others suggest that difficult caregiving is followed by a difficult bereavement (Bass & Bowman 1990; Schwartz-Borden 1986). Neugarten (1977) has argued that whether the death is sudden or prolonged is irrelevant in old age, because widowhood is expected at this stage of life. A study by Farberow et al. (1987) illustrates Neugarten's point well. They compared the mental health of elderly bereaved dealing with natural death and of those dealing with suicide. The impact of type of death was the same. Death by suicide was no more distressing for the survivors than death through natural causes, and both groups were substantially more distressed than a control group of non-bereaved.

Peterson (1980) has proposed that the resolution of bereavement depends on coping strength, social support and other stressors experienced during the adjustment period. Social support has been studied extensively in relation to widowhood. As Lopata (1979) points out: 'Widowhood generally disorganizes prior supports and social engagements of human beings and often necessitates the modification of old, even the forming of new, social relations . . . ' (p.3). Thus, widows and widowers can not only lose companionship and someone with whom they can share responsibilities, but also be denied the social activities which were made available to them with a spouse. It is interesting that widows often turn to their widowed peers for support so that they don't feel like the 'fifth' wheel in a couple oriented society (Lopata 1979).

Loneliness was the problem mentioned most frequently by just over half of the Melbourne widows studied by Rosenman and Shulman (1987) and was one of the three greatest difficulties experienced by widows and widowers who took part in the Ageing and the Family Project (McCallum 1986). Raphael (1983) purports that a functioning social network is vitally important in successfully dealing with widowhood. In their study of Melbourne widows, Rosenman et al. (1981) found that widows sought support from family and friends, although family were more important initially. Consistent with this finding are the data from the Ageing and the Family Project which showed that widows and widowers were most likely to turn to their children or kin for assistance at the time of the crisis (McCallum 1986).

Dimond et al. (1987) investigated the role of social support in adjusting to bereavement. Three weeks after the death, social support was significantly associated with less depression, higher life satisfaction and better coping. At the 2, 6, 12 and 24 month follow-ups, however, social support did not emerge as a consistently strong predictor. Far more important later on was how well the elderly people had adjusted earlier. These findings can be most readily interpreted in terms of Bankhoff's (1983) thesis that the effectiveness of social support depends on where widows and widowers are in the adjustment process. Dimond et al.'s data suggest

that the right time may be sooner rather than later. Alternatively, friends and relatives may prove less helpful later on because their advice and opinions are not necessarily congruent with those of a person moving towards independence and a new life. Social relationships have the capacity for undermining confidence and creating problems (Rook 1984), and this outcome may be more likely further on in the grieving process.

Where social participation declines during widowhood, Ferraro (1984) has argued that health and economic difficulties are to blame. These additional stressors emerged as important predictors of depression in widows and widowers in the Ageing and the Family Project data set. McCallum (1986) found three variables to be important in explaining whether a severe depression had been experienced in the past twelve months: duration of widowhood, health and income adequacy.

PHYSICAL ILL HEALTH

One of the most consistent predictors of life satisfaction and mental health is poor physical health (Diener 1984; George & Landerman 1984; Larson 1978; Okun et al. 1984). Physical health has been measured in a variety of ways, including physician's evaluations of the patient, patients' perceptions of their own health and the capacity to care for oneself and perform activities of daily living. Self-ratings of health have been linked with life satisfaction of elderly people (McCallum & Shadbolt 1989; Palmore 1981; Willits & Crider 1988) as has functional health (Osberg et al. 1987). Weaker relationships have been found with physicians' assessments (George & Landerman 1984). In a study of older women in a midwestern community in the United States, Lohr et al. (1988) examined the linkages between these health concepts. On the basis of a series of regression analyses, they concluded that physical conditions contributed to functional impairment and that both then resulted in a negative assessment of one's health. Self-assessment, in turn, adversely affected life satisfaction.

