

Copyright is owned by the Author of the thesis. Permission is given for a copy to be downloaded by an individual for the purpose of research and private study only. The thesis may not be reproduced elsewhere without the permission of the Author.

SUCCESSFUL AGEING: A CRITICAL ANALYSIS

A dissertation submitted in partial

Fulfilment of the requirements for the degree of

Doctor of Philosophy

In

The School of Sociology, Social Policy, and Social Work

at

Massey University, Palmerston North,

New Zealand

Jeanne Holmes

2006

Abstract

The demographics and implications of the growth of the world's population of older people have been well publicised. Frequently, this is linked to concerns about growing demands for social services. In liberal western nations, this rise in the proportion of elderly people is occurring at a period in history when governments are attempting to contain state spending on health care and welfare. Within this context, the gerontological concept of 'successful ageing', which encourages productivity and self-reliance among older people, has emerged.

The term 'successful ageing' was coined by R. J. Havighurst in 1961 and developed by Rowe and Kahn into a gerontological concept in 1998. Rowe and Kahn's search to identify the factors "that conspire to put one octogenarian on cross-country skis and another in a wheelchair" led them to put forward the view that 'successfully aged' old people are those who remain healthy and socially engaged. The concept of successful aging is widely regarded as promoting well-being in old age. As a result, it has become highly influential in the fields of nursing, social work, and social care. However, the concept has also attracted criticism, mainly for praising the fortunate and privileged elders who have managed to prolong healthy middle age; whilst labelling unwell, disabled, and lonely old people as unsuccessful.

In this thesis, my central criticism of the concept of successful ageing is that its definition of 'success' in old age is not based on the views and real life experiences of older people, but instead, on the expertise of scientists and researchers, many of whom have yet to experience the decline and losses normally associated with old age. Consequently, there is a significant difference between the concept of successful ageing and a proportion of elderly people regarding the requirements for the best possible old age.

The purpose of this study is to discover the factors which a diverse group of old people regard as essential to optimal old age. It compares and contrasts their self-assessed components of well-being with the externally assessed components of 'successful aging'. The process involved in-depth research with thirty elderly people in New Zealand and the United States. The majority were women. Several ethnic groups were represented. Participants included First Nations people, first generation immigrants, and the descendants of European settlers. Although it was not intentional, my entire sample consisted of people who would have been defined as unsuccessfully aged by the 'successful ageing' paradigm. Yet these people showed resilience, resourcefulness, and often, great satisfaction with their lives.

This research demonstrates that there is an incomplete fit between the factors, which older people say produce the best possible old age, and those promoted by the concept of successful ageing. It concludes that in order to promote optimum well-being among older people, it is necessary to take note of the experiences, views, and values of elders themselves.

Dedication

SUCCESSFUL AGEING: A CRITICAL ANALYSIS

Jeanne Holmes

To

Each of the Participants

and

In affectionate memory of:

Robert Gordon

Maisie Harrison

Allison Turner

Mabelle Armstrong

Fanny Gage

Annabelle Gregson

Agnes Schultz

Acknowledgements

Dr. Celia Briar with Dr. Mary Murray has been staunchly beside me in the writing of this thesis. The advice I have received has been insightful and the encouragement unflagging. I could not have wished for better supervision. I would also like to thank my husband John for the personal commitment he made to the completion of this work and to my children whose faith in my ability to complete it never wavered. Last, but not least, I would like to thank Massey University for providing a friendly and supportive learning environment.

Table of Contents

Abstract.....	ii
Dedication.....	iii
Table of Contents.....	v
CHAPTER 1 INTRODUCTION TO THE THESIS	1
My Background to this Study.....	2
Key Terms Used in the Thesis.....	5
Statement of the Problem	6
Aim and Scope	7
Overview of the Study.....	8
Conclusions	9
CHAPTER 2 CHANGES AND FLUCTUATIONS IN WESTERN THEORIES OF AGEING	11
Gerontological Theories of Ageing.....	12
“Good Old Age	13
Disengagement Theory	14
Activity Theory	15
Modernisation Theory.....	17
Continuity Theory	18
The Life Course Theory of Ageing.....	20
Theories Redefining the Life Course: The Third and Fourth Ages	21
Conclusions	24
CHAPTER 3 THE DEVELOPMENT OF SUCCESSFUL AGEING AND RELATED CONCEPTS	26
Introduction	26
The MacArthur Foundation Study of Successful Ageing	26
The Significance of Early Lifestyle Practices.....	27

The Significance of Late Lifestyle Practices	28
Healthy Ageing.....	29
The Role of Exercise and Nutrition in Healthy Ageing.....	29
Productive Ageing	31
Vital Ageing	32
Positive Ageing	32
Successful Ageing and Social Inequality	34
The Measurement Problems of Successful Ageing.....	37
Conclusions	41
CHAPTER 4 AGEISM IN LIBERAL WESTERN NATIONS	45
What is Ageism?.....	45
Positive Ageism?.....	47
Ageist Economics.....	49
Ageism and Gender	50
Ageism in Practice.....	51
Ageism and Children.....	54
Conclusions	56
CHAPTER 5 RESEARCH DESIGN.....	58
Introduction	58
Developing the Research Design.....	58
Designing an Ethnographic Study	59
Ethnography and Life Course Perspective	59
The Participants	60
Data Collection.....	63
The Data	65
Limitations of the Study	66
Conclusions	68

CHAPTER 6 INTRODUCTION TO PARTICIPANT PERSPECTIVES.....	70
CHAPTER 7 MAORI PERSPECTIVES ON AGEING.....	77
Introduction	77
Simon Burgess	78
Edna Holt	79
Sarah Hunter	79
Emma Parker.....	80
Maori Models of Well-Being	81
Land and Well-Being	82
Water and Well-Being.....	85
Tradition and Well-Being.....	87
Te Reo Maori and Well-Being	90
Conclusions	92
CHAPTER 8 TWO CHEROKEE PERSPECTIVES ON AGEING.....	94
Harriet Carey	95
Estelle Doherty.....	96
History of the Cherokee.....	97
Loss of Cultural Identity and the Impact on Well-Being	101
Conclusions	108
CHAPTER 9 IMMIGRANT PERSPECTIVES ON AGEING	111
Introduction	111
Susan Eyres	112
Robert Gordon.....	112
Maisie Harrison.....	113
Theresa Landman.....	114
Eileen Richards	115
Neville Schuster	116

Anika Struthers	117
Jacob Traub	118
Allison Turner	119
Immigration, Old Age, and Well-Being	120
Conclusions	123
CHAPTER 10 PARTICIPANTS OF EUROPEAN DESCENT.....	125
New Zealand Participants.....	126
Mabelle Armstrong	126
Sally Dickerson	128
Fanny Gage	129
Mildred Howard.....	130
Nancy Robinson.....	133
Rose Winters	134
The United States Participants.....	136
Annabelle Gregson.....	136
Hannah Meyers	138
Agnes Schultz	139
Conclusions	140
CHAPTER 11 WELL-BEING IN OLD AGE: RESPECT	142
Introduction	142
Relationships with Adult Children, Respect, and Well-Being	143
Adult Children Who Controlled Their Parents' Lives	148
Uninvolved Adult Children and Participant Well-Being	154
Reciprocal Relationships and Participant Well-Being	157
The Importance of Social Support to Respect, Worth, and Well-Being	162
The Importance of Social Engagement to Respect, Worth, and Well-Being.....	166
Conclusions	168

CHAPTER 12 INDEPENDENCE AND WELL-BEING IN OLD AGE	171
Introduction	171
Defining Independence.....	173
The Role of Mobility in Retaining Independence	174
Conclusions	182
CHAPTER 13 THE ENVIRONMENT AND WELL-BEING.....	185
Introduction	185
The ‘Concept’ of Successful Ageing versus the Lived Experience of Old Age	186
The Environment of the Institution and Well-Being	188
Unsafe Neighbourhoods, Substandard Housing and Well-Being	191
The Tendency to Fall and Its Affect on Well-Being	194
Avoiding Institutionalisation	199
Conclusions	203
CHAPTER 14 SPIRITUALITY AND WELL-BEING	205
Introduction	205
Participants’ Expressions of Religion and Spirituality.....	206
Discussion.....	207
Conclusions	209
CHAPTER 15 CONCLUSION.....	210
Introduction	210
A Critique of ‘Successful Ageing’	211
Overlaps between ‘Successful Ageing’ and Well-Being in Old Age.....	213
Towards Well-Being in Old Age.....	214
REFERENCES	218
APPENDIX A MAORI GLOSSARY	308
APPENDIX B STEREOTYPING OLD AGE: A CASE EXAMPLE.....	311
APPENDIX C CHRONIC DISEASES AND DISABILITIES OF PARTICIPANTS....	314

APPENDIX D INFORMATION SHEET316

APPENDIX E CONSENT FORM.....319

APPENDIX F INTERVIEW GUIDE.....320

CHAPTER 1

INTRODUCTION TO THE THESIS

The demographics of the growth of the world's population of older people has been well publicised. Frequently this is linked to concerns about growing demands for social services. In liberal western nations, this rise in the proportion of elderly people is occurring at a period in history when governments are attempting to contain state spending on health and welfare services. Within this context, the gerontological concept of 'successful ageing', which encourages productivity and self-reliance among older people, has emerged.

The term 'successful ageing' was coined by R. J. Havighurst in 1961 and developed into a gerontological concept by Rowe and Kahn in 1998. Rowe and Kahn's search to identify the factors "that conspire to put one octogenarian on cross-country skis and another in a wheelchair" led them to put forward the view that 'successfully' aged old people are those who remain healthy and socially engaged. The concept of 'successful ageing' is widely regarded as promoting well-being in old age. As a result, it has become highly influential in the fields of nursing, social work, and social care. However, the concept has also attracted criticism, mainly for praising the fortunate and privileged elders who manage to prolong healthy middle age; whilst labelling unwell, disabled, and lonely old people as unsuccessful.

In this thesis, my central criticism of the concept of successful ageing is that its definition of 'success' in old age is not based on the views and real life experiences of older people but instead, on the expertise of scientists and researchers, many of whom have yet to experience the decline and losses normally associated with old age. Consequently, there is a significant difference between the concept of successful ageing and a proportion of elderly people regarding the requirements for the best possible old age.

The purpose of this study is to discover the factors which a diverse group of old people regard as essential to optimal old age. It compares and contrasts their self-assessed components of well-being with the externally assessed components of 'successful ageing'. The process involved research with thirty elderly people in New Zealand and the United States. The majority were women. Several ethnic groups were represented. Participants included First Nations people, first generation immigrants, and the descendents of European settlers.

This research demonstrates that there is an incomplete fit between the factors, which older people say produce the best possible old age, and those promoted by the concept of successful ageing. It concludes that in order to promote optimum well-being among older people, it is necessary to take note of the experiences, views, and values of elders themselves.

My Background to this Study

The selection of topics that individual researchers study is no accident...the vicissitudes of everyday life shape writers' research agendas and their interests become the 'stuff' of sociological thought. This is about universal concerns that become thematic. The everyday things that happen to scholars also happen to ordinary people. Because sense-making about the world serves to counter daily chaos, everyone is in a constant search to understand their own experiences within a broader context rather than as isolated events (Glassner & Hertz, 1999).

This study compares the the factors which a group of elderly people in a variety of circumstances and from a range of ethnic groups believe to be essential to optimal old age. It contrasts what they have to say about the experience of growing old with the opinions of 'successful ageing' experts. It was this thesis, which brought me to sociology and social policy. I came to my PhD study with an undergraduate degree in nursing studies and a graduate degree in organisational management. Though the two degrees may seem unrelated, the organisational management degree benefited my ability to work as a nurse

within both acute and long-term care facilities, and later it added to my qualifications as a nurse manager.

I approached this thesis with a desire to build it around the words, thoughts, and experiences of elderly people. My experience as a geriatric nurse taught me that they seldom have an audience. Their doctors are rushed, their nurses are stressed, and their children and grandchildren lead hectic, busy lives. Outside the environments in which elderly people live – private homes, rest homes, skilled nursing facilities, and retirement villages – society often rushes past with no time to communicate with them. As I became engrossed in my study, I put the experiences of the participants into the context of my experiences with my two mothers and my husband. When I did, I increasingly saw the shortcomings of the western model of medicine and the medically based concept of successful ageing.

Other factors have shaped this thesis. At the age of nine months, I became an adopted daughter, niece, and granddaughter in a family, which loved and cherished me and gave me the courage to do things that women in previous generations of the family had not done before. At the age of seventy-seven, my adopted mother was diagnosed with Parkinson's and Alzheimer's disease. She lost the ability to communicate and I was left wishing I had told her more often how grateful I was for the life she had given me and how much I loved and appreciated her.

While my adopted mother lived, I honoured her wish not to find and develop a relationship with my birth mother. After her death, however, I went in search of that mother. I found her eventually, living not far from the town where I had been born, in the foothills of the Ozark Mountains. It was a great surprise to me to learn that she is a member of the Western Cherokee Nation of Arkansas and Missouri; in fact, her mother, grandmother, and grandfather were full-blood Cherokees. That information created a

major shift in my perception of myself. In acknowledging my Cherokee ancestors, I had to redefine myself. When I attended a family reunion and met aunts, uncles, and cousins I never knew existed, I was in a place I had never been before. I had a new identity: I was a member of a Native American family as well as a member of mainstream America.

Soon after my mother and I were reunited, we attended a tribal council meeting. Four generations of my newly discovered family, all Tsalagi (Cherokee) women, were present. For each of us, it was an event celebrating my homecoming and the heritage we share. I was welcomed into the tribe and identified as a member; I was told my Tsalagi name, given me at birth by my mother, I heard my great-grandmother praised as a storyteller and woman of great strength in a time of turbulence, and my grandmother extolled as a healer. I observed the great respect bestowed on my mother as the oldest member of the Nation in attendance that day. It was a day of great personal joy.

These are the some of the experiences that led me to include older people from several cultures in this study. I could see the impact of the Cherokee culture upon the older people who attended the council meeting and I believed that my thesis could contribute more to a study of 'successful ageing' if it included a diverse range of older people. Thus, this thesis has included First Nations people, including Cherokee, and New Zealand Maori. It also includes first generation immigrants, as well as the descendents of European settlers. Some are extremely poor, others are better off. The great majority are women. In total, the study has involved in-depth research with thirty elderly people in New Zealand and the United States.

In my second year of work on this thesis, my husband became seriously ill and as a result, my research took on a personal meaning that it had not had before. Subsequently he has been diagnosed with Alzheimer's disease. We work and we struggle together – my husband has consistently encouraged me to complete my thesis, despite his own problems

and difficulties. Helping him has given me first hand understanding of the challenges, rewards, and needs that had also been experienced by many of the older women in my sample, who had cared for their partners in the later stages of their lives.

Although it was not intentional, my entire sample consisted of people who would have been defined as ‘unsuccessfully’ aged by the successful ageing concept: that is, they are either ill, disabled or lonely and sometimes all three. Yet these people showed resilience, resourcefulness, and often, great satisfaction with their lives.

Key Terms Used in the Thesis

In this thesis, the term ‘*successful ageing*’ refers specifically to the meaning attached to it by Rowe and Kahn:

“It is the *combination* of all three – avoidance of disease and disability, maintenance of cognitive and physical function, and sustained engagement with life – that represents the concept of successful aging most fully” (Rowe & Kahn, 1998: 39).

The key term ‘*liberal western nations*’ refers to countries which place high value on individual freedom, personal responsibility, self-sufficiency, and reliance on the market (Hyman, 2002; OECD, 2004; Smootha, 2002; Mendes, 2005; Mirowski, 2005; Binstock, 2004). Although there are several such countries in the world, in this thesis, these are specifically the United States and New Zealand – the countries in which the participants reside.

In this thesis, the term *well-being* describes the views and perspectives of the elderly people who participated in this study. For these participants, ageing with well-being means to age in such a way that even when they are ill, disabled, or no longer ‘attractive’ or powerful, they may still experience happiness and life satisfaction. It should also be noted that in the literature on ageing, well-being is frequently referred to subjective well-being (SWB), a term that can encompass aspects of life satisfaction, perceived quality of

life, and emotions such as happiness and peace of mind (Luo, 2006; Hagberg, Hagberg, & Saveman, 2002; Pinquart & Sorensen, 2000).

Statement of the Problem

According to Rowe and Kahn's health-oriented definition, successful ageing consists of "low risk of disease and disease-related disability, high mental and physical function, and active engagement with life" (Rowe & Kahn 1998: 38). These are not only the characteristics of 'successful' old age, but also of 'successful' middle age. The concept of successful ageing can thus be viewed as a process whereby the characteristics of middle age are extended into old age for as long as possible (Lucas, 2004). 'Successfully' aged individuals are therefore physically active; they jog and walk, they diet to stay fit and trim, take classes at the local university, and work as volunteers; their clothes are stylish and their hairstyles are fashionable; they are clean, tidy, and neat. They have "kept up with the times", they are not frail or senile and they are not needy – they do not burden society with responsibility for their care.

The successful ageing concept has little to offer elderly people who are dealing with disease, disability, loss of function, and isolation. In a brief discussion of senescence, defined as "the biological changes that occur with advancing age" Rowe and Kahn (1998: 17), have this to say:

... the MacArthur Foundation's Research Studies on Successful Aging have conclusively shown that differences in the rate of senescence are related not only to genetic factors, but also to a number of lifestyle factors that importantly influence the rate at which our bodies change with advancing age. In sum, how successfully one ages is largely determined by how hard one works at it throughout life (Rowe & Kahn, 1998, 208-209).

The majority of the participants in this study were over the age of eighty, few were self-sufficient and independent, and all but one was disabled and had more than one chronic disease. By Rowe and Kahn's definition, they had aged 'unsuccessfully.'

Aim and Scope

This thesis is not the first to examine the shortcomings of the concept of successful ageing. It has been previously described by gerontologists and other experts in the field of ageing as an oversimplified approach to old age aimed primarily at disease prevention (Marshall & Altpeter, 2005); as a concept which emphasises and promotes western middle class values (Torres, 2003); and as an effort to sustain middle age values of success and productivity (Moody, 2002). Other critiques have pointed to the failure of the successful ageing concept to address the meaning of loss (Scheidt, Humpherys, & Yorgason, 1999) and the importance of spirituality (Leder, 1999/2000; Wong, 2000; Flood, 2005/2006); and further, that it stigmatises and marginalises individuals who are ageing with disabilities (Minkler & Fadem, 2002). Nevertheless, this thesis adds a new dimension to the discussions because it distils the several criticisms of the successful ageing concept down to one major flaw – its failure to speak to elderly people. Because of this failure, the successful ageing concept misses essential components of well being in old age. From the perspective of the participants in this study, these neglected components include spirituality, a safe, non-polluted living environment, loving, meaningful relationships with family and friends, being respected, and having worth. As judged by the findings of this study, the greatest failing of the successful ageing concept is that it ignores the voices of aged people, those who know most at first hand about health and well-being in old age.

The successful ageing concept holds individual elders responsible for their “health status in old age” (Rowe & Kahn, 1989: 58; 28-29; 30; 37). As result, western societies sometimes find fault with elderly people for having produced the dilemmas of their old age, devalues their views and opinions (“The Elderly”, 2002; National Center for Policy Analysis, 2001), and fails to include them in the design of social policies aimed at alleviating the barriers to well-being. Older people are at times criticised for the circumstances of their old age and

for their neediness when they rely on public assistance. The underlying message is that their pensions, Social Security, health care and prescription drug programmes threaten the future of their countries' national economies and the well-being of their children and grandchildren (Lee, 2005; Levine, 2005; Follette & Sheiner, 2005; Engardio, Matlack, Edmondson, Rowley, Barraclough, & Smith, 2005; Lisiankova & Wright, 2005)

Today, when people are living longer than ever before, cultural attitudes toward older people are important because the social policies that these attitudes engender affect an immense and largely disenfranchised segment of the world's population. As a cultural concept supported by prominent English-speaking, modern societies, successful ageing attracts wide attention.

Nearly one hundred scientific publications related to the study [MacArthur Study] have followed, and successful aging has since been adopted as a theme of several major national and international meetings, including the Annual Meeting of the Gerontological Society of America, the world's largest group of scholars in gerontology. European research groups, including the Max Planck Institute on Human Development in Berlin and the Nordic Twin Registries, have dedicated their efforts increasingly toward studies of successful aging. The World Health Organization Global Program on Aging has initiated a broad-based study of successful aging in seven countries (Rowe & Kahn, 1998: xiii-xiv).

A re-examination of the concept of successful ageing is both timely and important.

Overview of the Study

This thesis is composed of fifteen chapters, and appendices A through F. Chapter 1 has introduced the problem addressed by the thesis – the differences between the participants' views of how to achieve the best possible old age, and the formula promoted by the successful ageing model. Chapter 2 is a review of several Western theories of ageing – Havighurst's notion of a "good old age", the theories of disengagement, activity, modernisation, continuity, life course perspective, and the third and fourth ages. Chapter 3 examines the development of the concept of successful ageing and the several discourses that attach to it: The MacArthur Foundation Study of Successful Ageing – the basis for

Rowe and Kahn's book *Successful Ageing* – healthy ageing, productive ageing, and vital ageing. Chapter 4 is a discussion of the impact of ageism upon well-being in old age.

Chapter 5 introduces the research design and describes how the need for an in-depth understanding of the real life circumstances of the participants led me to life course perspective and ethnography. Chapters 6 through 10 are given over entirely to the viewpoints and perspectives of the participants. Chapter 6 provides participant background information. Chapters 7 through 10 follow a similar design: each begins with vignettes of the participants based on ethnicity and culture, and follow with discussions attuned to their particular perspectives of health and well-being. Chapter 7 is devoted to Maori participants, Chapter 8 to Western Cherokee participants, Chapter 9 to Immigrant perspectives, and Chapter 10 focuses on participants of European descent. Chapter 11 examines respect and well-being, Chapter 12 looks at the value of independence to well-being, Chapter 13 discusses the impact of environment and well-being, and Chapter 14 is a discussion of spirituality and well-being. Chapter 15 summarises and closes the thesis.

Conclusions

The successful ageing concept, on the one hand, and the participants on the other, seeks an answer to the same question: How is the best possible old age achieved? They share a similar goal as well. The goal of the successful ageing concept is the enhancement of people's ability to function in later life (Rowe & Kahn, 1998: xii). Similarly, the enhancement of late life function is a goal for the participants. The interview data is rich with statements regarding the factors in their lives that motivate them to get out of bed in the morning and to remain active. However, major differences exist between the theoretical concept and the participants' perceptions of the best possible old age. The successful ageing concept includes neither the viewpoints nor opinions of elderly people nor does it discuss subjective factors of happiness or life satisfaction. Instead, it chooses a

science-based, medical approach to achieving a good old age. In contrast, the participants are openly subjective about the factors that promote and those that discourage well-being. These differences are the focus of this thesis. While the concept of successful ageing seeks to improve the function of old age by delaying and avoiding disease and disease-related disability, the participants themselves seek to enhance their function by achieving well-being. In their view, it is spirituality, a sense of place, belonging to the land, having safe, good quality housing, an adequate income, having respect, and being of worth, which makes their lives significant and creates well-being.

CHAPTER 2

CHANGES AND FLUCTUATIONS IN WESTERN THEORIES OF AGEING

This chapter examines a range of theories of ageing which have emerged during the past fifty years. It links these theories to some of the changing economic policies and demographics during the same period. By this means, it identifies two types of theories. The first are those theories that attempt to prescribe a model for old age that fits with the current economic orthodoxy of their time. For example, theories that promote ‘active’ and ‘productive’ ageing have emerged at a time when the costs of old pensions have been highlighted as a major concern.¹ Second are theories that seek to understand what factors promote (or detract from) well-being in old age. These are somewhat less prone to fluctuate over time.

¹ Before industrialisation, working people did not ‘go out’ to work. Most people, including women, children, and the aged, worked at home (Haber, 1978; Coffin, 1998; McTighe, 1986). Individuals did not ‘exit’ the work force. Even in old age, individuals were expected to be productive and useful (Maples & Abney 2006; Dychtwald, 2002). In the early twentieth century, this situation is said to have changed when the invention of conveyer belt-based assembly lines made the speed of young workers more valuable than the creative skills of slower-moving, older workers (Hirshbein, 2001; Warnes, 1989: 70-71; “The Assembly Line,” 1996). This was the era into which retirement was introduced (Hannah, 1986: 22-24; Lee, 2005; Atkinson, 2004). Presented to workers as a reward for long years in the work force, retirement was a means of replacing older with younger workers, thereby lowering production costs, and increasing profitability (Appelbaum, Patton, & Shapiro, 2004; Bhattacharya & Smith, 2001; Greller, 1999). For men (Costa, 1998), retirement became the formal end to decades of work force participation, and the point of entry into old age (Denton, 1999; Walker, 1999: 369), a “fixed rite of passage” (Warnes, 1989:71; Hannah, 1986: 4). Old age pensions granted the right to withdraw from work with a secure, if small, income. However, this did not guarantee a rise in the status of older people.

Gerontological Theories of Ageing

The root of the word gerontology comes from the Greek *gera* and *geron*, and means great age and the privilege of age, the rights of seniority (Minois, 1989/1987: 64; Liebig, 2002). Despite the ancient roots of its name, however, gerontology, the study of ageing from the biological, psychological, social, economic, and other aspects of ageing, is a product of the twentieth century. Eli Metchnikoff, a Russian biologist, first used the word gerontology (Pearce & Cronen, 1980; Butler & Fillit, 2006), in this 1908 statement:

I think it is extremely probable that the scientific study of old age and of death, two branches of science that may be called *gerontology* and *thanatology*, will bring about great modifications in the course of the last period of life (as cited in Achenbaum, 1995: 23).

Beginning in the 1920's, and 30's, growing interest in old age led to the emergence of gerontology as a discipline in the United States and Europe. In 1922, American psychologist G. Stanley Hall published a book entitled *Senescence*; in the 1930's Edmund Cowdry convened a conference of American scientists to set the parameters of the new field of gerontology. A similar interest in old age was occurring in Europe. In 1938, a congress on senescence was held in Kiev, a survey on old age was published in France, in Germany, the first periodical on old age was published, and in 1939, English doctors and scientists founded an international club for research on old age (Port, 2006). Through organisations such as the International Association of Gerontology (IAG), the growth of gerontology as a field of study has continued. Today, the IAG has member organisations in Africa, Asia/Oceania/ Europe, Latin America, the Caribbean, and North America (International Association of Gerontology, 2006).

Generally using a life-span approach, (Information for Life-Span Development, 2006; Maples & Abney, 2006), where old age is perceived as “the end result of a life-long developmental process”(Woolf, 1998), gerontologists study old age from chronological, biological, psychological, and social perspectives (Hooyman & Asuman, 1999;

Cunningham & Brookbank, 1988). In 1961, R. J. Havighurst, a western scholar and proponent of activity theory, proposed that the function of gerontology is to provide guidance to society and individuals on decisions regarding issues of old age such as retirement and social security, housing, where and with whom to live, how to relate to one's family, and what to do in retirement.

Many social changes have taken place since Havighurst's 1961 comments (Pampel & Williamson, 1989), and gerontological theories of ageing have changed as well. For example, in the 1960's the large 'baby boomer' population was aged ten to fifteen and welfare spending was at its most generous in liberal nations (Hall, 1996:245; Peterson, 1991: 7-12). Today, the elderly, rather than the young, are the fastest growing segment of society and concern over the funding of old age pensions and services has contributed to welfare reform (Binstock, 2004; Choi & Sharpe, 2005). Consequently, in the early twenty-first century, populations of healthy, active, productive, and vital older people seems more beneficial to the modern welfare state than disengaged elders who have withdrawn from their social responsibilities.²

"Good Old Age"

The idea that old age can be defined in terms of 'success,' did not emerge until the second half of the twentieth century. Havighurst first used the term 'successful ageing' in the 1961 introductory issue of *The Gerontologist*. Writing at a time when life satisfaction, morale, and mental health were the means of measuring optimal old age (Johnson, 2005:

² Binstock points out that in the U.S., in the decades since the 1960s and 70s, "...we have been returning to our ideological roots as a nation – emphasizing individualism, personal responsibility, and reliance on the market. This trend was aptly expressed in the title of the welfare reform legislation enacted during President Clinton's first term – The Personal Responsibility and Work Opportunity Reconciliation Act of 1996" (Binstock, 2004: 49).

375), Havighurst believed that ageing could be a “lively and creative experience”, (as cited in Powell, 2001). As regards the development of a gerontological theory of successful ageing, he warned:

“As long as there is disagreement as to what constitutes successful ageing, caution must be used in selecting measures of successful ageing. ...At present, a theory of successful ageing is an affirmation of certain values” (The Gerontologist, 1961).

Havighurst’s cautions regarding the successful ageing concept are as relevant today as they were when they appeared in *The Gerontologist* nearly half a century ago.

Disengagement Theory

In 1961, the same year in which *The Gerontologist* was launched, and Havighurst’s comments were published, sociologists Cumming and Henry authored a book entitled *Growing Old*, in which they presented the theory of disengagement. Unlike the successful ageing concept, which proposes that older people can retain the health and vitality of their middle-age, *Growing Old* depicted old people as weak, prone to illness and disability, and unable to work as productively and efficiently as younger people. For these reasons, disengagement theory argues for a two way process in which older people voluntarily withdraw from work and social responsibilities, and society responds by accepting their withdrawal and replacing them with younger, more productive people. In this way, society avoids the social disruption that the death of elders occupying positions of power and authority might otherwise cause (Tornstam, 1994:204; Green, 1993:58-59, 141-142; Zeev, 1991:11-12). Furthermore, being free of social responsibilities, older people are able to engage in activities more meaningful to the final stage of life – contemplation and preparation for death, the ultimate disengagement (Cumming, Dean, Newell, & McCaffrey, 1961; Pilcher, 1995: 103-104).

Today, disengagement theory is largely disregarded as a viable approach to health and well-being in old age (Sneed & Whitbourne, 2005; Thomas, Martin, Alexander, Cooley,

& Loague, 2003; Goldberg, 2002). Philibert describes disengagement as a Western view of old age (as cited in Johnson, 1995) which considers ageing from the perspective of decline and demotion, as little more than anticipation of death, and as ageist and antipathetic to growth, life, and happiness in the last stage of life.

Disengagement theory was a product of its time – a time when an anticipated large influx of post World War II ‘baby boomers’ into the labour force made it desirable to retire and to ‘disengage’ older people. Circumstances are much different today; the world population is ageing and the number of young people of working age is declining. As a result, older people are encouraged to remain active and the theory of disengagement has become outdated. Organisations such as Age Concern England, Grey Power New Zealand, A.A.R.P. (American Association of Retired Persons), R.V.S.P. (Retired and Senior Volunteer Program), Eldercare Web, and Senior Japan, support active, engaged lifestyles for older people. These organisations promote senior citizen activities such as travel, education, volunteerism, exercise, and continued involvement with life. Most of these activities are irrelevant to all but a small number of older people because they require a degree of wealth, health, and leisure time that the majority of the world’s elders do not possess. Nevertheless, in liberal western nations of the early twenty-first century, the idea that engagement can optimise the lives of older people, even the very old, has taken root (Rodts, 2006; Kuster, 2006; McIntosh, Sykes, & Kubena, 2002).

Activity Theory

Activity theory is the converse side of disengagement theory. It proposes that disengagement is neither inevitable nor advantageous to society or to the aged. Instead, activity is promoted as the key to successful ageing. Rather than withdrawing when events such as widowhood and retirement occur, activity theory maintains that social interaction is important in maintaining high morale, a high level of life satisfaction, and in

counteracting psychological regression (Lebo, 1953; Burgess, 1954; Havighurst, Neugarten, & Tobin, 1968; Nussbaum, Pecchioni, Robinson, & Thompson, 2000: 9; Ben-Zira, 1991). Havighurst, while studying community life and ageing in the late 1950s, wrote extensively about activity theory, delineating its major points. These are first, that older people are the same as middle-aged people with essentially the same needs, and secondly that decreased social interaction in old age is often a result of withdrawal by society from ageing persons, and is contrary to their wishes. Havighurst argued that optimal ageing occurs when older individuals maintain the activities of middle-age as long as possible, finding substitutes for work lost by retirement and substitutes for friends and loved ones lost by death (as cited in Palmore, 1975; Atchley & Barusch, 2004).

Activity theory continues to develop. Today, ongoing activity and engagement with life is considered an important constituent of successful ageing (Horowitz & Pei-Fen, 2004; Penick & Fallshore, 2005). Activity theory takes a positive attitude towards growing old, proposing that older people participate in, rather than withdrawing from life. It is a theory that is likely to receive more credence in the current demographic situation.

The flaws of activity theory centre on the expectation it places on older people to maintain a middle-aged level of activity for long as possible. Focusing on the benefits of activity, it does not address adequately the barriers to remaining active: physical disability, chronic disease, declining levels of energy and motivation (Putnam, 2002; Wallace & Lahti, 2005), low retirement incomes, and ageism. It also fails to take adequate account of the depression and sense of loss that may occur when frail elderly people are no longer able to engage in activities of middle age (Marshall & Altpeter, 2005; Kivinen, Halonen, Eronen, & Nissinen A, 1998).

Modernisation Theory

Modernisation theory states that as a society transforms from rural to industrial, the social position of its elderly people declines (Thomas & Zhang, 1994; Frow, 1997: 34-35). That is, the status of elderly people is inversely related to the level of industrialisation. This theory argues that modernisation alters established cultural institutions and systems in ways that negatively influence the social position of aged people (Cheal, 1996: 2-4). Alexandre Kache, head of the World Health Organization's ageing and health division, has suggested that modernisation makes the structure of traditional societies fragile (as cited in Seabrook, 2000). Modernisation is held responsible for disempowering elders by reducing the value of traditional skills. It is also held responsible for disconnecting older people from younger generations by reassigning the education of youth to classroom instructors in systems of mass education, and for making the historical knowledge of older persons obsolescent by emphasising technology-based knowledge (Silverstein, Burholt, Wenger, & Bengtson, 1998; Chappell & Driedger, 1987: 19-23; Xu & Ji, 1999; Collings, 1999; Moody, 2002: 296-297). It is further suggested that the practice of ageism in modern societies is a logical outcome of a shift away from the traditional veneration of elders to the current tendency to view them as non-contributing members of society (Nelson, 2005; Cuddy, Norton, & Fiske, 2005).

Implicit in modernisation theory is the assumption that the status of older people is higher in traditional societies than in modern ones. This assumption has been challenged as a myth (Hareven, 2000: 4; Lye, 1996; Hareven, 1978: 57-58; Rybczynski, 1996: 3-4; Blaikie, 1999: 55; Hannah, 1986: 3). It ignores the poets and writers who for three thousand years have ridiculed the incompetence and senility of elderly people (Fowler, Fowler & Lamdin, 1982: 19-20). In addition, modernisation theory fails to acknowledge adequately that within both traditional and modern societies, at any given time several

variations in the treatment of older people may be in practice. Traditional societies do not universally revere their elderly, nor do modern societies universally despise those who are old (Yanagisako, 1985; Phillips, 2000: 20-21; Stearns & Van Tassel, 1986: 5). Nevertheless, the status of elders amongst first nations is undoubtedly higher than amongst dominant groups in liberal-western societies, and this lends support to modernisation theory (Okoye, 2006; Litwin & Zoabi, 2004; Nyangweso, 1998).

Continuity Theory

First proposed by Robert Atchley (1989), continuity theory developed from the findings of the Ohio Longitudinal Study of Aging and Adaptation (OLSAA), an American study of retirement conducted from 1975 to 1995 (Austrian, 2002: 296). Atchley describes continuity theory as a “theory of continuous adult development, including adaptation to changing situations.” He uses it to explain a major finding of the OLSAA: “Despite significant changes in health, functioning, and social circumstances, a large proportion of older adults show considerable consistency over time” in overall patterns of thinking, choice of activities, social arrangements, and living arrangements (Atchley, 1999: 1; Lysack & Seipke, 2002).

To explain the consistency of adult patterns of behaviour over time, continuity theory suggests the existence of two types of continuity: external and internal continuity. External continuity refers to consistency over time in individual choice of activities, social roles, relationships, and living arrangements. Internal continuity represents persistence in personal values, temperament, preferences, and ideas about the self and the world (Nussbaum, Pecchioni, Robinson & Thompson, 2000: 34-35; Bowling, Hill, Morrison, & Thorn, 2002: 11-12). Therefore, unless poor health or disability interferes with their ability to do so, older people provide continuity and stability to late life by choosing to engage in the behaviours and activities of the earlier stages of their lives (Kim & Feldman,

2000), thereby (Hendricks & Cutler, 2005). Continuity theory postulates that continuity of personal habits and temperament is helpful in adjusting to the changes and losses of late life (Salmon, 1981), and it also suggests that, “individual choices are made not only to achieve goals, but to adapt to constantly changing circumstances” (Atchley, 1999: 5-6). Consequently, when faced with changing life situations, older people reshape themselves in ways that are consistent with their personal values, character, and identity. Although continuity theory was first proposed as an explanation of normal ageing, Atchley later used it to define successfully aged people as those who, despite the losses of old age, are able to adapt in ways that help maintain their identity (Atchley, 1980).

Continuity theory may be more relevant to the realities of ‘young’ old age where middle-age activities, lifestyle arrangements, and social relationships are more sustainable. In deep old age, as energy levels decrease, the ability, and the motivation to maintain middle-age levels of activity are also likely to decrease (Moody, 2002: 299; Bearon, 1996; Nussbaum et al, 2000: 10). Few studies examine continuity theory from the perspective of the very old. The study of Lysack and Seipke is an exception. This ethnographic study, which focuses on the role of “feminine-sphere activities” in the lives of a group of women over the age eighty-five, found “well-being and meaning in life to be associated with the ability to continue these activities” (Lysack & Seipke, 2002: 138). More studies such as Lysack and Seipke’s are needed on the link between activity as described by continuity theory and the notion of successful ageing. With the rapid growth of the over eighty-five population, an especially important research question of such studies would be whether continuity theory could provide well-being and life satisfaction in deep old age.

The Life Course Theory of Ageing

By the 1960s longitudinal studies of children in the United States had in some cases followed study members since the 1920s (Sorensen, Sherrod, & Weinert F. E, 1986: 294; Offer & Sabshin, 1984: 133). Since earlier studies of human development had focused on child development, there were no appropriate comparative adult models available for researchers to apply to older study participants. In the 1970s, with the launching of several new longitudinal studies of adults and children in both Great Britain and the United States (Smith & O'Sullivan, 2004; Panel Study, 2005), a model for studying human development from birth to death became an imperative (Elder, 1999: 12). This need led to the development of new concepts of life-span development and ageing, new concepts of how human lives evolve over time, and new views of the effect of social change on ageing (Elder, 2000: x-xi).

Life course perspective is one such concept. When considering human ageing, it looks at the influence of factors such as gender, race, environment, ethnicity, social class, and sexual orientation on life, family, education, work and leisure (Schuster, Francis-Connelly, Alford-Trewn, & Brooks, 2003: 844-845). When examining old age, life course perspective takes into account the circumstances of the entire life course, stressing the “life-long interaction of person and social context” (Elder, 2000: xii). Old age is not a separate period of life, fixed by chronological time. Instead, it is merely the last of the stages of life that carry people from birth to death (Sadler, 2000: 203; Hoyt, Whitbeck, & Yoder, 1998). Individual old age is therefore most fully understood when considered within the context of a person’s childhood, adolescence, and middle age – as a summation of the factors that have influenced their whole lives (Blaikie, 1999; University of Toronto, 2003; Settersten, 2005).

The direction and outcome of the life course is the result of at least three interrelated influences: historical time and place (Elder, 2000), society (Schulz & Heckhausen, 1996; Hechter, Opp, & Wippler, 1990: 4), and personal choices (Hareven, 1994: 437-438). The choices we make as individuals within the context of the society and the time in which we live, and our membership in social groups and subcultures form the personal experience of ageing (Elder, 2000: xxiii). Because life course theory recognises the importance of culture and uses it to clarify the circumstances and experiences of old age, it is a useful theory for understanding the cumulative effects of life's experiences upon well-being in old age.

Theories Redefining the Life Course: The Third and Fourth Ages

On average, older people are now living longer and healthier than those of any previous generation. There are growing numbers of healthy retired people, with life expectancies of perhaps several decades. This is producing a sizeable population of 'old' people who, because they are active and fit, no longer match the image conjured up by stereotypes from the past. These are often described as the 'young-old'. In addition, however, there are also growing numbers of frail elderly and very old people, sometimes known as the 'old-old'. One of the responses to these conundrums has been a re-evaluation of the structure of old age.

One such re-evaluation is that of Peter Laslett, a co-founder of the University of the Third Age in the United Kingdom, who, in the 1980s explored the concept of the "third and fourth" ages, describing it as a novel rearrangement of the three life stages of childhood, working life, and retirement (Glendenning, 2001). Within the four stage concept of life, the first stage is designated as childhood and adolescence, the second as independence, earning and saving; the third age as "an era of personal fulfilment"; and the fourth age as "an era of final dependence, decrepitude, and death" (Laslett, 1989:4).

At the time of its conception twenty years ago, the “third age” was a relatively small category of retired people between the ages of sixty and sixty-five. Now, it loosely encompasses individuals from fifty to seventy-four, a growing number of people who, having completed their first full-time career, may live an additional thirty years in active, good health (Freedman & Moen, 2005). Unlike, and in contrast to the stigmatising label ‘senior citizens’, the third age has acquired a generally positive image through the use of life-long learning to achieve well-being. It is from the ranks of the third age that individuals matching the definition of successful ageing are most likely to emerge. The third age is not a “short rest before dependency or death” (Barber, 1998), it is a life stage of twenty to thirty years duration.

The creation of the third and fourth ages has sub-divided erstwhile old age, with the third age extending through a long period of relatively good health. One of the goals of medical technology is to lengthen the third age by extending the years of health and activity and to shorten the fourth age by compressing senility, final illness, and death, into a brief terminal period ((Fries, 1980; Gorin & Lewis, 2004; Kalache, Aboderin, & Hoskins, 2002; Kerr, 2002: 25-26; Radcliffe, 1984: 62). A foreshortened fourth stage is not only beneficial to the individual; it is also important to the state because the numbers of people reaching it are growing rapidly. In developed nations, the over eighty-five-age group is the fastest growing segment of the population.

The current outside view of life in the fourth age is so overwhelmingly negative that it is sometimes characterised as the bad news of longevity, a depository of decline, frailty, and dependence ((Baltes, 2006; Baltes & Baltes, 1998; Max Planck Institute, 2002; Kirkwood, 2001:20-21). Some recent studies describe it as an age of Alzheimer’s dementia, characterized by high levels of frailty, dysfunction, and multi-morbidity, with maintenance and management of losses the central tasks of daily survival (Helmchen,

Baltes, Geisselmann, Kanowski, Linden, & Reischies, 1999; Melzer, 1999; Rosenwaike, 1988). Thus, the prospect of a prolonged fourth age is an intimidating prospect, one that led Laslett to comment:

The biological and medical uncertainties of the length of the Fourth Age, now and in the future, pose the most serious of all the difficulties in the way of accepting the suggested theory of the life course and the Third Age (Laslett, 1989:154).

Fortunately, a more positive prospect for the fourth age is emerging. Although the frailties of advanced old age are undeniable, census data and surveys reveal another picture: most people over the age of eighty-five are not in poor health, do not suffer from Alzheimer's dementia, and are not institutionalised (New Zealand Ministry of Health, 1997; Perls, 1995; Yi & Vaupel, 2002; Palmore, 1999:55). Additionally, data from studies such as the New England Centenarian Study (NECS), and Okinawa Centenarian and Georgia Centenarian Projects indicate that a significant proportion of the oldest old are healthy and robust (Willcox, Willcox, & Suzuki, 2002; University of Georgia, 1995; The New England Centenarian Study, 2005). Thomas Perls, Director of The New England Centenarian Study, has called for a rethinking of traditional views of aging, asking, "Could it be that many people in their upper nineties enjoy good health and that the oldest-old constitute a special – and long-misunderstood – population" (Perls, 1995)? When interviewed, very old people often describe themselves as contented and well aged, judging their lives more on their well-being than on their losses (Depp & Jeste, 2006; von Faber, van der Wiel, van Exel, Gussekloo, Lagaay, & van Dongen, 2000; Garfein & Herzog, 1995; Bauman, Adams, & Waldo, 2001). Yi and Vaupel, who surveyed more than eight thousand Chinese between the ages of 80 and 105, found that despite ongoing physical and cognitive deterioration, self-reported well-being remained almost constant, declining only slightly after the age of ninety-four. Based on their findings, these authors suggest that well-being may be a secret of longevity (Yi & Vaupel, 2002). As eighty-

seven-year-old Miriam Reibold, chair of the Senior Federation and NCCO (National Coalition of Consumer Organisations on Aging) informs us, contentment, happiness, and a positive self-feeling may also be a secret of successful aging. In 2002, Miriam described her fourth age experience in words that indicate clearly the strength of her well-being:

I am 85 years old. I have no desire to hide behind clichés, to say I am 85 years young, or that I am a golden ager, or that I am only growing old. The truth is, I am old, an old woman, and I am happy to be old, because of the freedom, the choice, and the opportunities I have (Reibold, 2002)

Conclusions

The theories surveyed by this chapter reflect the views of gerontologists regarding elderly people in modern liberal nations during the past half century. As we have seen, some of the ideas have changed very little. For example, some of the liberal humanist ideas, such as activity theory and continuity theory, which regard the individual in old age as much the same person as they were in their youth have undergone little change since the 1960s. However, in this same fifty-year period, with a shrinking of the working-age population, a lowering in levels of fertility, and increased restrictions upon welfare spending, the popularity of ‘disengagement’ theory, which encouraged passivity amongst the elderly,³

³ It is worth noting that older people have not been passive in this process. In the 1960’s, during the ‘disengagement theory’ era, older workers experiencing age discrimination in the workplace claimed to right to continue in paid work. Decades later, in the context of shrinking labour forces, an accelerating growth in the number of retirees, and a consequential growth in pension and social security budgets, a number of western nations brought in statutory measures to allow older workers to continue working (Organisation, 2005; Trade Union Advisory, 2003; European Employment, 2002). New Zealand prohibits age discrimination in employment through its Human Rights Act of 1993 and the Employment Relations Act of 2000 (Buttersworth’s 2003); and members of the European Union do so through Employment Directive 2000/78/EC, a memorandum designed to ban discrimination at work (World Europe, 2000; Department for Work and Pensions, 2003). However, currently, despite a high demand for labour, many older workers continue to exit the paid workforce before reaching the age of sixty-five. Sometimes this is a result of redundancy and forced early retirement (Ilmarinen, 2001;

waned. Instead, today's elders are encouraged to age 'actively', 'productively', and 'successfully'.

Moberg, 2001; McMahan & Phillips, 1999). Some people retire early due to poor health. In some occupations – airline pilots and the police for example – early retirement, before health declines, has long been the norm (Cato Institute, 2004). Others choose retirement as a way to exit highly demanding and stressful work. Significant numbers of professionals (teachers and doctors for example) are choosing early retirement (Editorial, 2001; Adams, 2006). Consequently, the number of older employees in all industrial nations continues to decline significantly. In most European Union countries, the exodus of older workers is so marked that it has been suggested, “working after the age of 65 has been eradicated” (Walker, 2000).

CHAPTER 3

THE DEVELOPMENT OF SUCCESSFUL AGEING AND RELATED CONCEPTS

Introduction

The underlying principles of successful ageing concepts are avoidance of the diseases associated with old age, high physical and mental functioning, and ongoing engagement and productivity (Rowe & Kahn, 1998: 38; Motta, Bennati, Ferlito, Malaguamera, & Motta, 2005; Marshall & Altpeter, 2005; Nussbaum, Pecchioni, Robinson, & Thompson, 2000: 332-333; MacArthur Foundation, 2003). These principles reflect latter twentieth century Western standards for health, fulfilment and meaningfulness (Murphy, 2005; Flood, 2002; "Anti-Aging" 2001; Torres, 2002; Saucier, 2004; Loefer, 2003; Martens, Goldenberg, & Greenberg, 2005).