In Australia, over 80% of the population over 65 have experienced an illness condition in the past 2 weeks (Rowland 1991). Ory and Bond (1989) quote a comparable statistic for the United States in relation to chronic disease or disability. While the likelihood of poor health increases with age, it is important not to exaggerate the extent of the problem. Rowland notes that the per cent ill for those 65 and over is only 10% higher than for the 45–65 year olds. Both Ory and Bond (1989) and Rowland (1991) have pointed out that other health indices present a less alarming picture. Using data from the Australian Bureau of Statistics, Rowland cites the proportion sick in bed at home as 6% and the proportion having 'reduced activity' on account of an accident or illness as 6%. These statistics differ little from younger age groups. The hospitalisation rate for the aged, however, is higher at 1.5%, as is the average number of days taken to recover from an illness (8 days). Rowland explains these

statistics in terms of older people being more likely to have serious illness.

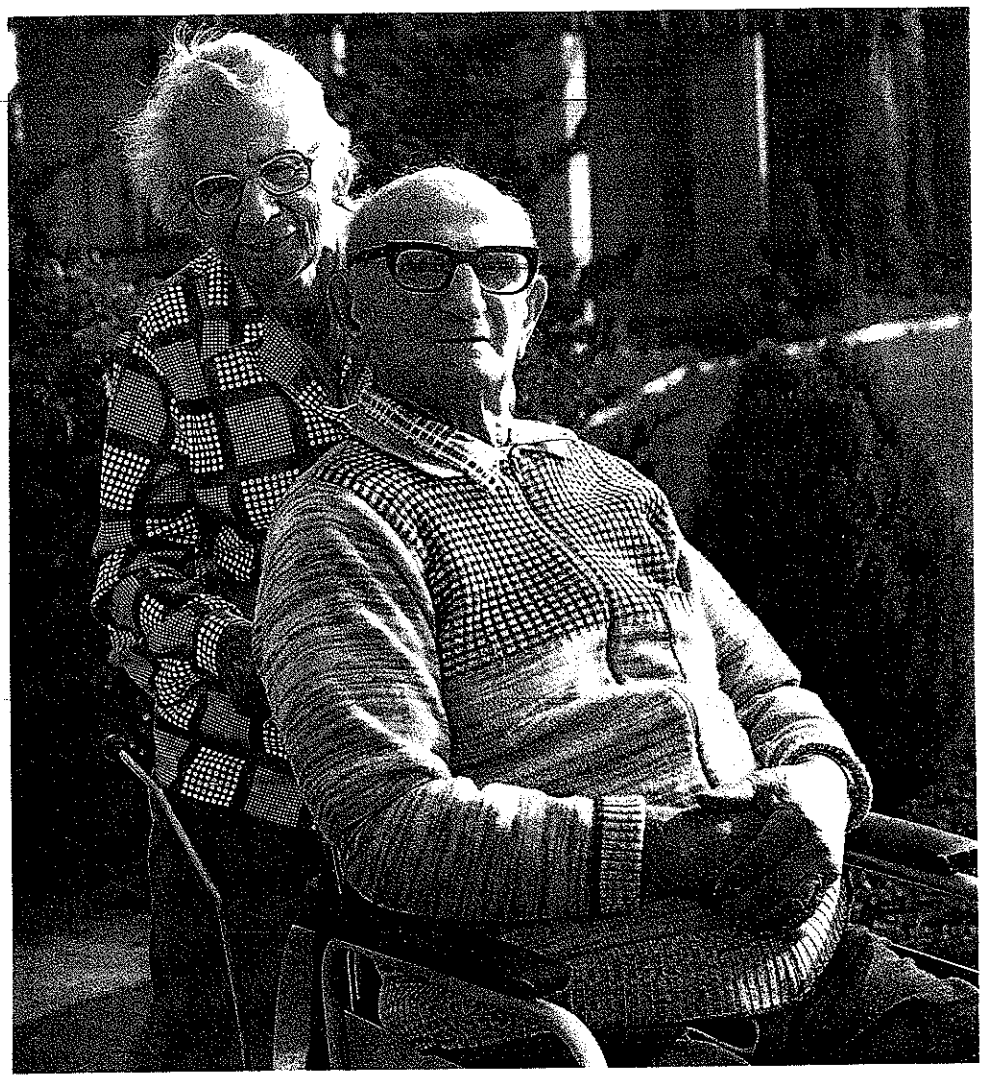
The Ageing and the Family Project also collected detailed data on the health of those over 60 in Sydney. Gibson (1983) has summarised the health status of elderly people in the following way: 'Most people aged 60 and over living in the community consider themselves to be healthy, and lead lifestyles relatively unaffected by sickness and disability. The stereotypic view of this group — frail, sick, and dependent — has little factual basis.' (p. 64) Nevertheless, she points to 10% who were in poor health at the time of the survey. In terms of handicaps and disabilities, Gibson concluded that about one-third of older people experienced problems with their eyesight, their hearing, or their feet; almost a third reported difficulty with one aspect of mobility (e.g. shopping, visiting friends); and one-tenth (11%) had difficulty in undertaking at least one of the personal care tasks (e.g. bathing, dressing).