Concepts of successful ageing are made up of a number of discourses. Through the use of slightly different approaches, each seeks the improvement of old age by reducing the negative physical and mental affects of ageing. The names of these discourses, *healthy ageing*, *active ageing*, and *productive ageing*, identify their specific focus. What follows is a sampling of the discourses clustered around the concept of successful aging. Some may appear to be no more than quibbling over semantics, but they merit a review because of the light shed on the basic principles of the successful ageing concept.

The MacArthur Foundation Study of Successful Ageing

In 1984, the MacArthur Foundation assembled an interdisciplinary team of sixteen scientists from the fields of biology, neuroscience, epidemiology, sociology, genetics, psychology, neurology, physiology, and geriatric medicine. The purpose of this team was to provide new insights into the ageing process. Over a period of ten years, these investigators collected data from more than 1,000 high-functioning seventy to seventy-nine year old people. They studied hundreds of pairs of twins to determine genetic and

lifestyle contributions to ageing, conducted laboratory-based studies of the responses of older people to stress, and conducted studies of brain ageing in humans and animals (Rowe & Kahn, 1998: xi-xiii).

From their review of data derived from the MacArthur Foundation Study, the coordinators of the Study – Dr. John Rowe, president of Mount Sinai Hospital in New York City, and Robert Kahn, professor emeritus of psychology and public health at the University of Michigan – formulated a definition of successful ageing. Using the three principles of their definition, avoidance of the diseases of old age, high mental and cognitive functioning, and productivity and engagement, Rowe and Kahn measured the 1000 high functioning elderly participants of the MacArthur Study, concluded that the majority were at substantial risk for disease and ill health, and therefore, had not aged with ‘success’. Consequently, Rowe and Kahn deduced that within the wider population, “a large percentage of all older people” would fail to meet the standards of their definition of ‘successful’ ageing. This large group of ‘unsuccessfully’ aged elders, Rowe and Kahn categorised as “suffering from the syndrome of ‘usual aging,’ a condition associated with significant risk of disease and premature death” (Rowe & Kahn, 1998: 54).

The Significance of Early Lifestyle Practices

The successful ageing concept draws from the findings of the MacArthur Study to suggest that variables relating to mental, physical, and emotional health are more important to successful ageing than “holding a winning ticket in the genetic lottery of heredity” (MacArthur Foundation, 2003). Therefore, to achieve the best old age possible, the successful ageing seeks to modify the variables that lead to disease and poor health through programmes of disease prevention and health promotion (Rowe & Kahn, 1989: 66-67). Thus, the path to ‘successful’ old age is a lifetime of good nutrition, regular exercise, intellectual challenges, and rich interpersonal relationships. Conversely, a

lifetime of smoking, alcohol abuse, high fat diet, sedentary lifestyle, and social isolation, increases the likelihood of functional loss and multiple morbidities in old age. This concept is not entirely new. The notion that a healthy lifestyle can postpone or even avoid age-related decline dates back at least twenty centuries. For example, Cicero's prescription for ageing well was to take care of one's health, be moderate in food and drink, retain the ability to think, and remain independent (Torres, 2002; Simmons, 1945/1960: 71-72). Although there is certainly merit in disease prevention programmes that instruct individuals who can afford to do so, to eat nutritiously, exercise, and work and live in healthy environments, much more is required. Individuals living in communities where unemployment, crime, drugs, and air pollution are major problems need more than behaviour modification programmes. They need solutions to these problems – problems that are much more social than personal in nature.

The Significance of Late Lifestyle Practices

Based on the findings of the MacArthur Study, the successful ageing concept suggests that it is 'never too late' to adopt healthy lifestyles (Bonn, 1999; Shrier & Pipe, 2004; Jette, Lachman, Giorgetti, Assmann, & Levenson, 1999; Healthy Aging, 2004). Later studies have reached the same conclusion – adopting a healthy lifestyle in old age helps to maintain function even in the presence of chronic disease (Willcox, Willcox, & Suzuki, 2002; Pullen & Walker, 2001; Nunez, Armbruster, Phillips, & Gale, 2003). Unfortunately, 'successful' ageing fails to address the cumulative effects of disadvantage upon health and wellbeing in old age. For example, many people grow old in polluted living and work environments, both major causes of adverse health outcomes in late life (Primm, 2005; Maki, Moore, & Grunberg, 2005; Oginska-Bulik, 2005). With its focus on individual responsibility, successful ageing implies that people can control the condition of their old age, even those living and working in undesirable environments, thereby

discounting the role of society in making it possible for people (other than the privileged) to age 'successfully'.

Healthy Ageing

The work of many researchers supports evidence of a link between healthy ageing, nutrition, hydration, and exercise and is of such importance that it cannot be overlooked in a discussion of 'successful' old age. Healthy ageing, defined as a state of contentment and vigour (Vaillant, 2002: 187), is dependent upon factors of disease prevention, screening for common illnesses (for example, breast, cervical, colorectal, and diabetic screenings), healthy lifestyle, independence, and quality of life. In the United States, a national *Healthy Aging Campaign* interchanges the term healthy ageing with successful ageing and defines four aspects of healthy ageing: physical fitness, social wellness, financial fitness, and mental wellness (Healthy Aging, 2004). Other Western societies have similar programmes that interchange the term healthy ageing with those of positive ageing, active ageing, and ageing well. Examples are the National Health Service of the United Kingdom (National Health Service, 2004), the Ministry of Health in New Zealand (Ministry of Health, 2003), and the Australian Government's Department of Health and Ageing (Australia Department of Health, 2004).

The Role of Exercise and Nutrition in Healthy Ageing

The benefits of regular exercise to older people are well-established (Rowe & Kahn, 1998: 97). For example, muscle training has considerable positive effect upon endurance and strength, stamina, balance, cardiovascular health, muscle mass and tone, glucose regulation, appetite, and mental health (Nicholas, Andrieu, Nourhashemi, & Rolland, 2001; Williams, Higgins, & Lewek 2002; Brennan, 2002; Tanaka, Dinunno, Monahan, Clevenger, DeSouza & Seals, 2002; deJong et al., 2001). Correct as this may be from a physiological point of view, weight training may be alien as a form of exercise to

generations who obtained most of their exercise from walking and/or their paid and unpaid work.

As with regular exercise, nutrition plays a similarly important role. For example, malnutrition contributes to a condition known as geriatric failure to thrive, a potentially lethal disease in frail elders (McCool, Huls, Peppones & Schlenker, 2001). Malnutrition also increases the risk of infection of depression, and of chronic disease (High, 2001). The reverse is also true: with adequate nutrition, risk of infection decreases and depression and chronic disease are more likely to respond to treatment. Thus, in seeking to achieve optimal old age, there is a strong case for paying careful attention to the exercise and nutritional routines of older people.

Studies examining the relationship between 'successful' ageing and nutrition provide evidence that high intakes of antioxidants and B vitamins can deter Alzheimer's Disease and other cognitive declines (Nicholas, Nourhashemi, Lanzmann-Petithory & Vellas, 2001; Nicholas, Andrieu, Nourhashemi, and Rolland, 2001; von Faber, van der Wiel, van Exel, Gussekloo, Lagaay, & van Dongen, 2000). In addition, Vitamins C and E, beta-carotene and zinc have been shown to slow the progress of age-related macular degeneration (Laszio, 2002; Harvard Women's Health Watch, 2001). Good hydration is also important. Drinking six to eight 8-ounce glasses of water each day can eliminate dehydration, one of the most frequent causes of hospitalisation among people over sixty-five (Finn, 2000). Balanced nutrition, hydration, and exercise are essential components of 'successful' ageing. However, the difficulties for people on a low retirement income of affording a nutritious diet, and especially vitamin supplements, tend to receive less attention.

Productive Ageing

Productive ageing is a discourse that focuses upon the MacArthur Study's finding that engagement in meaningful activities in later life contributes positively to health, life satisfaction, and longevity (Rowe & Kahn, 1998: 167; Bambrick & Bonder, 2005). Productive ageing refutes the stereotypical image of older people as dependent and frail, and incapable of performing well within a work environment. Instead, it asserts that when older people are actively engaged in volunteerism and paid activities, the quality of their lives and of their families, friends, and communities is significantly enriched (Rowe & Kahn, 1998: 169; Ranzijn, 2002; Bass, Caro, & Chen, 1993: 6; Galambos & Rosen, 1999; Butler, 2002; Hagestad & Uhlenberg, 2005; Powell, 2005). Rowe and Kahn summarised their argument for productive ageing in these words:

...older people have an apparent ability for and interest in paid work, as well as in volunteering. Nine percent of all men and women fifty-five to sixty-four years of age are not working for pay, but are willing and able to do so. That percentage increases to thirteen among people aged sixty-five to seventy-four, and even among those aged seventy-five and older, 8 percent report themselves as willing and able to work (for pay). To put it in terms of potential additions to current employment, the gains would be about 20 percent in the fifty-five to sixty-four-year group, 80 percent in the sixty-five to seventy-four-year group, and 200 percent (!) in the oldest (seventy-five-plus) group.

In short, by any available measure, older men and women are an underutilized productive resource. The great challenge to policy makers and leaders of organizations is how best to tap the experience, energy, and motivation of older people (Rowe & Kahn, 1998: 188).

However, rather than promoting well-being amongst older people, 'productive ageing' may be used to pressure seniors to continue in paid and voluntary work to meet labour shortages. The age for receiving retirement pensions has already been raised for women in the UK and New Zealand; and in the United States the full age of retirement has been raised to sixty-seven (United States Social, 2005; Weller, 2000; "Raise the Retirement Age," 2004; Economic Policy Institute, 2000; Wittenburg, Stapleton, & Scrivner, 2000).

One major problem with a rising retirement age is that many people, especially those in less privileged ethnic groups, are likely never to have the opportunity to retire at all.

Vital Ageing

Some of the more important vital ageing projects, in terms of resources and influence, are the University of Minnesota's Vital Aging Network and the Vital Aging Project of The National Council on the Aging. Other organisations similarly engaged are the Fisher Institute for Wellness and Gerontology, and the CLSC René-Cassin/Institute of Social Gerontology of Quebec and the Foundation for Vital Aging, which publishes the Vital Aging Bulletin. Vital ageing is an approach emphasising independence, physical and mental health, and social and civic engagement (Carlson, 2002). Typifying the work of these organisations was a Vital Aging Network workshop held in 2003 at the University of Minnesota. At this workshop, the tenets of vital ageing were declared to be elder self-determination and self-sufficiency, the right of elders to be included and recognised as community resources, and the right to live in a social environment free of ageism (Hively, Gates, & Britts, 2003).

Positive Ageing

In 1999, a manifesto posted to the website of Age Concern New Zealand suggested that New Zealand needed to develop a national plan on ageing "to insure the population ages in best health, and with security for the future" (Age Concern, 1999). To introduce its manifesto, Age Concern used a quote from the American Association for Retired Persons (AARP), which takes a life course approach to ageing, and very succinctly places the responsibility for well-being in old age not only upon the individual, but also upon society:

The foundations for a healthy and fulfilling old age are laid very early in life both through our own decisions and behaviour and through wise social policy and supporting structures (ibid).

In 2001, the United Nations published national targets for its Member States based on the Vienna International Plan of Action on Ageing, which prioritised infrastructure, health, housing, family, education, social welfare, and income security for older people worldwide (United Nations, 2003). That same year, New Zealand launched a national positive ageing strategy with a focus similar to that of the UN: improvement for older people in areas of income, health, housing, transport, the ability to age in place, cultural diversity, rural communities, social attitudes, employment and opportunities (New Zealand Ministry of Social Policy, 2001; United Nations, 2003). Other local and national governments have also developed strategies of positive ageing – among these are Australia (Australia Health & Ageing, 2005), Canada (Canadian Intergovernmental Conference, 2005), the United States (109th U.S. Congress, 2005), and the UK (Suffolk County, 2006; Bury Metro, 2005). In each instance, the determinants of positive ageing are similar to the United Nations model – financial security, social engagement and relationships, contribution, productivity, independence in lifestyle, and personal decision-making. Unlike the successful ageing concept, which places the responsibility on older people to be ‘successful’ without providing the social support that allows them to do so, positive ageing emphasises the role of society in enacting policies which, deal with rather than ignore, the real impediments to ageing well. Because of this, as a social policy, positive ageing has the potential to make a significant difference in the lives of older people. However, to be effective, it is vital that positive ageing strategies incorporate the ideas and experiences of elderly people first, into its start-up structure; and then, in order to insure that the strategy keeps pace with changing circumstances, engage in systematic, ongoing communication with older people of diverse cultural backgrounds. If it does not, the perspective of the strategy will lose touch with older people, becoming warped and outdated. New Zealand appears to have begun its positive ageing strategy with input

from older New Zealanders. A report from the Office for Senior Citizens states that New Zealand's Positive Ageing Strategy was developed from consultations with older Maori and Pacific peoples, and the general public through community consultation with older people (Office for Senior Citizens, 2005).

As the Positive Ageing Strategy was to become a strategy *for* older people, it was very important that they were not disillusioned or disappointed. To avoid this risk, the consultation focussed specifically on identifying *priorities* for future action. The feedback from the consultation, combined with the information available through research and statistics, directly informed the establishment of the strategy's goals and principles (New Zealand Ministry of Social Policy, 2001).

The basic tenets of positive ageing are sound. They are based upon fundamental needs of older people: housing, financial security, social engagement, respect, and the freedom to make independent life decisions. Given these tenets, if elderly people are included in the formulation and implementation of positive ageing strategies, the outcome could be social policies that truly address the real issues of twenty-first century ageing in western liberal nations. The major drawback to the use of positive ageing as a tool for improving the lives of older people outside western liberal cultures is that, as with other discourses clustered around the successful ageing concept, it is based on western values of independence, productivity, and personal decision-making. For this reason, it is not the focus of this thesis.

Successful Ageing and Social Inequality

The main components of successful ageing – good physical and mental health and social connectedness – are mediated by social inequalities based on social class, gender and ethnicity, but the successful ageing concept fails fully to acknowledge this fact. For example, good health outcomes are strongly linked to higher incomes and social status work (Laxminarayan et al., 2006; Murray, 2006; Alter et al., 2006; MacArthur Network, 2003). And the differences between the health status of the highest and lowest social

classes (based on occupations during working life) are consistent, clear, and striking (Czerny, 2006; "Low Status Job Hazard," 2005; Lundberg, 1999; Across the Boundaries Project, 2002: 7).

Gender is an important variable. Women not only have lower incomes and lower status work than men throughout their lives (The U.S. EEOC, 2004; Institute for Women's Policy Research, 2004), but are more likely to perform unpaid caring work (Canadian Women's Health Network, 2002; *Women & the Economy*, 2006), doing so into old age. Then, due to their greater longevity and the common age difference between spouses, a high proportion of women become the main caregiver for sick and dying husbands (Lang, 2002; Else, 1999). This emotionally and physically demanding work, often performed around the clock throughout the week, and sometimes for many years, is not resourced and often does not allow time for earning money, maintaining social connections, or keeping fit (Ongley, 2001; The Project on Global Working Families, 2002; "Women Face Extra Hurdles," 2004). It often takes a huge toll on caregivers' health. Individuals performing this work (mainly women) are officially described as economically inactive, reinforcing their low status and making it more challenging for them to maintain healthy levels of self-esteem (United Nations, 1997; Else, 1997). In contrast to men, who may elect to become the main caregiver for their ailing wives out of love rather than social pressure (National Alliance for Caregiving, 2004: 8), there is a strong social expectation for women to take on the care-giving role for declining husbands (Marks & Lambert, 1999: 9).

Members of underprivileged and impoverished ethnic groups have significantly shorter lives and poorer health status than the average for the nations in which they live. For example, the difference in life expectancy between New Zealand Maori women and women in the rest of the New Zealand population was eight years in 1997 (Ministry of

Maori Development, 2000). Although Maori women who are involved in their own cultures often enjoy higher social status and social connectedness within those cultures than other New Zealand women within their cultures, the standards of the 'successful ageing' concept, may label them 'unsuccessful'. For example, due to their poorer health status, female First Nations people (and male as well) have poorer health statistics than the rest of the population, suffering the effects of alienation from their tribal lands, the pollution of their earth and waterways, and the devaluation of their spiritual beliefs. The 'successful ageing' concept does not adequately consider this fact. In short, the 'successful ageing' concept means that the people who are already enjoying the beneficial effects of higher social status receive even more positive acknowledgement, whilst those experiencing the cumulative effects of disadvantage are further devalued (Wong, 2000).

As countries such as New Zealand and the United States become increasingly multicultural, nurses and other health care providers in these countries are challenged to provide care that is culturally sensitive (Wood & Atkins, 2006; Newman, Davidhizaar, & Fordham, 2006; McNeal & Walker, 2006). Cultural sensitivity, defined as an awareness of one's own culture and respect for the culture of others (Kim-Goodwin, Alexander, Felton, Mackey, & Kasakoff, 2006), has become essential to the delivery of competent care and for altering the diverse ethnic behaviours which lead to chronic disease and disability. For example, in New Zealand, nurses are urged to be "culturally sensitive to alternative ways of looking at the world", and to deliver care which recognises that "culture affects a person's health, well-being and health care choices" (Wareham, McCallin, & Diesfeld, 2006). In contrast, the concept of successful ageing – which also aims to change behaviours leading to disease and disability – does not address the influence of culture upon health (Luborsky & Sandar, 1993; Katz, 2000), nor is it culturally sensitive to alternative ways of looking at well-being. (In fact, the successful

ageing concept does not discuss culture or ethnicity and their relationship to 'successful ageing'). As a result, the concept of successful ageing is unlikely to improve the health and well-being of elders who do not define well-being in Western terms of independence and autonomy, but instead, in terms of harmonious relationships with family, environment, community, and ancestral land (Kendig, 2004; Orimo, 2004; Ohno et al., 2004; Woo, Ho, & Yu, 2002; Yau, Kwai-Sang, & Packer, 2002). As it is currently defined, the concept of successful ageing is most applicable to a small privileged group of mainly 'young' third-age elders who, because they are physically, mentally, and financially healthy, are best positioned to be regarded as 'successfully aged.'

The Measurement Problems of Successful Ageing

To determine the extent to which elders are 'successfully' or 'usually' aged, the concept of successful ageing uses performance-based criteria developed in large part from the findings of the MacArthur Foundation Study of Aging. John W. Rowe, chair of the MacArthur Study has expressed the purpose of the Study in these words:

We wanted to pinpoint the many factors that conspire to put one 80-year-old on cross-country skis and another in a wheelchair. The goal was to move beyond the limited view of chronological age and to clarify all the factors responsible for retaining and even enhancing people's ability to function in later life (MacArthur Foundation, 2004).

Although the several discourses on successful ageing take different approaches to 'successful' ageing, they generally agree that the criteria for successful ageing include freedom from disease and disability, high physical and intellectual functioning, and social engagement. These criteria are important because they make it possible to objectively measure quality of ageing; with these criteria the extent to which individuals are 'successfully' and 'usually' aged can be determined. The higher the level of functioning and the greater the freedom from disease and disability, the more successful the old age of an elder is judged to be (Andrews, Clark, & Luszcz, 2002: 762; Schulz & Heckhausen,

1996). Therefore, largely for reasons of objectivity, the successful ageing concept dismisses subjective criteria used by the elderly themselves, such as sense of well-being, life satisfaction, contentment, and realisation of personal goals (Lucchetti, Spazzafumo, & Cerasa, 2001; Flood, 2005/2006)). The weaknesses of subjective criteria are considered to be first, that they “open the door for any indicator to meet the criteria of success because the criteria are individually determined” and secondly, they “are subject to the rationalization biases characteristic of individuals when they evaluate their own experiences and accomplishments” (Schulz & Heckhausen, 1996). The concept of successful ageing therefore ignores the personal triumphs and achievements by which the elderly themselves measure personal well-being (Strawbridge, Wallhagen, & Cohen, 2002).

When older people are examined as to whether or not they have aged successfully, the labels they are given are the examiners’ interpretations of the criteria and the same examiners’ perceptions of the extent to which these criteria are consonant with the behaviours and actions of the older people they are examining. Even the criteria “low risk of disease and disability”, which, because it is based in part upon the results of medical, laboratory and x-ray tests (and could therefore be considered the most objective criterion of the three), is dependent upon interpretations of tests for its results. As regards the other two criteria, their meaning is even less precise. What exactly is the meaning of “high mental and physical function” and “active engagement with life”? The dictionary definition of ‘high’ is greater than average, but what is average? Rowe and Kahn attempt to answer this question by the creation of a category of ageing they refer to as “usual aging”:

We propose the term ‘usual aging’ to describe the elderly who are functioning well, yet are at substantial risk for disease or disability. This is a large percentage of all older people (Rowe & Kahn, 1998: 54).

The creation of the category 'usual ageing' does not resolve the problems inherent in the measurement of successful ageing. It merely introduces additional terms such as "functioning well" and "at substantial risk for disease or disability" which also require interpretation. Within the concept of successful ageing, the responsibility for interpretation is delegated to an 'objective' outside examiner. Because it is primarily a medical model (Holstein & Minkler, 2003: 787), interpretation of the terms and criteria of successful ageing is most often made by a physician or other health care professional. To argue that the successful ageing of individual elders can be decided by domains of physical, and cognitive functioning and social relations, because they are objective, external measurements rather than subjective and personal, disregards the biases of the practitioners and other professionals whose opinions will be incorporated in the labels they use to describe their elderly clients. In addition, by adopting performance-based measurements as the standards for measuring successful ageing, much of what elderly people have to say on the subject of ageing has been excluded and the "how it is for me" of ageing remains a mystery. As Holstein and Minkler have aptly expressed it:

"How it is for me" opens narrative possibilities that trade the ability to generalize about old age for increased understanding and reduced risk of a false universality (Holstein and Minkler, 2003: 790).

Without denying or minimising the goal of the successful ageing concept to positively change the view of old age, its impact upon society is not entirely positive. The comparison of a wheelchair bound eighty-year-old with a cross-country skier of the same age implies that someone other than the two octogenarians has judged that the skier has aged successfully and the elder in the wheelchair has not (Scheidt, Humpherys, & Yorgason, 1999; Minkler & Fadem, 2002; Leder, 1999/2000). And, because the successful ageing concept holds that individuals determine the success of their old age by their lifestyle choices and the behaviours in which they engage, the successfully aged

person will be judged to have lived wisely and the unsuccessfully aged to have lived unwisely. In the words of Rowe and Kahn:

To succeed in something requires more than falling into it; it means having desired it, planned it, worked for it. All these factors are critical to our view of aging which, even in this era of human genetics, we regard as largely under the control of the individual. In short, successful aging is dependent upon individual choices and behaviours. It can be attained through individual choice and effort (Rowe & Kahn, 1998: 37).

Are we to conclude therefore, that the wheelchair bound octogenarian is not only unsuccessfully aged, but in addition, that the disabilities creating the need for a wheelchair are the result of unwise choices and behaviours? The fact is that, when older people are classified on the basis that some are successfully aged and others are not, value judgements regarding their lifestyle choices, the wisdom of their behaviours, and the manner in which they have lived their lives are necessarily involved.

As defined by the concept of successful ageing, where successful ageing occurs, it results from the accumulated effects of good decisions, choices, and behaviours made by individuals over the course of their lives, and where it does not, it is the result of poor decisions, choices, and behaviours. The concept of successful ageing makes individuals responsible for ageing 'successfully' without due consideration of the constraints within which the decisions must be made. In his discussion of personal and social responsibility for health, Wikler makes these comments:

The encouragement of a sense of personal responsibility for health can be part of a program of 'positive freedom' or 'empowerment' – a realization that actions taken can have a marked and positive impact on one's health while also radiating good effects on other dimensions of life and on other people. In stressing what the individual can do to stay healthy, there is a risk that an individual's actual power will be exaggerated, and consequently that people can come to blame themselves, wrongfully, when they fall ill (Wikler, 2002).

Wikler's comments highlight a major concern of this thesis regarding the successful ageing concept. It sets the conditions for ageing successfully (Holstein & Minkler, 2003:

787) and places the responsibility for doing so on individuals without duly acknowledging that the ability to make sound, informed lifestyle choices requires a wide range of experiences, opportunities, education, and resources often denied to people because of their gender, race, and class (Meyers, 1989).

In what he refers to as “a quarrel with the ‘successful aging’ model”, Leder makes this response to Rowe’s analogy of the elderly skier and the elderly wheel chair bound individual:

Using this spiritual model [of successful aging], it is no longer clear that Rowe and Kahn’s successful octogenarian on cross-country skis is better off than that apparent failure in the wheelchair. After all, the cross-country skier may be a shallow chap despite having powerful legs. Conversely, the wheelchair bound elder might be richer of soul. Disability may have attuned this person to the suffering of others, fostering a deep compassion. ...To some, successful aging means coming to a wholeness of soul, whether on skis or in a wheelchair (Leder, 1999/2000).

As Leder suggests, there are subtle factors involved in ageing ‘successfully’ which cannot be completely described by the facile image of a healthy eighty-year-old skier (Strawbridge, Wallhagen & Cohen, 2002). Ageing people with disabilities, who have survived the hardships created by significant and perhaps life-long disabilities, may have assigned meanings to physical and mental function, social relations, and occupation, which cannot be conceived by the concept of successful ageing (Minkler & Fadem, 2002).

Conclusions

The messages associated with the various discourses of successful ageing are positive: old age can be productive, healthy, and vital. Old age does not have to be characterised by disability and disease. Altered lifestyles, even those made late in life, can improve quality of life. These messages are intended to convey hope, to inspire and motivate older people to make wise lifestyle choices. However, they also place the burden of responsibility for health and social well-being ultimately on the elderly themselves.

Productive ageing exhorts older people to engage in paid and unpaid work. However, to do so requires dependable, safe transportation. A high proportion of the very old do not drive; they have not renewed their driving licenses for health and safety reasons, many cannot afford the upkeep of a car or the gasoline that runs it, and in addition some live in areas where public transport is not available. Rowe and Kahn make the claim that a significant proportion of older people are ready and willing to re-enter the paid work force, but how many opportunities are available which will not underpay them and where they will not be patronised?

Healthy ageing urges older people to eat well and to consider the benefits of dietary supplements. However, fresh fruits and vegetables, lean meat, milk, cheese, and eggs are often not within reach of many superannuitants and dietary supplements are very expensive. Healthy ageing also encourages the drinking of six to eight glasses of water daily, but older men and women are often prone to bladder infections; it can be difficult to convince elderly women with a history of such infections and men with enlarged prostates that to avoid the discomfort of urinating they need to drink more, rather than less water.

At a McDonalds Restaurant not far from where I live, a seventy-year-old woman sweeps the floors and cleans the tables for a minimum wage salary that pays for her insulin and diabetic supplies. At a nearby Wal-Mart store, an older man sits on a stool greeting the customers who come through the doors. Each day he dons a different costume. On some days he wears dog ears, on others his face is painted with cat's whiskers, and on others he has a large yellow 'happy face' stuck to the end of his nose. The money he makes from this job helps pay his rent and utilities. These two elderly citizens are productive and independent by the standards of the society in which they live – they require very little state assistance. Nevertheless, they have not aged 'successfully.' Their need to work

deprives them of the time and energy to engage in the middle-aged activities they once enjoyed. On the job three to four days a week, they do not drink the prescribed amount of water and they cannot afford the recommended vitamins. They suffer from diabetes, high blood pressure, and coronary heart disease. As defined by the successful ageing model, they have not aged 'successfully'.

Modern liberal societies have produced a concept of ageing, which states that elders are personally responsible for ageing 'successfully' – that is with health and vitality, productively and independently – while frequently withholding the opportunities by which 'success' in old age can be achieved. For a majority of older people, the message of the successful ageing concept is doubly negative. First, from successful ageing campaigns they learn that they could have avoided the disabilities of their old age if, earlier in their lives, they had made wise lifestyle choices. Secondly, it is implied that, having made unwise lifestyle decisions, it is they who are mostly responsible for the failed condition in which they find themselves, an implication that is certainly no remedy for disability.

To a large extent, 'successful ageing' has developed into a means for measuring and judging the ageing of older people. The standards of measurement are the performance-based and externally measurable criteria of disease and disability, physical and mental functioning, and social activity. However, critical examination reveals that these criteria are incapable of faithfully measuring the true nature of ageing because they ignore personal, individual visions of successful old age, relying instead upon practitioners and examiners to apply objective criteria. Having silenced the voices of the elderly on the grounds that what they have to say about their ageing is subjective, the concept of successful ageing disregards the subjectivities of those who interpret the measurement criteria. This is a fundamental flaw in the successful ageing model: it presumes that optimal ageing can be measured in the same way, for example, that success in the

classroom, on the playing field, or in the stock market can be measured. It cannot. Optimal ageing has an intangible aspect not amenable to the measurement methodology used to measure these types of success. The use of the successful ageing concept as a means by which to judge success in old age is an overstepping of its function. Providing pertinent information for healthy, vital ageing is a valid role for the successful ageing concept. Making value judgements over who is successfully aged is not. At the present, 'successful' ageing is of value to a limited number of older people in western societies, who on account of their education, position, and wealth are able to adopt healthy lifestyles, to delay the onset of age-related disease and debilitation, and to engage in productive and meaningful activities.

If we were to talk and listen to what elderly people from a range of ethnic groups, in a variety of circumstances, have to say about the factors that are essential to well-being in old age, we would learn the true factors that contribute to optimal old age. For a majority of older people, those whose occupations have not brought them financial independence, whose limitations of education, living environment, family situation, and access to health care do not produce healthy lifestyles, the successful ageing concept is incompatible with the reality of their lives. And finally, as will be discussed in the next chapter, successful ageing has increased the number of stereotypical images describing older people, so that in addition to being 'dear', 'doddering', "wise", 'senile', 'slow', 'childish' and 'infirm', elders today are also being labelled 'successfully' and 'unsuccessfully aged'.

CHAPTER 4

AGEISM IN LIBERAL WESTERN NATIONS

Ageism targets both children and old people, (Schaie, 1993; Palmore, 1999; Snape & Redman, 2003), depriving them of social status, power and authority because of their age (Schroots, 2003; Presbyterian Older Adult Ministry, 2003; Gerber, 2001; Duncan & Loretto 2004; Westman, 1994), but it is a term most widely used to describe discrimination against older people. The basis of this discrimination is a view that the ageing process is a dehumanising one; it is a process by which “people cease to be people, cease to be the same people or become people of a distinct and inferior kind” (Comfort, 1977:35). As depicted by the writer below, growing old is a catastrophic experience.

The process of ageing is a catastrophe that will befall all of us that reach old age. Ageing is really something terrible; it takes away everything: first, your physical fitness, then your capacity to have children, your attractiveness, your sex drive – it turns you into a eunuch – it slowly erodes your intelligence, your sanity, your physical health – often condemning you to years, decades of physical pain, until finally it kills you (University College, 2003)

Asserting that ageism is “woven into the woof of our social fabric”, Hendricks describes ageism in these words:

In the case of ageism, old age is cast as a territory apart, a country of the old, so to speak – inhabited by a bygone people (Hendricks, 2005).

What is Ageism?

The definition most commonly applied to ageism is R. N. Butler’s original description of ageism as a “systematic process of discrimination, which accomplishes with age what racism and sexism accomplish with regard to skin colour and gender” (Butler, 1969; 1993; 2002). Racism, sexism and ageism are each based on unmistakable, automatically noticed human characteristics – we seldom fail to note an individual’s race, sex, and age

(Cuddy & Fiske, 2002:3; Nelson, 2002: ix; Nelson, 2005) – and all are represented by stereotypical images.

In the three decades since the term ageism was first used to censure discrimination against older Americans, much has been written to explain the reasons for its entrenchment and the difficulties involved in eradicating it (Rupp, Vodanovich, & Crede, 2005; Cole, 1986: 120; Palmore, 1999:81; Ryan & Butler, 1996; Osgood, 1995; Blaikie, 1999: 75-76; Walker, 1993). One such explanation is the notion of cultural and institutionalised ageism.

Cultural ageism ascribes the reason for the stigmatisation of older people to a widespread fear of old age and death (Giles & Reid, 2005), or as one writer has expressed it, as “prejudice against our feared future self” (Nelson, 2005: 213-214). In their discussion of ageism, Martens, Goldenberg, and Greenberg suggest:

...ageism exists precisely because elderly people represent our future in which death is certain, physical deterioration probable, and the loss of current self-worth-enhancing characteristics a distinct possibility (Martens, Goldenberg, & Greenberg, 2005)

Elias elaborates on the cultural fear of growing old in these words:

That people grow different in old age is often involuntarily seen as a deviation from the social norm. The others, the normal age groups, often have difficulty in empathizing with older people in their experience of ageing – understandably. ...Whether consciously or unconsciously, people resist the idea of their own ageing and dying as best they can (Elias, 1985: 68-69).

However, even in societies where ageism is a well-documented practice, resistance to ageing – the “quest to be not old” (Calasanti, 2005) – is not universal. For example, in the United States, in the rural American town where this study interviewed three elderly women, deep respect for old age has resulted in extensive community involvement in caring for the town’s elderly citizens. Cherokee people demonstrate a similar respect for old age by requiring the members of its powerful Council of Elders to be no younger than

fifty-years old. Likewise, in New Zealand, while dominant Western views have eroded traditional Polynesian social mores to a degree, there are still strong elements of traditional respect for elders within Maori society. This study found the elderly Maori participants (in contrast to the non-Maori participants) to be highly esteemed by their whanau and iwi.

Institutionalised ageism explains the role of the state in the distribution of resources and retirement benefits to older persons (Nussbaum, Pitts, Huber, Krieger & Ohs, 2005: 298-299; Hagestad & Uhlenberg, 2005). In economies where expenditures such as pension plans, health care, and welfare services conflict with the central activities of the financial system – profit and growth of capital – marginalised populations such as the elderly are apt to be viewed as an economic burden (Phillipson, 2002; Smith, 2005: 213; Breitzkreuz, 2005; Barber, 2005; Shaikh, 2003; Korpi, 2003; Biggs, 2001). In this situation, there is a tendency to blame elderly citizens for overuse of health and welfare services (Binstock, 2005; Ng, 1999; Davey, 2003; Smith, 2005:214-215; Sayers & Nesbitt, 2002: 15; Alliance for Aging, 2003). The result is an increasingly negative view of older adults (Ng, 2002; Nelson, 2005).

While ageism within government offers an explanation for the pervasiveness of ageism in liberal western societies, there are also many members of government and other organisations in these societies who fight to expose and eradicate institutional ageism (Butler, 2002; "Ambitious Federal Elder Justice," 2005; Burstow, 2005; Batty, 2005; 50plus.com, 2005; Age Concern, 2006). Through their efforts, there is scope for improved provision for elderly people.

Positive Ageism?

The term 'ageism' was first used to describe bigotry and social discrimination against older people. It was a deliberately negative label. As he had hoped it would, Butler's

public use of the term ageism focused attention on negative attitudes towards older people. It also led to close scrutiny of the meaning of ageism.

In some of the debates that have followed Butler's coining of the term, it has been argued that ageism has positive as well as negative effects upon older people. Cited as examples of the positive effects of ageism are non-means tested reductions in the cost of prescription medicines, in eye and hearing tests, and in fees for public transport, theatres, and museums (Binstock, 2005). In her report on ageism in the NHS, Gilhooly (2002) suggests two additional examples of positive ageism. One, the distribution of health resources to local communities based on their elderly populations, and another, the fact that United Kingdom citizens over the age of sixty-five, who represent 16 percent of the total population, receive 40 percent of the NHS budget. In his examples of positive ageism, Palmore (1992) lists positive stereotypes (those that describe elderly people as kind, wise, dependable, affluent, powerful, and happy), state sponsored tax breaks, housing programs, Social Security Income, and Medicare. In response, some writers point out that 'positive' ageism (also known as 'compassionate' ageism) is just as ageist in practice as its negative counterpart, melding elderly people into a group defined by weakness, political powerlessness, and poverty (Minkler, 1991). Hendricks also disputes the value of positive ageism, saying:

What is called benign or compassionate ageism, sometimes labelled the "poor dear" syndrome, is no less dehumanizing than its negative counterpart – either way people are viewed through a stereotypic lens, subverting personal characteristics to the point of invisibility (Hendricks, 2005).

A benefit of positive ageism is that it aids elderly people (Binstock, 2005). It serves to offset the effects of negative ageism. Positive ageism may dehumanise the elderly, and meld them into group characterised by weakness, but it is preferable to negative ageism, which not only dehumanises, but also denies elderly people the assistance they need.

Ageist Economics

There is no doubt that the new demography of oldest-old life spans and lowest-low fertility rates is going to drive policy in the twenty-first century. The age distribution of populations will shift from hordes of children to crowds of the elderly (Vaupel, 2000).⁴

The Nigerian Irigwe have a saying which translates into English as, "It's a tough world when none of the old people die" (Sangree, 1989: 38). In many societies today, this is exactly what appears to be happening. The old people are not dying; they are growing older, their numbers are increasing, as is their need for support and care. Based primarily on rising life expectancy and declining fertility, this 'burden of support' is perceived by some western economists and social scientists as a looming social crisis. As a result, it is argued that the care of large populations of older people will become an unsustainable economic burden carried on the backs of a shrinking number of young working people. According to this apocalyptic view, these factors will produce, on the one hand, a diminishing public purse, but, on the other, an expanding need for funds to sustain government programs such as retirement pensions, Social Security, and health care. Without prompt, incisive action by governments, it is a situation that some predict will lead to the structural collapse of liberal western nations (Thurow, 1996:96; The World Bank, 1996: iii; Schactman & Altman, 2000: 252; Borowski, Encel, & Ozanne, 1997:8). The basis of apocalyptic economics is an unbalanced view of older people as non-contributing members of society who take, but do not give back (Thurow, 1996). Such a view fails to acknowledge the contributions of elderly people. For example, in the United

⁴ The demographics described here may represent an interregnum between the present and a time in the future when the world's population will have stabilized as a result of the deaths of the "crowds of the elderly, and their replacement by the aging of a smaller number of children.

States, at the beginning of the twenty-first century the number of grandparents serving as their grandchildren's primary caregivers had reached 2.4 million. According to data from the U.S. Census Bureau, nearly 40 percent of these American grandparents have had the job for five years or more, 64 percent are women, and 20 percent live in poverty (Population Reference Bureau, 2004).⁵ In volunteer labour, the story is the same; organisations which depend upon volunteers look primarily to older people for the skills and experiences they need (Callow, 2004; Payne, 2002).

Ageism and Gender

Women, more than men, suffer the oppression of ageism – the ultimate prejudice, the last discrimination, the cruellest rejection (Palmore, 2004). The reasons are several. First, the longevity of women⁶ makes all the problems of old age, including ageism, a more feminine than male experience. For example, after more than three decades of research on ageism, Palmore concludes not only that most humour about older people displays ageist attitudes and very little positive attitudes, but also that humour directed at older people tends to single out older women more often than men (Palmore, 2005). The fact that there are many more elderly women than men certainly contributes to Palmore's observations, as does the fact that ageist humour tends to focus on loss of physical

⁵ In the year 2000, 5.8 American grandparents lived with grandchildren under the age of eighteen. Demographers have coined a new phrase for this child-care trend – the 'skipped-generation' household, where a grandparent and grandchild reside with no parent present (Population Reference Bureau, 2004).

⁶ In the United States, the 2000 census counted 3 million women aged eighty-five and over compared to 1.2 million men aged in the over eighty-five age category (U. S. Census Bureau, 2002). In New Zealand, the statistics are just as startling; in the year 2001, of the 63,000 New Zealanders aged eighty-five and older, 48,000 were women (Statistics New Zealand, 2002).

abilities, loss of attractiveness, loss of sexual ability or interest, and age concealment – characteristics often used to stereotype older women (Ibid).

Women are also particularly vulnerable to ageism because they carry with them into old age all the expectations, attitudes and prejudices practiced against them in their earlier life stages; these include prejudices of gender in the work place, which transform into poverty and inequality in health care after retirement (Grybaite, 2006; The Old Woman's, Project, 2006; National Partnership, 2006). In addition, they carry with them the expectation that just as they were the caregivers for children, in their old age they will become the caregivers for elderly spouses. They also carry with them into old age social attitudes of patronisation, the view that women are dependent and childlike throughout life, that young women who 'speak up' for themselves are 'uppity' and old women who speak up are 'feisty', and the view that women are not 'bright' because they do not 'think like men' (Lipscomb, 2006). And finally, although this list of ageist attitudes towards women is by no means complete, there is the notion produced by the concept of successful ageing that unless an elderly woman is healthy, slim, discreetly sexy, and independent, she has 'let herself go' – she has failed to age as she should (Calasanti, Slevin, & King, 2006).

Ageism in Practice

When ageism pervades a society, it affects on the well-being of elderly people (Nussbaum, Pitts, Huber, Raup-Krieger & Ohs, 2005; Giles & Reid, 2005; Sneed & Whitbourne, 2005; Cuddy, Norton & Fiske, 2005). Ageism consists of illegal practices of discrimination in areas such as housing, employment, health care, and transport (Ontario Human Rights Commission, 2002; New Zealand Management, 2001; Minichiello, Browne, & Kendig, 2000; Loretto, Duncan, & White, 2000; McGregor & Gray, 2002; American Journal of Nursing, 1999). Ageism can also be the practice of a subtle expression of distaste. Its practitioners include priests and ministers, teachers, health care

professionals, corporate presidents, political representatives elected by elderly constituencies, and older people themselves.

In the health care industry, ageist attitudes contribute to 'non-compliant' patient behaviours. Among geriatricians, geriatric nurses, social workers, surgeons, stroke rehabilitation and speech therapists, audiologists, ophthalmologists and health care administrators, there are those whose interactions with older clients are characterised by impatience and patronising speech (Gunderson, Tomkowiak, Menachemi, & Brooks, 2005; Rayer, 1999; Emberton, 1999; Macdonald, 1997; Davis, 2003; Bernard, 2004).

Patronising speech is a deviation from normal adult patterns of speech. Often a spontaneous adaptation to the presumed mental and physical deficits of older persons, it is slow, simple, loud and repetitive (Ng, 1994; Hummert & Nussbaum, 1992; Ryan & Hummert, 1995; Edwards, 1998). Similarly, secondary baby talk (SBT) is characterised by the same speech modifications often used by mothers when they respond to a child's cry; the voice becomes soothing, the vocabulary restricted, and key directives reiterative. Among nurses and auxiliary personnel, the use of SBT may be due to a perception that mental and physical age-related impediments make it impossible for older people to engage in adult communication (Sachweh, 1998; Hummert, Shaner, Garstka, & Henry, 1998; Gould & Shaleen, 1999). As a result, communication between elders and their caregivers is often caregiver directed and patronising, consisting primarily of directives, commands and statements to which older persons need not reply (Redfern, 1989). Notwithstanding evidence presented in professional journals and in nursing in-services that SBT can cause harm, it is a care giving technique that some nurses find difficult to relinquish (Levy and Banaji, 2002:65; Lookinland & Anson, 1995).

A proportion of nurses use SBT routinely with dependent patients of all ages. A small number use it intentionally to signal affection, to comfort, to ease anxieties, and to relax

elderly patients; for others, it is a reaction to physical appearance, canes, walkers, and wheelchairs, and to the roles assumed by nurse and patient within the care-giving environment (Ryan & Hummert, 1995). While many older people feel patronised and demeaned when SBT is directed at them, in certain circumstances it is taken as a reflection of a nurse's concern and consideration. As a part of my work in quality assurance at a facility where older patients were admitted frequently for emergencies such as stroke and hip-fractures, I made it a practice to talk to patients and their families about their nursing care. I made it a particular practice to avoid SBT. Interestingly, however, I found that Filipino staff nurses, for whom SBT was a well-practiced technique, were given consistently high marks for empathetic care by older patients from Samoa, Tonga, the Philippines, and Malaysia; when I questioned these patients about SBT, they described it as comforting and reassuring. However, this was not the usual response of European and North American patients to SBT. Over time, complaints from these patients about the practice of SBT in the Hip, Stroke, and Rehabilitation Unit drew the attention of hospital administrators. After review, Administration issued a formal ban on SBT describing it as a debasing and demoralising practice, which prolonged the period of recovery by undermining the older patient's self-confidence. Subsequently, some nurses decried the stinging condemnation of SBT and its banning at the facility as an unfair reaction by hospital authorities to the petty complaints of a few disgruntled elderly people. To provide a venue through which they could vent their anger to management, I scheduled a team meeting with a single agenda – secondary baby talk. It was to become the first of many meetings on the subject. In the quest to improve the quality of patient care delivery, the issues of SBT and ageism became enduring topics in staff meetings. Some nurses were opposed to SBT under any circumstances, while others defended the right to its use on the basis that it was beneficial to elderly patients of certain ethnic types

and cultures. Regardless of their position on the use of SBT, its condemnation by hospitals administrators as a form of ageism placed it at the top of the list of ‘best’ practice issues.⁷

Ageism and Children

Calasanti has commented that, “...because our culture is ageist, we learn this form of bigotry from the time we are born” (Calasanti, 2005: 8). Research suggests that the ability to differentiate on the basis of age begins in infancy; by the age of three, some children associate aging with decreasing physical attraction; and by the age of four the preference for youth may be well established (Montepare & Zebrowitz, 2002: 81-87; Levy & Banaji, 2002: 63-64). This is not surprising; intolerant attitudes pass from adults to children in several ways. An examination of children’s literature reveals that in both texts and illustrations, older people are often depicted as unhealthy, ugly, eccentric, passive, and dependent, and described by adjectives such as little, old, ancient, poor, wise, and dear (National Academy, 2002).

Research has not documented the frequency with which negative attitudes of children towards elderly people develop into intolerance of old people. The controversial aspect of F. Scott Fitzgerald’s statement – he disliked old people because they professed to the wisdom of experience, when most of them had few experiences and had gained nothing from them (Gale, 1998:454) – lies in the fact that it was publicly made. It is unusual for an adult, particularly, a prominent public figure, to openly make such an extremely ageist

⁷ This incident is discussed in depth in Appendix B.

statement. The following remarks by psychiatrist Alistair Macdonald are similarly unusual.

I hated old people when I was young. Having been dragged around to see army aunts and elderly lunatics as a boy, my every sense was offended by what I saw, heard, felt, and smelt. In the old people's home I was consigned for what seemed like an eternity to the day room to a view of tatty armchairs, leering smiles, clawing fingers, and spittly remarks I could not understand. Me and my more resilient sisters were often abandoned for tea with a mad old lady whose flat was plastered with cuttings about the Queen. (Princess Diana had not yet been born). The blended aroma of disinfectant and strawberry jelly is one of the few smells I can still recall from my childhood, together with instant nausea (Macdonald, 1997).

The attitudes, opinions, and behaviours of young children towards older people are replications of parental (or the equivalent) attitudes; in later childhood they will be influenced by other adults, friends, and the media. Fortunately, as with Macdonald, some children can and do become adults who realise "that one day most of us will become victims of our own prejudices" (Macdonald, 1997). Macdonald continues his remarks above by saying:

I finished training and moved on to research work in a team studying older people. The people in it were very clever, far smarter than me, and – to my amazement – they liked older people. Many of the older people I interviewed lived at home and were not in any psychiatric, social, or medical crisis. My contact with them was quite different from anything I had experienced before. All of a sudden I was with old people who were as intelligent, warm and enjoyable, to talk to as anyone else. They did not smell or dribble. I came across the term 'ageism' and identified myself as a chronic victim of this condition. The next encounter with older people (attending their general practitioners) exposed me to many normal, intelligent people leading active and fruitful lives, and for the first time I found myself envying some of them for their happiness and history (Macdonald, 1997).

What then, are the forces that encourage change in cultural attitude towards older people? In Macdonald's case, it seems to have been the converging of two specific experiences – first, an encounter with elderly people who were intelligent, active, and fruitful, while at

the same time working with individuals whom he admired and respected who had strong positive feelings about elderly people.