One of the most interesting aspects of these findings and others (Day 1991; McCallum et al. 1991) is that while functional health declines with age, respondents' self-ratings of their health show little evidence of decline. In the remainder of this section we will look at some of the factors that enable elderly people to evaluate their health positively in spite of difficulties they may be experiencing.

In a study of adults of varying ages with cancer, heart disease or stroke, Levine and Zigler (1975) found that denial was a coping strategy which helped psychological adjustment. (Note that effects on prognosis were not examined.) Patients were required to describe their ideal and real selves before their illness and at the time of the study. Stroke patients attained their relative well-being by denying normal levels of functioning and lowering their aspirations. Levine and Ziegler observed an age effect in their study such that older participants had a lower ideal self image even though their real self image remained the same. Levine and Zigler suggest that age may bring less hope and lowered expectations.

The findings of Felton and Revenson (1987) complement this interpretation. They observed older people minimising their illnesses. In spite of perceiving their illness as serious, older adults were less likely to cope by seeking information, reconstruing their illness to have positive aspects, or engaging in wishful fantasies. In an Australian study, Westbrook and Viney (1983) found that elderly patients expressed less anxiety in relation to illness than did middle aged or young patients. Neugarten's notion of events being 'on time' (Neugarten & Datan 1973) or being expected at that stage of life, is useful in explaining why older people are less likely to put energy into adopting an active, optimistic stance.

The question of whether such patterns of coping enhance the quality of life of elderly people was addressed by Lohr and her colleagues (1988) in their study of the linkages between health concepts and life satisfaction. Lohr et al. examined whether coping strategies had any effects at any points in the model. Direct action coping strategies, such as a change of lifestyle or avoiding harmful things had little effect. Passive-cognitive strat-



Elderly people evaluate their health positively in spite of difficulties

egies, such as trying to think of other things or turning to religion were not helpful and had a deleterious effect on health. Positive-cognitive strategies, on the other hand, such as reminding oneself of the good things about one's health and that one's health is better than most women of the same age, buffered the effects of physical conditions at each point in the health–life satisfaction model. Day (1991) also documents this kind of optimistic response in her study of remarkable survivors.

Support for these conclusions also can be found in studies that have focused on the chronically ill rather than the elderly. Generally such

studies show that coping strategies have a small effect on psychological adjustment (Felton et al. 1984). With regard to the use of coping strategies which seek to do something about the problem (direct action), the findings are mixed. Some studies show that information seeking helps (Felton et al. 1984; Mayou 1979). Others like that of Lohr et al. (1988) have failed to show problem-focused coping as effective (Terry 1991). Greater consistency surrounds the strategies of wishful thinking, blame and avoidance. These passive coping responses appear to be detrimental to well-being (Felton & Revenson 1984; Mayou 1979; Terry 1991). More useful strategies for controlling distress involve optimistic comparisons of one's situation with past experiences or with the experiences of peers (Menaghan 1982; Pearlin et al. 1981). Positive thinking is also characteristic of personality traits that have been associated with successful adjustment to serious illness such as internal locus of control (Ell 1986) and low anxiety (Mayou et al. 1978). In a study of the adaptation of myocardial infarction patients in Canberra, Terry (1991) demonstrated the importance of personal resources in the adaptation process. She found that adaptation was facilitated by low anxiety, internal control beliefs, high self-esteem and high self-efficacy. Self-efficacy referred to the extent to which individuals believed they could perform the behaviours necessary to deal with the event (Bandura 1982).

A second factor which appears to be important in determining the psychological adjustment of those who are physically ill is social support. As both Gibson (1986–1987) and Day (1985) have cautioned, the support must be of the kind that meets the needs of the person concerned. Stephens et al. (1987) investigated the role of positive and negative interactions and found that higher frequencies of negative interactions with family and friends were related to poorer morale and more psychiatric symptoms. Terry (1991) found that patients who reported having good family relations characterised by closeness and little conflict were better adjusted than those without this kind of support. She has suggested that families with low quality relations probably have difficulty achieving the right balance between supportiveness and overprotectiveness. Overprotectiveness in families has been found to have adverse effects on the adaptation of post-infarct patients (Mayou 1984) and of stroke patients (Brocklehurst et al. 1981).

RELOCATION

Rowland (1991) has discussed three kinds of migration among the elderly population in Australia — retirement, disability and widowhood migration. While retirement migration has been the most publicised, research in the United States suggests that relocation generally occurs in response to losses, particularly the onset of disability and widowhood (Colsher & Wallace 1990; Speare et al. 1991). Litwak and Longino (1987)

have proposed a three stage model of residential mobility in later life which emphasises the importance of health. The first stage follows retirement when the need to be near the place of work no longer exists and retirees can move to other areas to be closer to desired amenities (e.g. warmer climate). This is the stage which was not substantiated by the work of Speare et al. and Colsher and Wallace. One explanation is that this kind of migration is relevant to a small, select group. The healthier, younger, well-to-do couples are the ones most likely to seek warmer climates (Biggar 1980; Flynn 1980).

The second stage involves responding to a moderate increase in disability by moving closer to children or to those who can offer assistance. Elderly persons may move in with a child, although research suggests that independence is the preferred option (Day 1985; Kendig 1986; Soldo et al. 1984). Finally, severe disability requires more care than kin can provide and institutional support becomes necessary.

While health and disability may underlie changes in living arrangements, Rowland (1991) has reminded us that 'the middle aged and elderly in Australia are noted for their relative immobility compared with other age groups' (p.66). Australians, on average, change their place of residence about ten times in their lives, but only one occurs in middle age and one in old age.

The move which is most feared by other people and their families is entering a nursing home (Morgan 1982). At any one point in time, the percentage of elderly people who are institutionalised is approximately 5%, although the rate of institutionalisation is higher (Wingard et al. 1987). Rowland (1991) cites research which estimates the US rate as 25% for those over 65. Nursing homes have a negative image in our society and are widely associated with lack of privacy, loss of freedom and sometimes poor quality food and over-sedation (Harwood 1980; Minichiello 1986; Ronalds 1989). The stress is further increased by the fact that the time of entry coincides with heightened vulnerability because of losses in physical or mental functioning. Added to this are the stresses of relocation of any kind — parting with the familiar in both a material and social sense.