There are several current, interrelated discussions in the literature on ageism that emphasise the fact that ageism is neither natural nor inevitable. One of these discussions centres on the idea that negative attitudes are ego protective devices that serve to distance younger people from their own eventual old age, frailty, and death (Nelson, 2005: 213-214). Another related discussion, deriving from Becker's terror management theory (Becker, 1971; 1973; 1975), suggests that being generally threatened by thoughts of their own death, younger people avoid the elderly because they are a powerful reminder of the transience of youth and life (Martens, Goldenberg & Greenberg, 2005: 224; Koch, 2000). Yet another discussion entertains the social changes that could result if negative stereotypes of old age were exchanged for positive "subtypes of elderly people" (Giles & Reid, 2005: 393). This discussion addresses the question asked above – what are the forces that encourage cultural attitude change towards older people – by asking one of its own:

What if death salience was manipulated in different ways such that it was not feared but construed as following a full, successful, and rewarding life and death being defined (as above) as a merciful release or even comfort (Giles & Reed, 2005).

Conclusions

Ageism is a significant problem in contemporary liberal western societies. It is not limited to liberal western societies – other societies practice ageism as well – but it is more widespread and deeply entrenched in western than in non-western societies. Public censure has failed to eradicate ageism, as have education and campaigns of public awareness. Ageism is an oppression occurring at time when it is particularly difficult to endure because it adds another problem to the list of those created by factors of declining independence, autonomy, income and health. Ageism conveys to elderly people that they

are obsolete, that their skills and experiences are of little social value and their contributions insignificant. Ageism targets both male and female, but older women are the targets more than are men. Ageism may be a white man's first encounter with discrimination; many women will add ageism to a long experience with another form of discrimination – sexism.

Ageism is tool of avoidance. It convinces 'us' that the old are different from ourselves, thus allowing 'us' to avoid our own ageing. It enables 'us' to believe that 'we' are self-sufficient and independent; 'they' are needy and dependent; 'we' are healthy and free of disease; 'they' are diseased and chronically ill. 'We' are productive; 'they' are non-contributors. 'We' are successful; 'they' are not successful. 'We' will never be as 'they' are. However, at some point, regardless of having done all things possible to age 'successfully', retirement, diminution of social status and income, deaths of partner, siblings and friends, and decreasing vitality and energy, will intrude. Ageists grow old, themselves; they too become the targets of age discrimination. These losses will be particularly shattering for individuals who have made great efforts to be seen as 'not old', who have refused to admit the reality of their age, and who have failed to prepare for end-of-life challenges. Nelson's statement, that "our understanding of the far-reaching influence of age prejudice on the lives of older adults is nascent" (Nelson, 2005: 217) is correct. However, it is also correct to say that our understanding of the far-reaching influence of age prejudice on the lives of *both young and old* is similarly nascent.

CHAPTER 5

RESEARCH DESIGN

Introduction

This thesis explores and analyses the concept of successful ageing. It does so by comparing and contrasting the self-assessed well-being of a group of elderly people with the externally assessed successful ageing concept. In doing so, the thesis identifies the term 'successful ageing' as one used by professionals and experts in the field of ageing, not by aged people themselves, who, when referring to a fulfilled latter stage of life, utilise a vocabulary better reflected in the term 'well-being'. This research describes and discusses the differences between the terms 'successful ageing' and 'well-being' in relation to achieving a satisfying old age. Its findings indicate that the factors defining well-being as described by the elderly people in this study differ from the professional health-based concept of successful ageing in a significant number of respects.

Developing the Research Design

Old age is personal and private. Even when social support is strong, and family relationships are good, it can be difficult for an older person to communicate the realities of old age to others (Traphagan, 2004; Kosberg, 2005; Vincent, 2003: 38-41; Erikson, Erikson, & Kivnick, 1986: 293-295). Having cared for elderly people in a wide variety of environments, I knew that I would not be able to grasp the participants' views of well-being in single face-to-face meetings. To understand their personal definitions of a good old age, I had to have an accurate and deeper picture of their lives. I needed to see the challenges of their old age as they saw them. Lastly, I had to have sensitivity to understand the lifestyle choices and constraints, which had led them to their individual circumstances. These were the imperatives driving my search for a research design.

Designing an Ethnographic Study

Having identified the special needs of my research, the perspectives of several authors provided guidelines in my choice of design. One was Gubrium and Holstein's definition of ethnography: "Ethnography points broadly to the careful and usually long-term observation of a group of people to reveal the patterns of social life that are locally experienced" (1999). Another was Hammersley's analysis in which he describes the components of ethnography as small-scale observations of behaviour in everyday contexts, where data collection is necessarily unstructured, and data analysis takes the form of verbal descriptions and explanations (1990: 1-2). Still another was Spradley's depiction of ethnography as a means of learning from people rather than studying them (Spradley, 1979: 3). Finally, and equally valuable, was Janet Finch's perspective that qualitative research encompasses techniques that are suitable for small-scale analysis by researchers whose tools are participant observation and in-depth unstructured or semi-structured interviews, supplemented by literary sources (Finch, 1986: 5).

Ethnography and Life Course Perspective

The design of this qualitative study is that of an ethnographic approach built around informal observation of and dialogue with a group of elderly individuals who expressed an interest in sharing the routines of their lives with me. Beyond this ethnographic approach, the study is one that views ageing from a life course perspective, considering old age from within the context of the entire life span, not as a separate period of life determined chronologically (Neugartern, 1996: 2). This thesis views old age as the end of a life continuum played out within the context of cultural mores. It considers old age to be largely shaped by each of the life stages preceding it, and further, that all life stages are profoundly influenced by culture. Old age is therefore seen to be not only

consonant with earlier life stages, but also with the cultures within which the life course has occurred.

The Participants

During the years I lived in New Zealand, I made three visits back to the United States. Each presented me with the time and occasion to talk to elderly people in environments other than New Zealand. Taping of all interviews in the United States followed the same process approved in New Zealand by the Massey Human Ethics Committee – that is, contact was made first by an individual well known to them; this person obtained permission for me to interview them, and then handled the formal introductions. In one West Texas town, I interviewed three women between the ages of ninety-four and one hundred-and-one.⁸ Additionally, on each of the three trips I met with two elderly Cherokee women with whom I had been corresponding for several months. Their interview data includes the letters that passed between us. In the course of one of the three trips, my husband and I found ourselves, along with an elderly man and woman, waiting in the office of a doctor who was late seeing patients because he had been delayed in surgery. For thirty minutes, the four of us sat together, without being interrupted by others coming into the office, engaged in lively personal conversation. During this time, with their permission, I wrote down notes on paper which they supplied.

Back in New Zealand, I interviewed two men, each a number of times over a period of four weeks while they were visiting friends in the same community in which I was

⁸ This West Texas community is an ideal location for an ethnographic study on the subject of successful aging. The three elderly women I interviewed there were among the oldest and the healthiest, and expressed a greater contentment and life satisfaction than many other interviewees, other than perhaps the Maori participants.

living. In addition, I met several times with three elderly Maori women who later dropped out of the study; one became seriously ill, another became entangled in an abusive relationship, and the third moved out of the area. Although I have pages of notes from our meetings, I do not have their written permission to include them in this study and have not done so. However, my meetings with these women made a deep impression on me and I do not doubt that these impressions are reflected in the write-up of this study. Two of the women were very poor and lived alone. One was relatively affluent and well integrated into the upper-middle class neighbourhood in which she and her husband lived. All three were deeply involved in the lives of their adult children. Two of the women lived far from their rural birthplaces and their extended families. They had little social support, except for their children, who were also struggling to survive financially. Two months into our meetings, one of these displaced women moved back to her birthplace. Her daughter and granddaughter stayed behind and I witnessed their separation. It was an emotional experience. The third woman was urban, well educated, and surrounded by whanau.

To obtain long-term New Zealand participants for my study, I spoke to ministers of several churches, nursing home managers, retirement complex administrators, field officers and staff for community health organisations in the New Zealand community in which my husband and I lived. I was unsuccessful in finding participants close to home, but referrals to ministers and rest home managers in other communities eventually allowed me to put together a group of twenty elderly people living within easy walking or driving distance from each other in an area approximately thirty-five kilometres from where we were currently living. It was a small convenience sample, and the distance from home was a problem, but the participants had not been easy to recruit; we therefore packed up our apartment and moved to a community central to where the participants

lived. This became our home base for three years. During this time, I visited in the homes of all participants, and when invited, I accompanied them to church, club meetings, restaurants, funerals, and other events. Initially, I made at least one introductory visit to each potential participant. I was an outsider, new to the community, and they were as interested in hearing my story as I was in hearing theirs. Over time, as I became more and more immersed in their lives, the sample size, though small, proved to be as large as I could manage.

All participants are English speaking, although for several it is a second language. Twenty of the participants reside in New Zealand. Of these, nineteen are native-born New Zealanders, including six of Maori descent, and seven are European immigrants. Of the remaining nine, all live in various parts of the United States, with two dividing their time between the United States and Europe. Three are natives of the American Southern Plains; two are European immigrants to the United States; two are Native Americans living in cities of the American West, and two are of Hawaiian descent and live in Honolulu.

Participant gender is preponderantly female, only five of the twenty-nine are male. This was not intentional, but it reflects a larger gender imbalance than in the wider elderly population. The reason for this imbalance is that in the New Zealand community in which I settled, men were not only the minority gender, but many were disinterested in participating. In contrast, the women were eager to participate, to talk, and to continue our social contact. The widely varying responses between men and women to my invitation to participate can be partly attributed to the fact that a high proportion of the elderly women I approached were widowed and living alone, while most of the older men were married and had their social needs met. The gender imbalanced demographics of the elderly population of the New Zealand community in which I

resided support the fact that, worldwide, elderly women outnumber elderly men by ever-increasing margins. In 2002, when The World Health Organization ranked 191 countries on Disability Adjusted Life Expectancy (DALE), it found women's life expectancy in richer countries around the world to be seven to eight years longer than that of men in those same countries. Similarly, in a 2005 discussion of the sex ratio of the world's older population, the United Nations reported:

Since female mortality rates are lower than male rates at older ages, the proportion of women in the older population grows substantially with advancing age. In 2000, women outnumbered men by almost 4 to 3 at ages 65 or older, and by almost 2 to 1 at ages 80 or above (United Nations, 2005).

In 2001, women accounted for 60 per cent of New Zealand's 75-84 population and 70.6 per cent of the 85 and over age group (Statistics New Zealand, 2002). This was the situation I found in my community there. In the supermarkets, shops, churches, bowling, and croquet clubs, there was a preponderance of women amongst the elderly.

Data Collection

All participants signed a consent form. I made no payment to any participant. At each interview, I obtained permission before taping began and also reminded participants that I would turn the recorder off at their request during any stage of the interview.⁹ Although most interviews took place in private, some included friends and family members; this was particularly true of the Maori interviews that usually concluded with the sharing of a meal. I deleted identifying information such as names, any identifying personal details, and geographic locations when I transcribed the interviews. All data are in my possession.

⁹ I was only asked once to turn the tape recorder off. The un-taped conversation that followed was a fascinating discussion of an elderly widow's search for sexual intimacy.

Taping of interviews began after several weeks of meetings and visits. I had prepared a list of questions to 'jump-start' the interviews, but they were not needed. By the time I began to tape, the participants and I were becoming well known to each other. This fact greatly facilitated the interview process. At times, I asked participants to clarify specific statements, sometimes I probed for understanding, and at other times, I would return to an issue I wanted to pursue, and they did the same with me – we were friendly and comfortable with each other.

I felt a great deal of compassion for the elderly people who were helping me produce this study and their behaviour indicated to me that they felt much compassion for me as well. Even though I was becoming more well known to them, I was still an outsider, a stranger to New Zealand with customs and ways of expressing myself, which were at times quite different from theirs. They were sensitive to those differences – several were immigrants themselves – and the stress it sometimes added to my understanding of what they had to say. Maisie Harrison, a Glaswegian, had a way of laughing and referring to me as her "Yankee-Doodle-Dandy" when I asked her to explain a word or phrase spoken in her broadly Scottish accent. Added to that fact was the illness of my husband, which began to develop a few months into the study. All the New Zealand women who participated had cared for ailing spouses and they communicated concern and compassion for my situation.

As I reflect back on my years with these elderly participants, I believe the richness and depth of the interview data in this study is primarily the result of three important researcher characteristics. The first is ethical – all information shared between us was held private, it was never repeated or discussed with others. The second factor was continual awareness of their age-related and circumstantially produced vulnerabilities (Yassour-Borochowitz, 2004) and the consequent danger of exploitation (Thapar-

Bjorkert & Henry, 2004; Tee & Lathlean, 2004). My awareness of their vulnerabilities was heightened by the fact that I was myself close to the age of my youngest participant, and at the age of eighty-one, my husband was the age of several of the participants. I was well placed to understand the vulnerabilities of elderly people. The third behaviour was the blending of empathy and respect in my interactions with them, which further helped to avoid exploitation (Finlay, 2005; Fitzgerald, 2004). Blodgett et al. have made these comments regarding their relationships as researchers with the participants of their study:

In fact, as a result of weaving together interpersonal kindheartedness with professional and ethical approaches, we found that our procedure with the preschool community was not a cumbersome undertaking but a humane, respectful and more interesting way to approach a research study. We learned that we do better, produce more, and live more enriched lives as researchers by being compassionate to our participants and each other (Blodgett, Boyer, & Turk, 2005).

Interviews were seldom longer than ninety minutes. If participants became tired, I stopped and returned another time. Taped interviews with the most enthusiastic participants total six to seven hours. I met with participants in their home environments. Most individuals lived in their own homes or flats, a few in nursing homes. In the nursing homes, it was sometimes a challenge to maintain the privacy and continuity of the interview process because of staff activity and intrusion by other residents.

The Data

The study focuses upon the life circumstances of the participants and their views on well-being. Data consists of observations, interviews, audiotapes, and field journals. It discusses distinctly personal and sometimes unique challenges met during the ageing process, but it also discusses other broad challenges to well-being related to gender, chronic disease and disability, ethnicity, institutionalisation, and social support.

I transcribed the taped interviews verbatim, in their entirety. Background noise, low voices, difficult accents, and speech peculiarities, made occasional sections of the recordings difficult to decipher. Thus it is possible that a few words in these sections have not been transcribed exactly as spoken, but these instances are rare and do not distort the sense of the passages in which they occur. Of greater concern was the means by which I would convey especially moving portions of interview material from the audiotapes to printed word. I found myself including long excerpts from participants' narrations in order to convey the fervour of the spoken word, but shortening them later in favour of brevity and succinctness. Many of the participants' statements have therefore been lifted from the context in which they were spoken. The choice of which statements to include in the write-up was based on the fact that they were repeated by several participants and could be regarded as themes; and also, because they could be lifted from the surrounding text without altering the speaker's meaning; and because they were particularly expressive and well-articulated statements. In all instances, I have accepted the narratives of the participants as they were spoken. I understand that their stories are based upon their personal interpretations of events, recalled, and reviewed in the presence of an empathetic listener. However, the frank discussions by these elderly participants of the private aspects of old age, repeated over time, in multiple interviews, settings, and environments, established my confidence in the reliability of the interview data.

Limitations of the Study

The actual words of elderly people yield the most descriptive and also the most accurate picture of old age. We listen, comprehend, and then interpret their words, however, within the context of our personal circumstances and experiences. Although I believe myself well placed for this research project, I acknowledge that my own understanding

of old age has influenced the examination, understanding, and translation of the interview data. Consequently, this work is not a case where I claim to have “simply recorded what really happened.” On the contrary, I acknowledge that it is a rendition that has been filtered through my “particular mental lens” (Brubaker & Thomas, 2000: 109). Commenting that “descriptions of social life can only be approximations of people’s lived realities,” Karp (1999) addresses the issue of reality versus representation of reality in research write-up, advising that data be carefully gathered and examined for regularities and reoccurring themes and that the write-up be rendered as “faithfully and interestingly” as possible. It is clear that Karp’s advice is conceptually sound. It has sometimes been difficult to be consistently guided by it, for while my write-up has certainly required perceptiveness and a long-term commitment to honesty and accuracy, it has also required the realisation that I could never fully understand the mental processes of another person, or view the world through the eyes of anyone other than myself. My response to Karp’s advice has been to construct my writing with much thought and in a way that is in as much accord with the facts as my understanding allows.

The fact that this thesis examines the views of but a small number of elderly people may mean that their status and position and the treatment they receive from younger people are not typical of the experiences of a majority of older people. On the other hand, with the current literature on ageing in mind, and from what we all observe of the elderly people with whom we come into contact, the experiences of the participants are not unusual. Nevertheless, attitudes toward old people are extensively divergent, and, even in the same society, individual experiences of old age can vary significantly. As a consequence, discovering the “lived realities” of other people’s lives has been a major

challenge of this study and the parameters of my process of discovery must be born in mind in judging the significance of my findings.

Conclusions

When I began this project, I felt my nursing experience had prepared me well for the undertaking. Although this turned out to be largely true, my prolonged involvement with the elderly individuals in this study created relationships that cannot be compared with the patients I had briefly cared for in institutional settings. As a nurse, I had maintained a nurse-client relationship. In contrast, as a researcher, I established relationships that have endured several years. As my involvement in their lives increased, the distance between us reduced and our rapport increased. As my compassion for their circumstances grew; the details they shared of their lives touched me. When I listened to the transcripts of their interviews, their words changed my perception of “good old age”.

My search of the literature has been an ongoing process extending through the entire study. Statements made by the participants regarding the components of a happy and satisfying old age led me back to the literature repeatedly to compare and contrast the views of the experts in ageing studies with those of the participants. Somewhere along the way, I began to ask, “Who are the true ‘experts’ in the field of ageing?”. As I read what those outside the experience had to say about ‘successful ageing’ and compared it with the remarks of people who were actually experiencing old age, I sensed a descriptive difference; and the views of the elderly participants understandably appeared to me to reflect greater reality. As I became increasingly immersed in this study, the focus of the elderly participants upon well-being, life satisfaction, and happiness, and their desire to be loved, respected, and valued came into sharp contrast with the biomedical standards of the concept of ‘successful ageing’. I began to question the rationale for inserting the values of ‘success’ and ‘failure’ into any gerontological

concept. I also began to ask when and under what circumstances is it appropriate to categorise and label older people. The majority of the participants in this study are poor women in failing health. As a result, by the standards of the successful ageing model, they wear the label 'unsuccessfully' aged. But the rationale for the satisfaction they feel with themselves lies in having persevered and having overcome each of the obstacles they have encountered in their old ages. Their positive assessment of their ageing experience is founded in their successful adaptation to poverty, care giving, widowhood, loneliness, chronic disease, and the deaths of spouses and friends. However, in contrast to their self-conceived concept of 'successful' old age, their need for assistance ensures that on occasions they will be viewed as burdens to their families and to society.

CHAPTER 6

INTRODUCTION TO PARTICIPANT PERSPECTIVES

What are the factors that promote well-being for the elderly participants in this study? What are the factors that detract from it? How do the participants' views of well-being compare with the concept of successful ageing? The remaining chapters in this section provide the information required for understanding the similarities and differences between the concept of successful ageing and the participants' perspectives of well-being in old age. To accomplish this aim, these chapters will look personally at the participants, their belief systems, environments, and social support systems. It will listen to what they have to say about 'real' old age and what the barriers are to achieving a 'good old age' in their societies. The participants in this study live in New Zealand and the United States. Some are almost completely powerless while others occupy positions of authority. The obstacles that impede their well-being result not just from their actions as individuals, but from the attitudes and behaviours characterising the societies and subcultures of which they are members (Rashmi & Pillai, 2002: 567-568). That is, not only have personal lifestyle choices affected their ability to age with well-being, but also pressures and opportunities presented by society throughout the life course have affected the extent to which they are currently able to experience well-being. For example, smoking, which was an accepted social practice in New Zealand and the United States during the greater part of the twentieth century, has caused serious problems for many of today's elderly people and interfered with their well-being. Among the participants in this thesis, Neville Schuster, Robert Gordon, Jacob Traub, Allison Turner, Rose Winters, Simon Burgess, Estelle Doherty, Emma Parker and Harriet Carey each began smoking when they were adolescents. Today, they all suffer from varying degrees of cardiovascular and lung diseases; and, although they did not

themselves smoke, Maisie Harrison, Fanny Gage, Susan Eyres, and Edna Holt were the primary caretakers for spouses who died from smoking related heart disease and lung cancer. A personal decision such as whether or not to smoke is as much a cultural decision as it is a personal one, being heavily influenced by family, peers, community, and advertising (Droomers, Schrijvers, Casswell, & Mackenbach, 2005; Torres, 2002: 417; Thomas, Fine, & Said, 2004; Unger et al., 2003). Indeed, in World War II, smoking was encouraged (Cushman, 1986; Evans, 1998) and seen as being good for mental health ('nerves'). The serious health risks associated with smoking only became widely known from the 1960s. Smoking was seen as a luxury, and like alcohol consumption, was seen as a right for working men, but not women (Glantz, 2006; (National Center, 2001; Craig, 1999). Among the individuals in this study, the men became smokers, but the majority of the women did not, mainly because their cultures did not approve of women smoking.

In addition to the influences of society and subculture, these participants came of age in specific historic circumstances: World War I, the Great Depression, and World War II. Notwithstanding the variety of their cultural affiliations and their individual circumstances at the time of those world events, the participants faced similar difficulties: family members were killed, spouses died in battle, homes were destroyed, jobs were lost, and a new post-war life had to be established. Because the participants have made some similar responses to the problems of their time, threads of common experiences run through their narratives. Some of these decisions have contributed positively to their old age, while others have not, and the consequences of those decisions have produced similar obstacles. It is therefore, the overall context, all of the circumstances forming the setting for old age, which must be examined in order to understand the concept of successful ageing (Torres, 2003: 80).

The participants interviewed for this thesis live in wealthy countries. Consequently, their levels of health care, living standards, and state-provided support systems are on the whole, better than they would be if they had grown old in some poorer regions of the world (although there are some exceptions – the United States has worse health statistics than Cuba for example (Kristof, 2005). None of the participants is homeless; none is hungry or cold; and none is completely devoid of social support. However, these facts do not tell the whole story of their old age. The reality is that sometimes their experiences, particularly those relating to social identity, roles, and status, are stark contradictions of the expressed standards of their societies. From some of them we learn that it is the attitudes and behaviours of society, including friends and family members, which present the most serious impediments to successful ageing. From others we learn that the reverse is true: when the functions performed by elders are deemed essential to the well-being of family and of society, and when the knowledge and experience of elders are esteemed, the likelihood of a happy, successful old age is increased.

Over a period of three years, I interviewed and socialised many times with groups and individuals between the ages of fifty-eight and one hundred and one. They were Maori, New Zealanders of European descent, Native American, Americans of European descent, male, female, and immigrants. The majority were female, and a small number were male. Sixteen of the New Zealanders lived within walking distance of my apartment, four lived in neighbouring communities, and nine lived in the mainland United States and Hawaii. Interviews with six individuals took place in single, one to four hour meetings. Interviews with two were spontaneous opportunities that lasted thirty minutes. Five were interviewed and taped over a series of two to four meetings; with six, I established longer-term relationships, meeting with them over an eighteen to

twenty-four month period, and with ten, close ties were established, and communication between us has continued.

The biographies of these individuals reveal similar obstacles to well-being as well as comparable coping mechanisms; however, their life circumstances are different in many ways. The reasons for these differences are related to gender, income, health, location and environment, but most importantly to the disparity in social status they are accorded and to the vastly different levels of autonomy which they are permitted to exercise. Their biographies are a striking demonstration of this fact. For example, Sally Dickerson and Mabelle Armstrong both experienced loss of control and autonomy when their children undertook to move them from the homes in which they had lived for decades to accommodations in other communities. For Sally the move was successful; for Mabelle it led to a devastating loss of independence and of long-standing friendships. The differences in outcome lie chiefly in the places the two women occupy within their families. Sally's children cherish and respect her personal rights and behaved in a way that protected those rights: they did not force their mother to move; instead, they persuaded her of its benefits. Not until she signalled her readiness to discuss relocation, did they take action. Then, as Sally will describe, they "did it all for me", making it as free of mental and physical hardship as possible for her by undertaking the physical labour of the move themselves. Mabelle's children acted in an entirely different manner toward their mother. Without her knowledge, they unilaterally and autocratically sold Mabelle's home and made arrangements for her permanent move into a nursing home. They acted without empathy and respect and Mabelle subsequently came to view herself as a woman without a role or place of significance within her family.

The biographies of Robert Gordon and Jacob Traub also substantiate the importance of family relationships to successful ageing. For different reasons, estrangement from their

children in old age has resulted in the forfeiture of the authority of these two men within their families, lowered their social status, diminished the respect with which they are regarded, and separated them from the support of their families and friends. Neville Schuster's biography demonstrates an opposite outcome. Through his excellent relationships with his spouse and children, Neville continues to occupy a central position within his family and to enjoy a high level of love and support.

Finally, the sharply contrasting status of the Native American and Maori participants within their families and tribes and the impact of those positions on the participants' lives, illustrate the influence of family on positive outlook and successful ageing. In this regard, in my discussions throughout this thesis, I have tried to avoid idealising Maori and Cherokee cultures. Certainly, to varying extents, the lives of older people in these two minority cultures have, with time, taken on the characteristics of those of the wider culture. That this is true can be demonstrated by the lives of Harriet Carey and Estelle Doherty, whose old ages resemble in most ways, those of their poor elderly white neighbours. It is also true that First Nations people have a significant number of negative social indicators (although in fairness, some of these are the result of colonisation). Nevertheless, of particular relevance to this thesis, there are two key aspects of old age where both New Zealand Maori and Native American traditional cultures differ from that of the current dominant culture. One is that amongst these First Nations people, old people in general have relatively high social status and are more highly valued. For example, it has been my observation whilst doing the research for this thesis, and it has also been noted by other commentators, that among New Zealand Maori, status tends to increase rather than decrease with advancing age. The second important difference is that elderly First Nations people – especially those who are

members of 'traditional' communities – are far less likely than are their contemporaries of European extraction to live alone, or amongst strangers.

The narratives in this thesis demonstrate that although the pathway to well-being is unique to the life experience of each individual, the physical, social, and psychological barriers to well-being are often similar. To varying degrees and in their own way, each participant is struggling with age-related changes caused by physical and intellectual decline, a shrinking circle of friends and companions, decreased income and financial reserves, and, for the majority, the loss of social status.

I found it troubling to listen to some of the events described by the participants. It was just as troubling to transcribe them later in the privacy of my home and it is now difficult to write about them, for they are at times stories of isolation from society and of separation from their own children. The openness and honesty of the participants was impressive. When they spoke of lost relationships and better times, I pulled back in order not to increase their distress by asking probing questions. They solved this problem for me by continuing their narratives with humour and strength of purpose; having committed to participate in my study, they never wavered. As a result of their resolve, several of these individuals have become friends and mentors and as a consequence, I have a greater sense of the energy they have had to expend in order to age with well-being.

In the chapters that follow, the participants provide an understanding of the constraints that modern liberal societies place upon the ability of elderly people to age in a manner that facilitates their personal definitions of well-being. To make clear the link between the definitions of the participants regarding well-being and the ethnic group to which they belong, biographies of participants appear in the chapters dedicated to their particular ethnic group. Thus, vignettes of the Maori participants are located in Chapter

7, the Western Cherokee in Chapter 8, a the immigrant group in Chapter 9, and those of European Descent in Chapter 10.

CHAPTER 7

MAORI PERSPECTIVES ON AGEING

Introduction

Four North Island Maori elders participated formally in this study. Three others were interviewed, but problems forced them to withdraw before formal taping could be undertaken and their content is not included. I was pleased to be able to include Maori elders in the study. Maori are an important part of New Zealand society; they have had a significant influence in the development of New Zealand art, history, politics, and religion, and I felt that this study would present a more balanced view of New Zealand if it were to reflect their outlook on ageing as well. I had another, more personal reason for my desire to include Maori elders. Three of my four great-grandparents were Cherokee. Two of the women who participated are Cherokee and from them I had learned much about Cherokee life perspective. I also discovered that we had much in common. Although their childhoods were influenced by traditional Cherokee elders, and mine was not, the three of us had an affinity between us that facilitated our communications. In part, this was because I had grown up in a traditional, fundamentally rural American society, in which, similarly to Cherokee society, elderly people, because of their wisdom and experiences, were held to be the most important members of the family and community. However, I also attributed some of our spontaneous liking for each other to our Cherokee connection. I could not know if this were true (and I still do not), but I wondered if a similar affinity might be established in interviews between Maori elders and myself. From my perspective, this is exactly what occurred. Like the Cherokee, Maori honour their elders, value tradition, the lands, language, customs, and religion of their ancestors. I felt at ease with the Maori

participants. The interviews of Maori elders were some of the most personally enriching experiences of the years of this study.

The four Maori whose narratives are recounted in this study range in age from sixty to eighty. Three of the four are female; all but the youngest are retired. They live in different communities, attend different marae, and are members of different iwi. When they speak of ageing, they do so from the diverse experiences of their individual life courses and social circumstances. However, in spite of their differences, these individuals address health and well-being from the same Maori multifaceted perspective.

Simon Burgess

Except for a brief period when he was a young man, seventy-five-year-old Simon Burgess has lived his life on the land of his ancestors in the house that he and his parents occupied until their deaths; it is the house to which he brought his bride and the place where his children were born.

When my dad retired, he had nothing to fall back on, so I moved back home. I came back to my dad and my matua wahine. Them two and me, I was the only son and child.

For generations Simon's ancestors have come back to die in the hills and valleys which he has walked since childhood. The well-being that typifies Simon's old age is based on his connection to the land of his ancestors, the mana granted by his age, and the service he performs as a kaumatua to his iwi. These were the major themes of what Simon had to say about well-being and health. Although he has been widowed for ten years, and admits to loneliness, his concern for the land and for his whanau keep him fully occupied in activities aimed at protecting and preserving Maori values and practices. Simon believes that his good old age is directly related to the work he does on the marae and he credits his mother and father for teaching him the traditions of his ancestors.

Well, frankly, I'm one of the lucky ones. I'm thankful for my Mum and Dad because they took me out to the marae all the time to learn the Maori culture.

Edna Holt

Edna Holt is seventy-seven years old. She takes pride in describing herself as the oldest woman in the village. Widowed in her eighth decade, Edna's first reaction to the loss of her husband was to withdraw from marae responsibilities. She related how for several months, she did not visit the pa, the urupa, or attend the uhunga of friends; but then, she says, she found help.

The hurt was there for a long time. But a friend of mine, who is a minister, was coming here quite often to see me and she asked me if I was asking for God's help.¹⁰ I told her I didn't like asking Him for me because I was all right. It might be one day if I needed Him badly I would, but right then I was getting by. Well, she gave me a talking to about it and she told me, 'Edna, what you're doing is not right. You should ask Him because that's what He is here for. You ask for your grandchildren, and for your daughter that's sick, and you should ask for yourself'. I started doing that and I found that when I asked God to help me, I had a lighter heart.

Sarah Hunter

My first meeting with seventy-seven-year-old Sarah Hunter took place in her daughter's home. There were other Maori women present, but Sarah was the oldest. Interviewing her was an exhilarating experience. Sarah is a fascinating woman; she has remarkable presence and she is highly esteemed. Her voice was low, but when she spoke, the others were quiet; they did not interrupt her. Throughout our meeting, which lasted almost

¹⁰ Edna explained her turn to religion for help as due in large part to the care and concern of a friend who was a Christian minister. During the several years that Edna was the primary caregiver for her husband, this friend came to their home often to visit. Edna's husband held strictly to old Maori traditions and he was often rude to their friend, at times even telling her not to speak to him of God or for that matter, to come to his house. Despite his rudeness to her, the minister continued her visits and after his death

three hours, she was in charge. It was on her authority that the meeting began and ended, that the subjects for discussion were decided, and the time and place for a future, formal, taped interview were set. That time and place, Sarah determined, should be my home; the meeting was to be private, there would be no one present other than the two of us; the major topic of discussion was to be the role of Maoritanga in successful aging.

Emma Parker

Sixty-year-old Emma Parker is the youngest participant. She has two married children and two grandchildren; her third and youngest child is nineteen, unmarried, and living at home. I met Emma by chance in the train station; sitting side by side on a bench waiting for our trains, we began talking. When she discovered that I was interested in interviewing older people, she volunteered to participate and suggested that she knew other Maori people who might consent to participate. In the months that followed, through Emma's introductions I interviewed several Maori elders.

Emma has a clearly defined, personal concept of how to achieve the best possible old age; it is comprised of mana, whanau, ancestral land, and tradition. For Emma, a good old age is not an abstraction; it is a personal and social goal. She has a well-developed plan for achieving it: she will retire from her job in two years and return to her mother's iwi and the marae of her childhood. There she will become a student of elders whom she knows are still practicing the old customs, and she will immerse herself in learning as much as possible so that when her time as a Maori kuia comes, in the way of her grandmother and mother, she will be prepared to teach the old traditions to the next generation.

continued her visits to Edna. Edna credited her friend not only for encouraging her to pray, but also take up her role as kuia once more and to re-engage with whanau and iwi.

Maori Models of Well-Being

Several models have been advanced to conceptualise Maori well-being. To demonstrate the several components upon which Maori well-being rests, three of these models are briefly described below. First, is the model known as “whare tapa whā”, the “four sides of the house” (Durie, 1994: 69-75). Using this metaphor, the four sides of the house are spiritual health (taha wairua), mental health (taha hinengaro), physical health (taha tinana), and family health (taha whanau). Just as a house requires four intact sides to remain whole, each of the four ingredients comprising health must be similarly intact if well-being is to be achieved and maintained. A second concept of Maori well-being is that of “ngā pou mana” in which well-being is composed of the four supports of whanaungatanga (family), ngā taonga tuku ih (ancestral treasures), te ao tūroa (Maori estates) and turangawaewae (ancestral land). And in the third model, the eight tentacles of the octopus (Te Wheke) are used to explain the various facets of Maori well-being. Four of Te Wheke’s tentacles are the four house supports of whare tapa whā referred to above; the other four tentacles are mana (status), mauri (life force), ngā taonga tuku iho (ancestral treasures), and whatumanawa (emotional life) [as cited in Palmer, 2004)]. As these three models demonstrate, the Maori perspective of well-being is the result of health in body, mind, spirit and family relationships and congruity with nature (Baskett, 2000; Hughes & Gray, 2003; Durie, 2003).

For the Maori participants in this study, ageing well is a life-long process built upon Maori values of family relationships, ancestry, land, and tradition. However, as their interviews inform us, it is mana, that is, the esteem and authority accorded to them by their whanau which is most crucial to good old age. For this reason one must name the whanau, described as the nucleus of all things and the custodian of traditional values (Robinson & Williams 2001: 55-56), as being of primary importance to well-being in

Maori society, for it is the whanau which extends the mana earned by advanced age. The other elements supporting well-being – ancestral land, the spiritual energy of the language, and traditions of ancestors – are likewise important themes, but foremost is mana. The central point of mana is that it grows with age and wisdom, it secures the social position of Maori elders, and verifies it their value. The barriers to well-being are appositional to these prerequisites, the loss of mana, unhealthy family relationships, loss of ancestral lands, and attenuation of Maoritanga.

The interview themes of mana, whanau, land, tradition, and language are so closely interwoven with well-being in old age that it has been difficult to separate them. As a result, in the discussions that follow, statements appearing under the heading of one theme could appear, with equal tenability, under the heading of another theme. I have seen no way of avoiding this overlap, and in fact, the difficulty in organising the themes into unambiguous sections is a testimony to the complex, holistic view of old age well-being described by the Maori participants in their interviews. In old age, with the growth of mana, family, land, and tradition become inseparable aspects of physical, mental, and spiritual well-being. A discussion of any one of these aspects of health and well-being inevitably relates to and overlaps into discussions of the others.

Land and Well-Being

“Te toto o te tangata, he kai; te orange o te tangata, heua” –
“Food supplies the blood of man; his welfare depends on the land.”

The Treaty of Waitangi, 6 February 1840, guaranteed Maori rights as owners of the land (New Zealand Department of Internal Affairs, 1945: 33).¹¹ More than one hundred

¹¹ In modern English the Treaty of Waitangi states: “The Queen of England agrees to protect the chiefs, the subtribes, and all the people of New Zealand in the unqualified exercise of their chieftainship over their lands, villages and all their treasures.”

years later, the Waitangi Tribunal found that, because of the ancient customs of whakapapa and ahi ka, the Crown had violated the Treaty of Waitangi. In its report on the Ngati Whatua claim for Orakei, the Waitangi Tribunal¹² asserted (1987: 3.4):

... we are talking of Maori ancestral land, and it is proper to use Maori determinators, not those of Europeans, to settle whose ancestral land it is. The Maori method is clear – it is done by whakapapa, the recitation of ancestral genealogies as is regularly done today. There is not one person of Ngati Whatua who cannot link to the ancient Ngaoho occupation that begins in the dawn of time, simply by reciting that person's line from Te Kawau.

Just as for the Ngati Whatua, Simon Burgess' whakapapa links him to a place of origin – the land of his ancestors (Clarke & Neuwelt, 2003).

Our ancestors got to this area, our tribe's land, in 1650. I've got a bit of a memory block, but I can whakapapa forty-odd generations. From Maui Tikitiki-a-Taranga, I can come all the way down to me and that's about forty-odd generations; to come from Kupe to me is twenty-seven generations, and to come from Whātonga to me is twenty-five generations.

The doctrine of ahi ka, which Simon refers to as keeping the “land warm”, establishes the right of the individual and of the tribe to continuing use of the land (New Zealand Ministry of Justice, 2001; Alves & Cleveland, 1999: 6). Simon describes how his grandfather used the doctrine of ahi ka to secure the family's future guardianship of the land.

My grandfather needed to go to New Plymouth, so he said to my dad, you stay here and look after the land; keep the land warm. That's a Maori custom.

¹² Established by the Treaty of Waitangi Act of 1975 as a permanent commission of inquiry, the Tribunal hears claims by Maori individuals and groups that their Treaty rights have been breached (Boruassa & Strong, 2002; Levine, 1999). In 1987, when the Waitangi Tribunal found in favour of the Ngati Whatua claim for Orakei (a 700 acre block of land in what is now central Auckland), it based its decision upon the customs of whakapapa and ahi ka, finding both to be legitimate determinants in settling land claims.

In Maori tradition, land bestows a sense of permanency to a world otherwise characterised by instability and change (Firth, 1959: 368). Maori today say:

Land provides us with a sense of identity, belonging and continuity. It is proof of our continued existence not only as a people, but also as tangata whenua of this country. It is proof of our tribal and kin group ties. Maori land represents turangawaewae. It is proof of our link with the ancestors of our past, and with generations to come. It is an assurance that we shall forever exist as a people, for as long as the land shall last (NZ Ministry of Justice, 2001).

In contrast to western societies, ownership of land is not a Maori concept; instead, the people belong to the land. Access to tribal lands is vital to Maori well-being.¹³ As such, it is a communal resource which living generations guard and protect in the same way their tipuna have done before them. Land is the link to past and future generations (Firth, 1959: 370; Ministry of Justice, 2001), imbuing in Maori a strong urge to be buried in their own tribal whenua (Cadigan, 2001:129). In 1882, W. L. Buller, Counsel for Ngati Apa, rested the case of one claimant's appeal upon a female ancestor whose dying words clearly signified her attachment to the land in question. "Take me not away from the land," she said, "but bury me within hearing of the Rangitahi waterfall" (as cited in Firth, 1959: 371-372). Land therefore becomes particularly important in old age when the urge to return to the lands of one's ancestors for burial and successful entry into the iwi of one's ancestors becomes increasingly stronger. It was for this reason, to maintain occupation and guarantee future access to the land, that Simon Burgess' grandfather left a son on the land when he took his whanau to live for a while in New Plymouth. Emma

¹³ Durie has stated, "A lack of access to tribal lands or territories is regarded by tribal elders as a sure sign of poor health since the natural environment is considered integral to identity and fundamental to a sense of well-being" (1994: 71).

Parker learned from her father the crippling effect of the loss of land upon a land-loving people.

My dad had a very hard life growing up. He always talked about the old people back then on the marae, about the Kingitanga Movement and how, after they lost a lot of land there, they were crippled.

For Sarah Hunter, who grew up on her grandparent's farm, life was a hard, but healthy existence. Like generations of Maori before them, her grandparents cared for the land and the land gave back the gift of health, well-being, and, in the case of her grandparents, longevity.

Well, they say Maoris die with a lot of diabetes, but it never happened where I came from. My grandparents were healthy. Grandfather was riding a horse when he was ninety.

Water and Well-Being

“He huahua te kai? E, he wai te kai” –
“Are preserved birds the best food? Oh no, water is.”

Pollution of water is a serious matter to Maori people. As with the land, Maori perceive an integral connection between themselves and the streams, rivers, and lakes (Tai, 2002). The water flowing in the rivers is the blood of ancestors; when the mauri of the water is harmed, “so too is the spirit of the tangata whenua” (New Zealand Conservation Authority, 1997: 47).

The purity of water is precious and jealously guarded because the mauri, the vital essence, is the same spiritual stuff as vivifies and enlives human beings and all other living things. To violate the purity of water is therefore to violate your own essential purity (as cited in Ministry of Justice, 2001).

Sarah Hunter spoke of the state of the land and water on her grandparent's farm eighty years ago.

We got all our meals from the land and from the sea. Everything my grandfather planted just grew out of sight. You know, we got our fish from the sea and from the rivers we got the eels. We had everything in the way of food. But everything is polluted now in New Zealand, our rivers, our lakes, our ponds. When my grandfather had his pond, he used to put

the eels in it and they would grow and then he'd get some out and kill them, but he kept filling it up. And it was clean. Oh, not today, no, no.

In the excerpt below, Simon Burgess discusses a well-known New Zealand lake, contrasting its pre-European condition with its present state.

Mauri is the spirit and also the well-being of the lake. It's been destroyed. When Toi te Huatahi came here, that lake was crystal clear. There was forest right around the lake, native birds were flying around, fish were jumping up – it was beautiful. It had everything until the coming of the Europeans. They cleared all the trees right around the lake. Once they'd done that – they did that to let the cattle come in – all the nutrients that once were there slowly started to degrade. But the biggest problem was that in 1952 the Council's sewer manhole blew and sewers blew out down the road. So what did they do? They dug a trench across the road to the lake and the sewage and everything went down into the lake and totally destroyed the mauri and the mana.

Mauri is conceptualized as a “life force” (Hawke's Bay Regional Council, 1995; Ahdar, 2003), and as a “life principle” (Tawney & Firth, 1929: 244) to be honoured and protected. For example, it is said that a river or forest will lose its vitality and fruitfulness when its mauri is not respected (Patterson, 1999), while the well-being of an iwi is linked to the condition of the waters within its territory (Kiro, 2003). As Simon points out, under continued assault mauri can be driven away and even destroyed. An individual can lose mana and still live, albeit without social authority and prestige; if mauri is lost, however, the individual must die because the life force or life principle is lost (Tawney & Firth, 1929:244-245; Best, 1954: 22-34).

The fish and eels that lived in the waters of Aotearoa once provided the protein that nourished the bodies of the tangata whenua. The mauri of the water, being well-respected, kept the seas, lakes, streams, and fisheries vital and productive. It was a physical, spiritual, and economically healthy lifestyle. Maori protected the purity of the water, which in turn produced teeming numbers of fish that fed the tangata whenua well, and kept them independent of the mainstream Pakeha economy. It was a cycle of

tradition which, until interfered with by outsiders, maintained well-being, self-reliance and the mana of the Maori people (Durie, 2003).¹⁴

Today, environmental degradation has depleted fisheries, driven away native birds, and, in some instances sickened those who eat and drink from polluted waterways (Waitangi Fisheries Commission, 1999; Cadigan, 2001; New Zealand Ministry for the Environment, 2001). In the following excerpt, Simon Burgess remembers the 'old days' and addresses the impact of pollution on the well-being of elderly Maori.

In the old days, we had everything – fish, eels, fowl, and even a few cows. There was a stream running through here then and we kept a full box of eels in it. Now when you talk to some of the old people today, you find that they're not doing so well and all those good kaumatuas, they're gone. They're all gone in the short space of about six or seven years. Besides me, there's only one kaumatua left and he's diabetic and on a dialysis machine. You see, the old Maori still eat the eels out of the lake and it hasn't been doing them too much good. It doesn't do them any good in the long run; that's what I'm thinking.¹⁵

For a people whose well-being is integral with the well-being of the natural world, the ill health of lakes, rivers and seas is a personal experience which negatively affects the ability to age well (Durie, 2003; Cunningham & Stanley, 2003).

Tradition and Well-Being

“Toi te kupu, toi te mana, toi te whenua” –
“The permanence of the language, mana and land.”

¹⁴ In 1979, Matui Rata who in 1981 would become the leader of a new Maori political party, Mana Motuhake, linked the loss of mana with the loss of land and culture by declaring that “the deteriorating state of affairs of the Maori people” required “dramatic action” to return to them their language, land, culture, and sense of self-reliance. “Above all”, he said, “We want our mana back” (Hazlehurst, 1993: 65).

¹⁵ Pollution of traditional food sources is a cause for concern among iwi throughout New Zealand (Kiro, 2003). On account of age and associated frailty, and, as Simon Burgess has suggested, their inclination to cling to traditional food irrespective of pollution, elderly Maori are particularly vulnerable to the effects of food contamination.

As translated by Īhaka, the message of this proverb is the dependency of Maori culture upon the traditional values of language, mana, and land; it emphasises that if these were lost, Maoritanga, the uniquely Maori view of the world, would cease to exist (Brougham, Reed, & Kāretu, 1996:89). One of the important roles of elders is to pass on the traditional knowledge and culture, which is largely orally transmitted, to younger generations and so keep the worldview alive.

The well-being of Maoritanga and the preservation of traditional Maori values, beliefs, and protocols is a major theme of the Maori interview data. After several generations of western influence, these elders fear that future Maori young people may view the ways of their ancestors as irrelevant to survival in modern society. They worry that the legends of Hawaiiki and Maui will be overwhelmed by the technology of PCs, laptops, PDAs, video games, and mobile phones. They are also anxious over the value of Maori elders in a society dominated by modern rather than traditional values. Although Sarah Hunter herself is accorded high status and respect, she fears that modern western values will jeopardise the status of future generations of elders. In her lifetime, she states, the old Maori way of life and the well-being it endows has weakened.

There is a big difference between my grandmother's generation and today's. The old life was simpler. It was hard, but it was a pleasure to work. Past generations worked with their hands and they were blessed by everything they got. And we could see it too, as children, you know. War changed the Maori. In my time we have had two wars. We had to struggle to make ends meet and for the first time it wasn't off the land. We had to go out to work. Maoritanga is dying away, you know that. It's sad. It is an inner turmoil for the Maoris in more ways than one – politically and spiritually.

Edna Holt also addressed the changes in Maori society which have occurred over her lifetime.

When I was a young girl, we respected our elders. It's different now. I'm not saying all of the young ones have a bad attitude, because there are some who still respect their mothers, but there are many who do not. I

hear some of them moaning and groaning and even swearing at their mothers.

Emma Parker personalised the changes she observes in Maori society in these words:

I don't believe my children respect me the way I respected my parents. They love me, but they don't respect me in the same way. We would never back chat my mum and dad. We were too scared to! Many of the old ways are not practiced today. They have been lost.

Even though older Maori still retain their mana amongst their people to a great extent, Simon Burgess also expressed concern over the erosion of old Maori values. A major proportion of the work he therefore does with the youth on his marae is aimed at countering that erosion.

In the old days it was an unheard thing for a Maori kaumatua or kuia to be placed in an institution for the elderly because then the younger generations cared for them in their homes. That is changing. Today's young Maori have left the old beliefs and teachings of their fathers. They work to buy material things, not to take care of their families. It is a sad situation. Our old people are being put away in nursing homes while the young people drive around in expensive cars.

In a 1999 look at Maori society, Durie¹⁶ states that it has retained a generally positive attitude towards elderly people, continuing to value their contributions to whanau and hapu. However, he also forecasts the possibility that:

Future generations of Maori elderly may be less able to depend on secure roles in Maori society and may have less opportunity to develop a secure cultural identity. Unless their position is adequately considered, in advance, there is a danger that they will become a seriously disadvantaged and alienated group (Durie, 1999).

The Maori elders interviewed for this thesis express a similar concern to that of Durie's.