In a recent study in a nursing home in South Australia, Rigby et al. (1991) found levels of happiness and negative affect to be lower than those found in a community sample. The differences were not as great as one might have expected, given that nursing home residents would have had poorer health, and lower morale for this reason alone. Lieberman and Tobin (1983) also found the mental health of nursing home residents to be lower than that of a community sample, but no differences emerged between nursing home residents and those on a waiting list.

A large number of studies have emphasised the variability in residents' adaptation to institutional living and have sought to identify the factors that make the transition easier for some than for others. In their study of 120 residents in nineteen wards of an Australian nursing home, Rigby et al. (1991) were able to relate psychological well-being to residents having:

(a) autonomy and playing an active part in the activities of the home; (b) achievable practical goals relating to functioning and rehabilitation; and (c) a clear understanding of the rules and the daily routine. Absence of conflict in the ward involving staff or residents was also associated with well-being.

Thomas and Hayley (1991) examined ease of adjustment in a cross-sectional study of 200 elderly people from fifteen nursing homes and nine hostels in Melbourne and concluded that those who were happier and more satisfied had a positive attitude to residential care and had been involved in the relocation process prior to entering the home. In a longitudinal study, Thomas (1990) identified perceived control as a central factor in older people's adjustment to nursing home life. Perceived control represented residents' perceptions of how much they wanted to control various aspects of institutional life and how much they expected to be able to control such aspects once they were admitted.

Overseas studies point to the importance of both the attitude of residents and the qualities of the nursing home environment. Having a positive pre-entry attitude and high perceived control appear to ease the transition for residents (Janoff-Bulman & Marshall 1982; Schulz & Brenner 1977; Stein et al. 1985). Lieberman and Tobin (1983) found that the greater the perceived mastery and control, the less likely were depressive reactions after relocation, which in turn affected long term outcomes. Lieberman and Tobin's thesis is that institutionalisation for the aged is a crisis which can be dealt with through the creation of a view that one has mastery and control over one's life. Thus, even though perceptions of high control before entering a home may seem at odds with reality, such perceptions are functional: They represent 'adaptive myth-making'.

Nevertheless, both Lieberman and Tobin (1983) and Schulz and Brenner (1977) have argued that conditions within nursing homes are important and that one of the major determinants of adjustment is the discrepancy between premove and postmove environments. Schulz and Brenner, in particular, have focused their attention on predictability and controllability.

Schulz (1976) undertook a field experiment in which institutionalised elderly people were assigned randomly to one of four groups. In the first group, participants determined both the frequency and duration of visits they received from college students. The second group had no control over the visits, but they were informed when visits would occur and for how long. The third group received random visits and the fourth group was not visited at all by the students. Schulz found that predictable and controllable positive events had a powerful positive impact on the well-being of the institutionalised aged. A similar theme emerged from the work of Langer and Rodin (1976). They introduced interventions for two groups of nursing home residents; one of which enhanced autonomy while the other encouraged dependency. One randomly selected floor in the

nursing home attended meetings to encourage them to accept responsibility and play a part in decision making in the home. They were also given a plant to take care of as part of this programme. Another floor attended meetings where they were told that the staff would take care of them, make decisions for them, and, of course, take care of the plants. Langer and Rodin found improvements in the well-being of those in the induced responsibility group, with benefits continuing into the 18 month follow-up (Rodin & Langer 1977).

More recently, two studies have been undertaken which link together the two perspectives which have been discussed so far; control as the autonomy given to elderly people in a social context and control as the individual's perception of personal power to choose and shape the environment. Arling et al. (1986) found that institutionalisation reduced the perceived control of residents even when taking functional status into account. Slivinske and Fitch (1987) demonstrated a reversal of this phenomenon. When a control-enhancing intervention was introduced for residents from three retirement communities, level of functioning not only improved but so did perceptions of control. Thus, while perceived control may be adaptive myth-making in some cases, it also fluctuates with environmental conditions. On this point, Lieberman and Tobin (1983) make an interesting observation. The well-functioning older people were the ones most responsive to environmental quality and environmental change.