¹⁶ Mason Durie is Professor of Maori Research Development and inaugural Assistant Vice-Chancellor (Maori) at Massey University, New Zealand. In addition to his teaching, research achievements, and extensive publications on the subjects of Maori well-being, health, mental health, and social policy, in similar fashion, he has served on a number of community and national organisations.

They are not concerned for themselves because their own positions are secure. Some of my most enduring memories of the years of this study are those relating to the relationships that existed between the Maori participants and their whanau. I remember the dignity with which Sarah Hunter was treated, the joy that resided in Edna Holt's home, the respect Emma Parker commanded, and the authority of Simon Burgess. It helps me understand the great contribution made by elderly First Nations people to the well-being of their societies.

Although the Maori participants fear for the future of Maoritanga, for the purpose of this thesis the important point to be made is that (with some exceptions and to varying degrees) Maori elders today have access to elements of well-being that are generally not available to western elders. Through their interviews, these Maori elders inform us that increasing status with age (mana) and strong, extended family relationships create an environment that encourages well-being.

Te Reo Maori and Well-Being

“Ko te reo te hā te mauri o te māoritanga” –
“Language is the very life-breath of being Māori.”

Beginning in the early 1980s, a resurging interest in Maori culture brought about political and social changes which led to the establishment of the Kohanga Reo (pre-school language nests), Kura Kaupapa Maori (alternative schools based on Maori philosophy and language), and Whare-Kura (Kura Kaupapa Secondary Schools) throughout New Zealand (Reedy, 2000; Battiste, Bell, & Findlay, 2002; Penetito, 2002). To bring its early childhood learning and development plan into concordance with the aims of these schools, the New Zealand Ministry of Education introduced a bicultural national curriculum statement called “Te Whariki.” This statement emphasises the principles of empowerment, holistic development, family and community, and relationships and the strands that pull it all together: well-being, belonging, contribution,

communication, and exploration. As such, Te Whariki is built upon the same principles that comprise whare tapa whā. Although intended to define the factors that produce health and well-being in children, much of what it says is equally applicable to elderly people. For example, Te Whariki is introduced with a statement of specific goals for New Zealand children:

[T]o grow up as competent and confident learners and communicators, healthy in mind, body, and spirit, secure in their sense of belonging and in the knowledge that they make a valued contribution to society (New Zealand Ministry of Education, 1996: 9).

With only a single change in wording this statement of goals becomes relevant to Maori elders.

[T]o age as competent and confident learners and communicators, healthy in mind, body, and spirit, secure in their sense of belonging and in the knowledge that they make a valued contribution to society.

The critical point is that Maori health and well-being is rooted in the land, family, tradition, and language. That this remains true today is due in large part to Maori elders who have worked hard to keep the traditions, language, and culture alive. Te reo Maori is as much the essence of Maoritanga in old age as it is in childhood.

One of the themes in the Maori interview data is the importance of the Maori language to the preservation of Maori culture. Of the four Maori participants, two (Sarah Hunter and Emma Parker) learned to speak Maori as children in their grandparents' homes, where Maori was the primary language of the home; they learned English in the local missionary schools they attended. In the case of the other two (Simon Burgess and Edna Holt), Maori was spoken neither within the home nor at school. Although it seems clear from Simon's remarks that he attended the marae regularly with his parents and heard te reo Maori spoken there, he did not become fluent in the language until the latter half of his sixth decade. Well-schooled in Maori history and practices from an early age, the addition of te reo Maori proficiency was important to his desire to become a kaumatua.

Now in those days, they never taught us to talk Maori. I didn't learn to speak Maori until I was fifty-five. And then I said to my uncle, 'I want a bit of a hand.' So he set me down something, just a bit of tauparapara and a bit of a karakia – a brief outline of what I had to do. And I'd say it just builds up and the confidence comes. It's not a problem now for me to get up and talk and even sing.

Like Simon Burgess, Edna Holt attended language classes in middle age for the specific purpose of qualifying herself for the role of elder. For a while, she was the only Maori speaking woman on the marae. However, after the 1980s, when Maori children were once more taught to speak their language,¹⁷ there were several Maori-fluent young people attending Edna's marae. In spite of her stated apprehensions over the future of the Maori culture, Edna says there are now a number of women on the marae, who will be well able to take over her responsibilities. It is in these young women that Edna sees hope for Maoritanga.

The young ones have the knowledge more so than my age group. It wasn't there for us. But the ones coming along now, they've got it all. They have the education, and the knowledge.

Conclusions

E tipu, e rea, mō ngā rā o tōu ao; ko tō ringa ki ngā rākau a te Pākehā hei ara mō tō tinana, ko tō ngākau ki ngā tāonga a ō tūpuna Māori hei tikitiki mō tō māhuna; ko tō wairua it ō atua, nāna nei ngā mea katoa –

Grow up and thrive for the days destined to you, your hands to the tools of the Pākehā to provide physical sustenance, your heart to the treasures of your Māori ancestors as a diadem for your brow, your soul to your God, to whom all things belong.¹⁸

¹⁷ When Maori were reclaiming te reo in the 1980s and 1990s through the Kohanga Reo movement, they turned to their elders, who were often still fluent, to teach it to their children. The Kohanga Reo movement produced a spectacular Maori lingual and cultural renaissance. (Cushner, 1998: 53; Cooper & Ah Nee-benham, 2000: 48; Reedy, 2000).

¹⁸ This whakatauka was written by Sir Apirana Ngata. Kāretu states that "it is probably the most widely quoted proverb of the last forty years" (Brougham, Reed & Karetu, 1996 :90).

The well-being of the four Maori participants is drawn from the land, their families, from the language and traditions of their ancestors, and from the mana attached to the respected roles of kaumatua and kuia. Maori have been deprived of a large part of their lands through wars, confiscations, and underhanded dealings. Maori children were once forbidden to speak their own language at school. Their parents believed they were doing their children a favour if they helped them become assimilated into Pakeha ways. However, as children the four Maori elders in this study were members of rural North Island communities in which, outside church and school, Maori traditions and beliefs were a way of life. Their Maoritanga was acquired from individuals born in the nineteenth century. They were taught to value the old ways and practices and they also learned that optimal old age is not achieved through passivity and withdrawal. They are members of a generation that has worked hard to retain and rebuild their language and culture. In the 1950s and 60s Te Reo had nearly died out and would have done if it had not been for a few elders that were still fluent speakers. Elders have been central to the Maori renaissance, including the kohanga movement and the kura kaupapa schools. They have mana and they continue to earn it.

CHAPTER 8

TWO CHEROKEE PERSPECTIVES ON AGEING

The values of the Western Cherokee people are well-defined. They respect tradition, teachings, elders, children and themselves. Throughout Cherokee history, elderly people have been known as 'wisdom givers'. Today, they are especially valued for their knowledge of cultural traditions and for the work they do. For example, the mission of the Elders Council (composed of Western Cherokee citizens who are at least fifty-five years old) is to promote and preserve the Cherokee language, traditions, and culture through community involvement and education.

Two of the participants, Harriet Carey and Estelle Doherty, are members of this tribe. As predicted by John Ridge¹⁹, a Cherokee of the nineteenth century, both are fair skinned.

Cherokee blood, if not destroyed, will wind its courses in beings of fair complexions, who will read that their ancestors became civilized under the frowns of misfortune, and the causes of their enemies (Breen, Snipp, & Thornton, 1992).

The two women share several other characteristics: they were both born in isolated, rural communities largely populated by other Cherokee families and they were taught to honour Cherokee values and traditions. As adults, they both moved to large cities in the American West where their fair skin allowed them mix freely in white society; each woman lives alone, and are extremely poor.

¹⁹ John Ridge is considered to be the first Native American novelist. In 1854 he wrote the first Native American novel and the first novel written in California: *The life and adventures of Joaquin Murieta: The celebrated California bandit*.

Harriet Carey

Because Cherokee people trace their ancestry matrilineally and Harriet's mother was a full blood, Harriet's tribal membership card states her blood quantum to be one-hundred percent Cherokee.²⁰ Born before Cherokees could vote, own land, or move about the country without fear, at the age of eighty-eight she is old in a world vastly different from that in which she learned the rules of survival²¹.

Harriet's slide into poverty began when her husband died. Unable to meet the mortgage payments, she lost the small ranch on which she and her husband had eked out a living and the modest home that had sheltered their extended family for most of their marriage. The family was unable to prevent the loss. They were poor Cherokee people, uneducated, their rights of citizenship only a few decades old and still frangible. They accepted Harriet's fate, as she did herself, with a resignation long familiar to the Cherokee. She had become a fifty-two year old widow, with no income, no job skills, and no home. Harriet has now spent thirty-four years in widowhood and poverty. For all those years poverty has been the predominant factor in her life. At \$550 a month, her income is below the national poverty level; she can afford nothing but subsidised housing. She has no savings, and she owns no property other than the well-used

²⁰ Harriet's father has an interesting history. He was born of Irish immigrants in Indian Territory in 1880. When he married Harriet's mother, he integrated so fully into Cherokee society that he was later able to instruct his children in Cherokee tradition, skills, and customs.

²¹ Harriet's great grandmother survived the family's removal from their homeland in Georgia and the forced march of Native Americans west across the Mississippi River. It was through her Grandmother's telling and retelling of the hardships and inequities of the Trail of Tears that Harriet learned the rules for survival in a predominately white world.

furniture in her apartment. As I taped the interviews with Harriet, I was most impressed by the strength with which she battles the problems of age,²² gender, and poverty, and by her ability to work her way successfully through the complex bureaucratic requirements for state and federal assistance for poor elderly Americans.

Estelle Doherty

Estelle Doherty is seventy-two years old, divorced, poor and in ill health. She lives in a low-income housing project for the elderly on the periphery of a large city in the American West. Her income is \$6000 a year. She survives in her community in the same way Harriet survives in hers; she taps into local assistance programs for the poor and for the elderly. Of the many difficulties Estelle confronts in securing basic necessities, housing is the concern about which she verbalises most often, and she frequently discussed with me her latest plans to move from her present apartment into a safer neighbourhood. The physical environment in which she lives seems to demonstrate the meagreness of her life more than any other aspect of her poverty. The following comments by Estelle are typical of statements scattered throughout her several interviews.

Since you were here last, I've signed up for another apartment, but as you know there is a long wait for senior complexes. Both my good neighbours have died. Management has moved a single man upstairs. People do drugs up there – running up and down, yelling and wrestling under my bedroom window. Another single man has moved in across the hall. He borrows from salt to anything. He urinates out the patio door onto the patio! So yes, I would move almost anywhere to get out of this mess. I

²² In the United States, a major difference between the old and modern worlds of Native peoples is the growing size of the elderly population. Although still small in absolute numbers, Native American elders comprise one of the fastest growing of any racial and ethnic classification of elders, outpacing both White and Black in the growth of their over sixty age group (Chapleski, Lichtenberg, Dwyer, Youngblade, & Tsai, 1997).

would prefer to stay in the vicinity, but living here is killing me by degrees.

History of the Cherokee

At the time the British discovered Appalachia in the eighteenth century, the Cherokee were the largest tribe in that part of North America, occupying thousands of lush fertile acres in what would later become the States of North Carolina, Georgia, Tennessee and Alabama. As settlement by Europeans grew, the quest for farm land grew as well. Concluding that their land could not be peaceably held against the influx of white farmers, the Cherokee along with the Choctaw, Creek, Chickasaw, and Seminole nations, entered into treaties²³ with the American government for the purpose of protecting their homelands from invasion. By 1830, these tribes had so successfully adopted the agricultural system of the white man, including the holding of black slaves, that they became known as the "The Five Civilized Tribes"²⁴ (McLoughlin, 1993: xii; French, 2000: 8; Lindquist, 1923: 149; "Five Civilized Tribes," 2004"). However, shortly after the discovery of gold in Cherokee territory in 1828, The United States government dissolved all its treaties with the Five Tribes. This action was followed quickly by

²³ This is the wording of the Treaty of 1828 between the United States and the Cherokee Nation:

Whereas, it being the anxious desire of the Government of the United States to secure the Cherokee nation of Indians a permanent home, and which shall, under the most solemn guarantees of the United States, be and remain theirs forever – a home that shall never, in all future time, be embarrassed by having extended around it lines, or placed over it the jurisdiction of any of the limits of any existing Territory or States ... the parties hereto do hereby conclude the following articles (cited in McLoughlin, 1993: xi).

²⁴ McGoughlin points out the irony of the fact that although they were recognised as the five most civilised of all the Indian tribes, they were removed west of the Mississippi River on the grounds that they were too savage to compete with whites.

Andrew Jackson's signing of the Indian Removal Act²⁵ – an Act designed to evict all Native Americans living east of the Mississippi River to Western prairie lands now known as the State of Oklahoma. With the passage of the Indian Removal Act, the lands, homes and property of Native Americans became subject to confiscation. The state of Georgia held lotteries to give Cherokee land and gold rights to whites. Cherokees were no longer allowed to conduct tribal business, testify in courts against whites, or mine for gold. Many were hunted and killed when captured.

In May 1838, the invasion of Cherokee homes began. Allowing them only moments to collect their belongings, Federal troops and state militias forced Cherokee families out of their homes at gunpoint. White looters followed, ransacking homesteads within view of their Cherokee owners. Private John G. Burnett, United States Army, wrote in his diary at the time,

“I saw the...Cherokees...dragged from their homes, and driven at the bayonet point into the stockades...I saw them loaded like cattle...into wagons... Many of them had been driven from home barefooted”
(Woodward, 1963: 215)

After months of imprisonment in the stockades, the journey west began in late autumn of 1838. In November the travellers walked through heavy autumn rains and in January they were trapped between the ice-bound Ohio and Mississippi Rivers. Four months later, after a march of almost one thousand miles, the survivors arrived on the west bank

²⁵ To powerful Americans such as Jackson, ‘civilised Indians’ were a greater threat than ‘uncivilised savages.’ Once civilised, Native Americans became literate, articulate, and competitive. The Cherokee, with their republican government, national newspaper, national seminary, and wealthy slave-holding plantation owners, were not only doing well, they were doing too well (Mails, 1996: 217). The removal of the five civilised tribes, particularly the Cherokee, was viewed by Jackson as critical to the sovereignty of the United States.

of the Mississippi River at a settlement called Cape Girardeau, Missouri. The trip had been arduous and the Cherokee had suffered greatly. They made this plea to General Winfield Scott, the officer in charge of the Removal:

We are Indians. Our wives and children are Indians, and some people do not pity Indians. But if we are Indians we have hearts that feel. We do not want to see our wives and children die. We do not want to die ourselves and leave them widows and orphans. We are in trouble sir and our hearts are very heavy. The darkness of night is before us (Breen, Snipp & Thornton, 1992).

The plea to General Scott did not stop the Removal or the death of many Cherokee people. By journey's end, as a result of starvation, cold, hardship, deliberate killings, accidents and disease, more than 4,000 Cherokee lay dead on the 'Trail of Tears' (Gilbert, 1996; Woodward, 1963: 218). Nineteenth century Americans had a saying, "The only good Indian is a dead one," and those who used it meant it; by 1840, the only Native Americans living east of the Mississippi River were small groups brave enough to do so in hiding.

For generations, my ancestors and other Western Cherokee lived in the Ozark Mountains of the United States, a region where, by statutes not rescinded until 1909, they were forbidden to hunt, trade, 'roam' or own property (Jones, 2000; Thornton, 1990; Gilbert, 1996); they were not enfranchised until 1924.²⁶ As members of a

²⁶ Because the right to vote was also governed by state law, in some states Native Americans were refused that right until 1948 when a federal court ruled that barring Indians from voting was "discrimination based upon race" (The Library of Congress, 2006). It has been difficult to dispel the notion that Native Peoples are inferior, savage, and heathen. For example, it required the enactment of mid 20th century U.S. civil rights laws to end the practice of installing separate drinking fountains and distinct sections in theatres labelled "Whites," "Colored" and "Indian" (United States DOJ, 2004). Nor is discrimination against Native Americans consigned to history. Schacht, in her University of Texas course *Rhetoric of American Indians*, asks why it should be acceptable to name a colour "Indian Red" or "Navajo White", but not "Caucasian White", "Asian Yellow", or "African Black" (University of Texas, 2002).

defeated nation, Cherokees were expected to assimilate themselves into White society.²⁷ Separated by the Removal from their traditional homelands, and prohibited by law to practice Cherokee customs and traditions and to speak their language, the American government anticipated that the Cherokee would become civilised and Christianised. In many instances, the government's campaign to acculturate Native people appeared to be successful. As far as could be seen, Cherokees assimilated into Caucasian society, changed their names and adopted western style dress and habits and rarely revealed themselves as Cherokee by word or written document. This apparent assimilation notwithstanding, in the backwaters of the Ozark Mountain region, many Western Cherokee continue to engage in the unobtrusive preservation and practice of the old traditions that have survived two hundred years of war, migration, and forced assimilation. For instance, until the present, each previous generation of Harriet Carey's family had produced a traditional healer. When Harriet left home during World War II to work in the California shipyards, she left her mother's teachings behind and when her mother died unexpectedly three years later, Harriet's training was never completed. For the first time in memory, the family has failed to produce a Cherokee healer. In the excerpt below, Harriet talks about this loss.

My mother was taught by her mother to use roots, flowers, and herbs to heal people and to keep them healthy. She walked the woods to find the plants she needed. She used life everlasting for headache, mullein for fever and dropsy, senna as a purgative, poke root for rheumatism, and poke root and mullein mixed together for a tonic. She used dandelion as a lotion for infection, pokeweed as a poultice for skin ulcers and eczema and burdock to cleanse the blood. She mashed the root of yellow dock and put

²⁷ A popular sentiment of Americans between 1860 and 1930 is expressed in the saying "kill the Indian, but save the man" (Garrett & Pichette, 2000) and in the derogatory description of acculturated Native Americans as "apples" – red on the outside, but white on the inside (French, 2000: viii; Spring, 1996: 193).

it on boils and abscesses; she mixed the yellow dock leaves with those of other plants and we ate them as mixed greens. And in the spring we all drank her sassafras tea to build our blood. Much knowledge died with my mother. She was the last healer in our family.

As with Estelle and Harriet's families, continued, close encounters with white society brought great social change to the Cherokee people (Poupart, 2002). In the social disruption of the eighteenth and nineteenth centuries, much of the art of storytelling and the ability to memorise the minutiae of traditional ceremonies and practices was lost (Anderson, 1997) and with the loss of those skills, many old practices disappeared or were altered. As one writer has suggested,

...the culture of the Southeastern Native American is like a great shattered bowl. Historians and anthropologists assemble the broken shards, knowing they will never be able to recreate the original, but sometimes their efforts produce discernable themes and patterns which provide a momentary insight into the diversity and harmony that once existed (Carden, 1994).

The shattering of Cherokee culture and forced assimilation into Western society has resulted in sharp differences between the traditional experience of old age and the experience of many modern Cherokee elders. As we shall see in the next discussion, the loss of culture has extensively damaged the ability of the Cherokee to age with grace and well-being.

Loss of Cultural Identity and the Impact on Well-Being

Is there a human being who does not revere his homeland, even though he may not return? ...In the language of my people...there is a word for land: Eloheh. This same word also means history, culture, and religion. We cannot separate our place on earth from our lives on the earth, nor from our vision nor our meaning as a people. We are taught from childhood that the animals and even the trees and plants... are our brothers and sisters. So when we speak of land, we are not speaking of property, territory, or even a piece of ground upon which our houses sit and our crops are grown. We are speaking of something truly sacred. Jimmie Durham, Cherokee (as cited in Fulmer, 2000).

Native American tribes share many basic values and beliefs. These include the belief that everything in the universe has life, the belief that all living things are interrelated, and the belief that individual and tribal well-being is the result of personal unity and balance with all living things. This relationship is referred to as the “Circle of Life” or “Web of Life” (Garrett, 1996). Seen through Native American eyes, the chief difference between humans and other life forms is that they live in different dimensions: humans live in the physical world and the domain of other forms of life is chiefly spiritual (Martin, 1980: 39-40; Martin, 1994: 28). The name Cherokee have given themselves, the AhNiYvWiYa,²⁸ meaning “human people”, expresses this Native American egalitarian view of the world.

There are also similarities in the beliefs and practices of Native Americans and the Maori, notably, health and well-being, the importance of the environment and the family. For Native Americans as well as for Maori, land was non-alienable. Traditionally, there was no concept of private land ownership: it was communally held and protected for the good of both present and future generations (Anderson, 1997: 17; Mitchell, 1998: 197-198). Tribal lands were treated as living entities and the health of the land’s rocks, trees, lakes, rivers, streams, and springs were important (Tobert & Pitt, 1994). To the First Nation people of North America and New Zealand, well-being in old age required harmony and balance between the family, the tribe, land, animals and all the life forms existing on the land of one’s ancestors.

²⁸ The pronunciation of AhNiYvWiYa is not as difficult as it appears. Spelled phonetically, it would read ‘Ah knee ya we yah.’ It is a distinctly Cherokee name. Many tribes designate themselves as “the people”, but each do so in their own language.

To understand the irreparable damage done by the United States federal government to the well-being of elderly Native Americans (Noor Al-Deen, 1997: 166), it is necessary to examine the policy of blood quantum and its effects. The United States Bureau of Indian Affairs (BIA), a branch of the United States Department of the Interior,²⁹ is responsible for administering the federal policy of blood quantum. The BIA legally defines a Native American as a person who, by proof of descent, is an enrolled or registered member of a recognized tribe,³⁰ or whose blood quantum is one fourth or more genealogically derived from Native American ancestry. The federal requirement of Native Americans to prove their ethnicity stands in sharp contrast to all other ethnic groups in the United States. They are the only Americans required by law to legitimise their racial identity by presenting formal proof of blood quantum as evidence of their claim to be Indian (Garrett & Herring, 2001; Garrouette, 2001). In measuring blood quantum, the Federal government determines the lower bounds of ancestry – the point at which the names of mixed-bloods can be struck from the rolls of eligibility for land and federal Native American aid programmes. Put another way, blood quantum establishes a point below which individuals cannot legally claim to be Native American (Snipp, 2003: 568). In Native cultures where European methods of recording birth, death, and parentage were unknown at the time of the passing of blood quantum regulations, and where

²⁹ The BIA also administers and manages the 56 million acres of land held in 'trust' by the federal government for American Indians, Indian tribes, and Alaskan Natives. In addition, it administers and manages education services to Native students.

³⁰ U.S. Government rolls of Native Americans are notoriously inaccurate. The names of many individuals of mixed blood do not appear because blood quantum cannot be proven and many full-bloods, with no trust in a government with a history of treaty breaking, refuse to be counted. In addition, corrupt federal officials have at times allowed whites to enrol (Prucha, 1975: 132), leading to the Cherokee expression "five dollar Indians" (French, 2000:36).

intermarriage with other races was a means of survival, proving the necessary blood quantum is difficult and many Native Americans of mixed-blood heritage are unable to do so. Of greater importance to the United States government is the resultant reduction in the numerical size of the tribes affected by the blood quantum regulations because the size and number of land allotments is proportionately reduced as well.

Today, there are two types of Native American tribes in the United States: those recognised by the federal government, and those that are not. The United States government 'recognises' 562 tribal governments; three of these are Cherokee: The Cherokee Nation of Oklahoma, the United Keetoowah Band of Cherokee Indians, and the Eastern Band of Cherokee Indians (Bureau of Indian Affairs, 2004). However, Federal recognition represents a mere 250,000 of an estimated worldwide population of 5 to 7 million Cherokees ("Cherokee", 2002), leaving a population of 4.75 – 6.75 million Cherokees who are denied their 'Indian' status. Altogether, there are currently 245 tribal governments, each representing a different Native People, applying for recognition by the United States government (Bureau of Indian Affairs, 2004). Until they succeed (if they ever do) in gaining federal recognition, these unrecognised tribes are considered effectively nonexistent and their members as being non-Indian (Lawrence: 2003: 18; Mather, 2003: 182).³¹

Meanwhile, for mixed-blood individuals such as Estelle Doherty and Harriet Carey, self identity, an important part of status, can be a difficult, complicated issue which interferes

³¹ The Tunica-Biloxi tribe first petitioned for federal recognition in 1826. It was granted in 1981 (Lawrence, 2003: 18). For more than one hundred and fifty years, the federal government denied the members of this tribe their Native American identity. In 1981, with the signing of a document, they became 'Indian' again.

with the process of aging well. Part of the difficulty lies in deciding which identity to pick. Depending upon one's ethnic mix and circumstances, there may be several options. Estelle, for example, while she has minimal knowledge of Cherokee rites and practices, has a storehouse of historical information that she learned from her great-grandmother. She uses this knowledge to compare her lonely life in subsidised housing with Cherokee elders of the past.