MULTIPLE EVENTS

Overall, elderly people meet the major life experiences of retirement, caregiving, bereavement, poor health and relocation with impressive capacities for adaptation. A possibly greater threat to their well-being is the phenomenon of 'pile-up' where a number of significant life events occur together. Murrell et al. (1988), on reviewing their own extensive work in this field, have concluded that the effects of aggregate events on well-being are weak. They do acknowledge, however, that high levels of life events continuing over 2 years can lead to elevated and more enduring levels of depression. Of greater significance is their conclusion that persons with poor mental health and resources can be expected, on average, and over time, to have more undesirable events than those who have better mental health and resources.

CONCLUSION

While the story of adaptation for the elderly population as a whole is a more positive one than social myths would have us believe, individual differences in adjustment are substantial. Some people feel losses acutely

at a time of transition, some are much more threatened than others and some construe the demands being made on them as neither losses nor threats, but as challenges which they will meet. Material and physical resources such as having an adequate income and reasonable physical health have consistently emerged as important predictors of well-being (Larson 1978; Markides & Martin 1979; Okun et al. 1984). Social-psychological variables have also played a role both as determinants of well-being in their own right and as special resources which buffer individuals from the impact of unpleasant events when they occur. This review of the transitions of later life draws attention to two such resources, social support and personal control.

Not only are these variables related to psychological well-being (Chappell & Badger 1989; Headey 1988; Holahan & Holahan 1987), but they appear to be related to each other. Holahan and Holahan found that feelings of self-efficacy contributed to building and maintaining social support and both had a beneficial effect on psychological health. Krause (1987b) has presented evidence showing that social support also contributes to perceived control. According to Krause, social support bolsters internal locus of control beliefs, but only up to a certain point. Beyond this point, personal control decreases.

With regard to both of these variables, the distinction should be drawn between the subjective and the objective. Perceptions and desired levels of support and control need not coincide with objective levels of support and control. Loneliness can be a problem for elderly people in spite of a large network of family and friends popping in regularly, and loneliness, not network size, is the variable which is more strongly associated with well-being (Chappell & Badger 1989; Gibson 1986–1987). Similarly, providing individuals with greater control is not necessarily going to improve their well-being, particularly if it is not what they want or if that control cannot be used effectively by them to improve outcomes (Rodin 1989). Clearly the giving of control in such circumstances will not lead to a heightened sense of personal control.

Although perceptions of and desire for social support and control closely linked to well-being than the objective environmental indices, changes in the objective indices influence perceptions (e.g. bereavement, relocation). The implication for well-being is that environments should give elderly people maximum opportunity for finding the type of social support and the level of control that suits their needs. On both these counts our society has significant challenges ahead.

The availability of social support for elderly people is hampered by our own prejudices and inadequacies. Dependency and loss of control in other adults, whether it be mental or physical, frightens us and we tend to withdraw (Langer et al. 1976). Traditionally we have tucked such people away in institutions and separated them from mainstream life. While we have become more enlightened in this regard, we still harbour anxieties about facing degeneration in older people (Braithwaite 1990). As a result,

we often don't get involved because we find it depressing, upsetting and we don't know what to say or do. Adding to the dilemma about what to say and do are the myriad of stereotypes we hold about elderly people (Green 1981). Opening our eyes to the heterogeneity of this population and seeing them as individuals who have lived full and interesting lives is an important first step in ensuring that our older adults have opportunities to find the social support they need — support which is generous, useful and mutual (Day 1991).

The experiences of old age do much to undermine feelings of control (Rodin 1989). Some are part of the ageing process, but others are induced by society's attitudes and policies. Rodin and Langer (1980) have documented a series of studies which demonstrate the way in which negative labelling and stigmatisation of elderly people can bring about lowered self-esteem and diminished feelings of control. Perhaps the most at risk of induced dependency are the poor and the frail elderly. Gibson (1985) argues that our concept of dependency must recognise not only limitations in capacity to do things as we age, but limitations in our choices for how these things can be done. Dependency can come about not just because of our physical and mental limitations, but it can be imposed upon us by taking away our choice for how we achieve our goals or compensate for our inadequacies. This point can be illustrated most dramatically by focusing on nursing homes. The interventions outlined earlier demonstrate the way in which induced dependency (Swain & Harrison 1979) can be reversed and more independent functioning restored. Gibson also argues that our health care policy for the aged induces dependency. When the assistance being received is not adequate, elderly people do not have an array of support services to choose from. Usually their only option is to ask for resources geared to meeting a higher level of dependency.

Finally, a brief comment should be made on new directions. In their work on adaptation to institutional life, Lieberman and Tobin (1983) used a theoretical framework on stress and adaptation which was much the same as that adopted here. At the conclusion of their book, however, they question the extent to which our notions of adaptation rise out of the values and assumptions of a youth-oriented society. They suggest that adaptation in old age may not have so much to do with happiness or psychological well-being, nor even physical well-being or survival, but rather the preservation of self. They emphasise that this is not about achieving a new sense of wisdom regarding the regularities of human nature, or resolving past conflicts, but rather about achieving the maintenance of a persistent self when internal realities (e.g. health) and external realities (e.g. society) are undermining it. Leiberman and Tobin point out that if coherence and consistency is the ultimate issue, our adaptational models which emphasise rationality may be inappropriate. For instance, the ability of people to create mythologies is not something that we tolerate in our good adjustment model, but it appears to be an

important part of the experience of old age (e.g. adaptive myth-making and reminiscing). Their idea is interesting and is compatible with many of the findings that have emerged from the studies that have already been outlined, particularly those relating to health adaptation.

After such a long chapter, it may appear somewhat insensitive of me to conclude by suggesting that we may have been 'barking up the wrong tree' in our quest to understand adaptation in later life. I was tempted, therefore, to press the delete key and erase the last paragraph from memory. But then I turned to a book entitled '*The Courage to Grow Old*' in which prominent men and women have shared their reflections on old age. This thought not only justified the 'troublesome' paragraph but seemed an appropriate note on which to finish:

> One of the blessings of maturity which is seldom sufficiently recognised is that of genuine humility. In early life there is a strong tendency to suppose that we have all of the answers, but some experience of life can cure this malady. One mark of intellectual growth is the recognition that there *are* no simple answers. The simple answers, we finally realise, are always wrong, because the world is not simple! The mystery of life, far from being dispelled by added years, actually increases with experience. On the whole, the wisest people are also the most humble because, in the heritage of Socrates, they have discovered that advancement involves the recognition of ignorance. A few years of real living can make any person realise that what we do not know far exceeds what we know . . . (p.299)
>
> (Trueblood 1989, born 1900)

TO DO

1. Consider ways in which individuals' behaviour toward elderly people undermines the qualities that we know are associated with psychological well-being.
2. Consider policies and societal attitudes and practices that undermine the psychological well-being of older adults.
3. Read through the research findings in each section on adaptation and evaluate them in relation to Lieberman and Tobin's (1983) hypothesis regarding the importance of preservation of the self in successful ageing.

APPENDIX I

Cross-sectional analyses involve comparisons of different people of different ages at one point in time. Unfortunately, observed effects may be due to either maturation or to a cohort difference. A cohort difference refers to the fact that people born at different times age in different ways

because of changing social circumstances, medical care, health behaviours and so on. Longitudinal designs attempt to overcome this problem through comparing responses from the same people at different times. Individuals act as their own control, but again effects are difficult to interpret. They may be maturational or they may be the result of an intervening historical event (e.g. ozone depletion regions). Time-sequential designs compare responses from independent samples of people of the same age, but the times of measurement differ for the groups. Cross-sequential designs compare responses from independent samples of people born in the same period but compared at different points in time.

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