You know, there were some American Indian tribes that took their elderly out into the wilds and left them to die; this happened mostly in the winter months. I do not remember the names of the tribes, but I do remember Great Grandmother telling about it. However, she said the Cherokee did not practice this. The Cherokee were very family orientated, always living in family quarters, so although it was communal living in a way, it was still divided into families. Also the Cherokee always cherished the old people, believing them wise because of their great age, ergo, they took real good care to preserve their lives as long as possible.

For many elderly Cherokee today, the language, traditions, and lands of their predecessors have all but disappeared. This fact does not present a problem for a proportion of elderly mixed blood Cherokees. Total assimilation into the dominant society has erased their Cherokee identity and as a result, bicultural tension is not a part of their normal, daily lives. For elderly Cherokees such as Estelle, however, the loss of land, language, and tradition represents a very real barrier to well-being. These Cherokee are marginalised. They exist in two worlds, yet are true citizens of neither; they are neither traditional nor assimilated (Jackson & Chapleski, 2000). They are similar to the mixed-blood Maori described by participant Sarah Hunter:

Some Maori do not take the Maori way of life. They have taken the white man's way, so they have denied themselves the Maoritanga, because they can't have them both. They have the two conflicts. In a lot of ways they'll tell you face to frontal that they are Maori, but in a lot of ways, spiritually, they have chosen something else.

This is the situation of many elderly mixed-blood Native American people living in multiracial American communities. With inadequate knowledge of the ancient practices

and beliefs of their ancestors, they are not accepted in the world of traditional Native Americans living in areas where the language and old practices have survived.³² Neither, however, can they completely assimilate into mainstream American society; their identities were forged in childhood by parents and grandparents who did not fully identify with modern American values and behaviours, but were instead, secretly practicing many of the old ways. Their position is very much that which the New Zealand Maori respondents fear for themselves and for the future of Maoritanga: continued erosion of traditional values, gradual convergence into modern society and ultimately, loss of cultural identity.

When they left their homelands, Estelle and Harriet found themselves in the situation described. Their identities were founded on the values of life in backwater Cherokee communities, but as newcomers to large American cities in the 1940s, their fair skin allowed them to assume the identity of white women. For Harriet, the move to urban America came about when she took a wartime job as a riveter in a shipyard; mistaken for a white woman, she did nothing to dispel that image. In Estelle's case, marriage to a white man separated her from her homeland. In the city where they lived, she socialised with her husband's white friends and family and they presumed her to be white. The ability to live as white women made their lives much easier. They competed equally for jobs and housing and formed friendships without suffering the ignominy of being Indian. That choice, however, has interfered with their ability to acknowledge and explore their

³² As with te reo Maori, the Cherokee language is an important aspect of Cherokee cultural identity. Fluency in the Cherokee language is used by many Cherokee as a sign of an individual's successful resistance to acculturation (Robbins, Stoltenberg, Robbins, & Ross, 2002)

Native American heritage. It is difficult to ascertain the extent to which they regret the assumption of white identities but in their interviews, both women referred to their Native American family with nostalgia and expressed regret over the loss of the 'old days'. Harriet, for example made these comments regarding her connection to the land and culture of her mother and grandmother.

Sometimes I am so lonely. When I was a little girl, I lived with my mother, my brothers and sisters, and my grandparents on the banks of a river. There were other families there as well and we all lived in teepees.³³ I've always wanted to go back to that river. I wanted to end my life where it began, but times have changed and I have changed and that is just the way it goes.

Those who once could have helped Harriet trace her family's history are deceased. Other than her memories, Harriet, now in her eighties, has only an old arrowhead collection, her mother's tribal enrolment card, and a few old pictures of cousins living on an Arizona Hopi reservation (whose names she can not remember) to remind her of her Native American roots. She cannot fulfil her desire to re-establish her link to her mother's people. Estelle is in much the same position. She has a large stock of Cherokee folklore and historical family information stored in her mind, which she would like to share and pass on to her daughters and grandchildren but they are not interested. They think of themselves as whites, and care little about their Cherokee heritage. Because of Estelle's excellent memory, that information has been intact, but as she ages her memory is failing; having not told the stories for many years, she is no longer able recall the rich details which once made their telling so powerful.

³³ Estelle is describing temporary or summer housing.

Conclusions

Estelle through her grandmother, and Harriet through her mother, have strong emotional connections to their Western Cherokee predecessors. Estelle's grandmother was a storyteller, and Harriet's mother a healer. As young girls, they learned a great deal about traditional Cherokee life. Although the United States of their youth was a predominately-white society, they both lived in isolated communities populated primarily by non-reservation Cherokee families. Consequently, their upbringing was similar to those of earlier, traditional Cherokee families. Estelle and Harriet's teachers were active, creative, and powerful older women. It is these women who have become their role models for old age. Estelle and Harriet's children, however, were born in large American cities. They attended American public schools, and married into white families. My observations of Estelle and Harriet's children and grandchildren were positive. These two elderly women are the recipients of respect, love, and good humour, despite the tendency of both women to belabour their families for the intermittent nature of their visits, which as perceived by Estelle and Harriet, contribute to the loneliness of their existence. Both women are truly lonely. They live in inner city public housing complexes where life is dreary and contrasts sharply with the hills and rivers of their youth. Their families, however, lead typical twenty-first century urban family existences. Husbands and wives work, children compete in after-school activities and weekends are busy with chores of the house and garden. Family members have little time for relaxation and when they do, they often go their separate ways, the children in particular, choosing to be with friends rather their families.

Estelle and Harriet's expectations for their old age were very different from its present reality. They remember that in old age, their mothers and grandmothers were the centre of their families and had great status and authority; they see themselves as having low

status and little authority. The differences between their circumstances and those of earlier women in their families deepens their longing to return to their Cherokee homelands, where, they imagine, elders are still central figures in their families and in tribal society. Paula Gunn Allen, a member of the Laguna Pueblo, confirms that in some traditional Native American communities, older women, as in Maori society, are still influential figures in the political and social life of their families and tribes. Writing about the lives of her grandmother and other older Native American women whom she has known, she says that from middle-age on, Native American women have great freedom of choice; their social systems do not limit them and they are free to be who they want to be.

It's been my experience that Indian women function in every capacity in their later years: they travel widely, take care of children, grandchildren, foster children, husbands, brothers, uncles, sisters, nieces, nephews, and assorted strangers; they are active in every profession, especially health and education; they are healers, shamans, traditional artists and dreamers; they serve as traditional leaders in their tribes, like on tribal councils, or as tribal presidents or chairs; they go to school; they lobby for tribal or national Indian issues at local, state and national levels; raise funds for children, elders, battered wives, destitute members of the community, and their own projects; they join in long walks, go to prison for political reasons, lead prayers and major dances at powwows, get on the radio, run businesses, farms, ranches, raise livestock, make rugs, blankets, pots ... (Allen, 1997: 237).

Estelle and Harriet are the last women in their line with memories of the traditional roles of Native American women such as those described by Allen. With the deaths of Estelle and Harriet, the visible mementoes of their families' Western Cherokee heritage will be limited to a collection of ancient arrowheads, tribal membership cards, and a few old pictures of unnamed, long dead relatives. Intangible and mystifying mementoes will be the memories carried by daughters and grandchildren, who like Harriet and Estelle before them, could have explored their Native American heritage but did not do so. However, with no firsthand memories of their Cherokee past, it is unlikely that a longing

for old Cherokee values and practices will intrude upon the old age of Harriet and Estelle's children.

CHAPTER 9

IMMIGRANT PERSPECTIVES ON AGEING

Introduction

Nine of the twenty-nine participants in this study were immigrants; six came from England, one from The Netherlands, one from Poland, and one from South Africa. Seven members of this group moved to New Zealand,³⁴ and two to the United States. With the exception of Jacob Traub who was twenty-eight, Susan Eyres who was sixty, and Theresa Landman who was eighty-six, the immigrant participants left their homelands in the 1960's at an average age of forty. Six immigrated with their spouses, two later married people who, like themselves, were immigrants, and one had never married. Several were parents and brought their children with them, and several had children who were born in their adopted countries.

They had emigrated with job skills; included among them and their spouses were three teachers, two engineers, a butcher, forester, and a nurse. They left their homelands for economic reasons, worked hard, and achieved a degree of financial success. With the exception of Maisie Harrison, who had become deplorably poor in her old age, their

³⁴ Of the 350,000 immigrants to New Zealand in the years between 1947 and 1975, (the years of 'assisted migration', 80 percent were English. In 1948, New Zealand re-introduced its 'assisted migration' policy. Assistance went primarily to British citizens of 'European race and colour'. Advertisements for immigrants appeared in newspapers and trade journals, and a movie entitled *Journey for Three*, based on the experiences of three assisted migrants, appeared in British cinemas. The New Zealand High Commission in London interviewed applicants for particular skills with one of the deciding factors being the 'applicants bearing and the estimates of his character as a potential New Zealand citizen' (Te Ara, 2006).

disposable income was higher than that of most of the other participants. Regardless of the current circumstances of their old age, self-reliance, independence, and personal autonomy were especially important to these participants. The interview data of these participants includes many references to these values. Even Robert Gordon and Theresa Landman, both of whom were living in nursing homes against their wishes, spoke with pride of the fact that it was the money they had earned, not that of their children, that was paying their nursing home expenses.

Susan Eyres

Susan Eyres was born in England in 1921. She remained there, in the community in which she had been born until 1980. In that year, at the ages of sixty and sixty-three Susan and her husband sold their home and belongings, said good-bye to their friends and community and moved to New Zealand to join their only son who had immigrated several years earlier. Susan explains the move by saying:

I rather liked the idea of getting to know my daughter-in-law better, especially as she was from another culture and also I'd got two grandchildren. We were going to have to move from the house that we lived in because it was too big. We were looking for a bungalow, which is as rare as hen's teeth with any kind of size. And if we got one that had any kind of size it probably would have been above our means. Anyway, John, my husband, said he'd like to come to New Zealand and I wasn't adverse to it.

Susan had polio in infancy and did not walk until she was almost five years old.

I remember a woman saying to my mother, 'Your little Susan is like a hot house flower. She needs careful nurturing.' I was a cripple you see, and I was very fair and fragile looking. My mother used to say to me when I was in my forties, 'I wish that woman could see that little hot house flower now.' But I made my mind up that I'd got certain things that I'd got to overcome.

Robert Gordon

Robert Gordon was born in Scotland in 1911; he immigrated to New Zealand in 1964.

Two of his four children live in New Zealand; a son who works for a New Zealand

university lives some distance away and a daughter who lives within a fifteen minute drive away from the nursing home in which Robert reluctantly resides. An important factor in Robert's adaptation to the nursing home environment is his resistance to the attempts of other people to control his life and he frequently discussed this resistance in our meetings together.

On the day of my first visit to the nursing home in which Robert lived, I noticed a very friendly cat named Mitten in the day room. When he later invited me to his room so we that could talk without interruption, Mitten was sleeping on Robert's bed. Although Robert himself had few personal belongings in the small room, Mitten had a litter box, scratching post, and food and water bowls; she had been his cat for years and moved with him into the home. I was impressed by the fact that Mitten was living in the nursing home with Robert and said as much to him. In response, he told me this story.

I've made it a practice to save a bit of meat from lunch, wrap it in my serviette, and take it to my room as a treat for Mitten. Eventually, the member of the Gestapo who serves my lunch table noticed that I do this and she reported me to the manager, who subsequently approached me and asked if this was true. I said yes. The manager then forbade me to do it anymore, saying that the Home was paying for the food for me, not for my cat. She told me I was to finish the food on my plate because I am losing weight and they are trying to build me up. I pointed out that I am paying for my room and board, not the Home. Once the food is on my plate it becomes my food and no longer belongs to the nursing home. What I choose to do with my food is my business! The manager then told me that I was wrong so I suggested that we use the courts to discover which of us was right.

Maisie Harrison

Maisie Harrison was born in Scotland in 1911. She immigrated to New Zealand in 1961 with her husband and son. When I met her, she was widowed and living alone in a council flat. She was diabetic, had poor kidney function, coronary artery disease, and she suffered severe, chronic back pain from an injury she had sustained while caring for her husband at home before he died. My visits to Maisie's home extended over a period

of two and a half years and during that time, we went to church and club meetings together, met in the homes of her neighbours, lunched with her friends, and shopped. Despite the fact that she was weak from chronic illnesses, and often in pain, Maisie was an exceptionally rewarding individual to interview on the subject of well-being. As she herself practiced, her formula for a good old age was straightforward; it consisted of friendship, faith in God, and self-sufficiency.

Maisie had many friends. She was a joy to be with, always able to laugh and to make others laugh by telling one of the stories for which she was famous.³⁵ This is what she had to say about the value of friendship.

I didn't come to New Zealand to be lonely. I'm not an unfriendly person and I've always made friends of anybody that was ever my neighbour. It's just up to you yourself. I have a saying that I read out the last time I was doing devotions: to have a friend is to be a friend. You see, you befriend somebody and you'll always have somebody.

Theresa Landman

Theresa Landman is an eighty-nine year old South African white woman. She came to New Zealand after she was assaulted in the parking lot of a Johannesburg mall three years ago. Theresa has a fifteen-minute soliloquy of her four children – their names, their children, where they live, how they earn their living, and how she came to move to New Zealand from Johannesburg. She repeats this story in exactly the same sequence and in the same words each time she tells it. It could be a recording. Sometimes when she was in the middle of telling her story to me, she would stop and ask me a question such as, “How many children do you have?” The question was usually one she had asked before

³⁵ Maisie's stories consisted of tales of Scotland and of her childhood. Born in the Alloway, the birthplace of Robert Burns, she often wove his poetry into her tales.

– in fact, she had three such questions: “What are you doing in New Zealand?” “Do you have children?” “Where do you live?” Having asked one of these three questions, Theresa would typically interrupt my answer to resume her story, surprisingly picking it up at the point she had left off rather than starting it over. Theresa’s long-term memory was excellent; she responded quickly to any question I asked her about her life in South Africa. The greatest difficulty I encountered in interviewing Theresa was her repetitiveness. Based on her short-term memory loss and the difficulty in obtaining new information, I was tempted to discontinue my interviews. However, she clearly enjoyed our visits together and the fact was that when I succeeded in interrupting her soliloquy, everything she said made sense and was consistent with the facts I obtained from her children and from the nursing home manager. Robert Gordon, who was at the time a resident in the same nursing home as Theresa, volunteered the information that Theresa did not “have it all together mentally” and that on account of this, she was not a suitable candidate for interviewing. Robert did not realise that there was more depth to Theresa than he perceived. He would have been surprised had he overheard Theresa making this comment to me regarding him and the other men in the home: “If they were as stupid when they were young as they are now, I don’t know how these old men were ever able to earn their living!” I continued my visits to Theresa and over the next several months obtained a wealth of information from her.

Eileen Richards

Eileen Richards was born in London in 1916. Her mother was an active member of the Suffragette movement and her father the youngest son of a family that owned a well

established business in the city. It was a family that believed in giving its daughters a good education. As a result, beyond the generally limited education she received in an early twentieth century English school for girls, Eileen was tutored in mathematics, sciences, and languages. This is how she described her parents.

My father was very different from other men of that time. He had nothing of the patriarch in him. And my mother was not a compliant personality. There were just my parents and myself. I was brought into discussions and my parents were totally honest and straightforward with me over financial and other matters right from very early days.

The family business provided Eileen's family a good life until ownership of the business passed to her father's eldest brother. Though her father retained his position in the business until retirement, life was never as easy as it had once been. When he retired in his mid-seventies, he was ineligible for a pension and had no means of support other than Eileen. After struggling for several years, Eileen and her eighty-year-old parents immigrated to New Zealand. Eileen's parents left England because in New Zealand they qualified for an old-age pension; Eileen went to care for them. After the death of her parents in New Zealand eleven years later, Eileen stayed on.

Neville Schuster

I met eighty-five-year-old Neville Schuster while he was vacationing in New Zealand. Our meetings took place over a period of a month in the home of the friends with whom he and his wife Barbara were staying. Neville and Barbara's friends were also my neighbours, and knowing something of my search for male participants, they introduced me to Neville for that purpose. Our meetings were convenient for everyone concerned: for me, because Neville was an intelligent, articulate, and willing participant; for Neville's wife and friends who planned their sightseeing trips around our interview times; and for Neville, who was recovering from influenza acquired within a few days of arriving in New Zealand and consequently lacked the energy to sightsee.

Born in England in 1921, Neville Schuster has resided in the United States since 1964. He lives with his wife of almost thirty years in a state that he refers to as a “happy union.” When I asked Neville to define well-being, the first component he mentioned was a happy marriage, a factor ignored by the concept of successful ageing. These are the reasons he gave for placing marriage first on his list.

My wife is that person with whom I communicate the things that are important to me. If I have something on my mind, it pretty soon gets expressed. Communication with my wife is an essential component of my life satisfaction and of happiness in my old age because it is through our discussions that I am induced to learn. I’m really talking about two aspects of communication which are important to well-being in old age; one is the need to have an open and frank discussion with a trusted person, that is, to say what is on one’s mind, and the other is the mental stimulation which results from engaging in interesting talks with other people.

Anika Struthers

Anika Struthers was born and educated in Holland. Her mother was Dutch and her father German. World War II had a devastating effect upon Anika’s family. Her father engaged in activities that alienated them from their family, friends, and neighbours, and under the stress, Anika’s mother, a schizophrenic, became almost completely dysfunctional. At the age of seventeen, Anika took charge of the household and her younger siblings, teaching them not to talk about the clandestine activities of their father in collaborating with the Germans, while at the same time trying to maintain a relationship with her mother’s Dutch family.

There was no one to whom I could talk because there was no one who would have understood. My mother was mad and my father, well, I had learned early, and I taught my brother and sisters, not to talk about the things that were discussed in our home. I was the eldest and had the most worries about the dangers of our circumstances. I was also in our family very often the buffer between those in the family who did not speak to each other any longer because of the circumstances. I was the in-between – visiting somebody and then telling the others about it, because they did want to know what was going on, though they didn’t speak to each other.

After the war, Anika worked in The Hague as a primary school teacher. At the age of thirty, she left Holland for New Zealand to marry a man her father had chosen for her. Arriving in New Zealand, however, she decided that she could not marry him and called the wedding off. As Anika tells the story, it was her first act of independence. When her father heard that Anika had called off the wedding he told her not to return to Holland, but “tough it out in New Zealand.” She was single, unemployed, and completely alone in a strange environment, but she was independent and, Anika says, she was happy.

I stayed with a nice couple for six months. I worked at a department store where I met nice people and made friends. I met one woman and her husband with whom I am still friends. I also met my husband there. Later, after my daughters were born, I joined a mothers’ group that met once a week. When the children started to school, I went to work at the public library for ten years, which I enjoyed.

Jacob Traub

Jacob Traub was born in Silesia in 1919; he immigrated to the United States in 1948. Today, he lives alone in the house he purchased thirty-five years ago. He has lived there during two marriages; the first ended by divorce, and the second by death. Except for a daughter with whom he has little contact, Jacob is the last surviving member of his family. However, he has many memories of a close-knit, happy family.

My grandfather had a dry goods store in Gross Strehlitz.³⁶ The beauty about this little place was that it was the seat of a landgrave and it had a park that was comparable to some of the most beautiful parks in England.³⁷ My grandparents had their fiftieth wedding anniversary there when I was just a little boy. I loved them both. They were wonderful people.

³⁶ In the years of Jacob’s childhood, Gross Strehlitz was part of Silesia. Now part of south-western Poland, it is known as Strzelce-Opolskie.

³⁷ Landgrave, lantgrave: A German count who ruled over a specific territory.

Despite the recent death of his wife, and rift that had recently occurred between him and his daughter and church, my meetings with Jacob were generally upbeat and lively. He spoke of the several joys that typify his life: his little dog, his friends, and his volunteer work.

Allison Turner

Allison Turner was born in a small village in Gloucestershire, England; she describes it as being so small that:

When we were schoolgirls, my sister and I would keep ourselves from falling asleep at night by naming the two hundred residents one by one.

When England declared war on Germany in 1939, she married a young man from the same village just before he left to join the war; a few months later Allison was a young widow. This is her story of the years that followed.

I was a nurse and I thought I'd never get married again, but I knew I'd got to go on living and decided I may as well travel. So first of all I went to Barbados for three years. It was lovely and yes, it was an interesting three years. And then I asked myself, where should I go next? I decided on Canada and went first to Kitchener in Ontario and then to Vancouver. I stayed in Canada for several years and then my mom, who was on her own, got dementia and needed looking after. Since my sisters were all married and settled, I was the logical one to look after her. So I left Canada and went back home to Gloucestershire. But I had a sister living in New Zealand; she was married and had four children and she wanted us to join her. It took a while to decide to do it, but in 1960 I sold our things, packed our bags and moved with my mum to New Zealand. I was almost forty.

Today, Allison Turner is eighty-four years old. She has end-stage chronic obstructive pulmonary disease, congestive heart failure, rheumatoid arthritis, and glaucoma; she is also deaf, but lip-reads well. She is on continuous oxygen therapy, and even from an upright sitting position, speech is slow and laboured. On one of my visits we sat together and discussed the well-being of elderly women; she made some unique comments.

I met my husband on the boat coming here from England. He is ten years younger than I. In the early years of our marriage, I was often embarrassed by that fact, but now that I am old, I see what a good thing it

is. As I see it, society has it all wrong. Instead of women marrying older men, society should encourage them to marry younger men. If this became the rule rather than the exception, fewer women would be left as poor widows and many, as in my case, would have a spouse to care for them. If you consider that generally speaking, women outlive their husbands, the arrangement my husband and I have is a logical one.

Immigration, Old Age, and Well-Being

The elderly immigrants in this thesis have seldom seen the families they left behind when they emigrated. The great geographical separation between their new homes and Europe and the expense involved in travelling that distance has kept them apart. In that interval many friends and family members have died. Theresa Landman, for whom immigration is a recent experience, captures the emotions of these facts most poignantly.

I had lovely friends until I left South Africa, but since I've been here many of them have passed away and I've lost track of the others. A few of them have children in South Africa, but most of their children went to England or Australia or America; they didn't stay in South Africa because it got very wild and unsafe there. So now, being old like me, my friends have moved away to be close to their children. I don't know where they are and they don't know where I am. So what can I do? My children are here. That's why I came to this country.

From the participants' interviews, it is difficult to ascertain the impact of immigration upon their well-being and scholarly studies regarding the effect of immigration upon old age are rare. My search in the three major databases used by the Apollo Library Group turned up no research into the impact of immigration on successful ageing. In this study, participants made several statements referring to the difficulties they currently have in the New Zealand and U. S. environments, some of which seem to indicate that the resultant stress occurring in old age has revived earlier feelings of homesickness. However, their comments are equivocal, expressing on the one hand the desire to "go back home", but on the other hand, expressing satisfaction with their present circumstances. As I thought about and tried to understand their equivocation, it seemed to me that it was an example of resilience and ability to survive difficult circumstances. The decisions they made to

immigrate many years ago are immutable. It is too late to return home and so they make the best of where they are. Their well-being in old age is affected by mixed feelings about where they belong, where their roots are, and where their most important social networks are. Developing and maintaining deep and meaningful social networks is more challenging for people who emigrate in middle or old age. This is a missing discussion in the 'successful ageing' concept. Maisie Harrison expressed her homesickness for Scotland in these words:

Everybody who leaves their home feels a similar way. If there was a bridge between here and Glasgow I'd be well on the road.

In the following excerpt, Allison Turner explains how she and her husband managed their periodic bouts of homesickness after they emigrated. Like the other immigrants, she equivocates:

We have a way of dealing with it. We pretend that we are going back until the homesickness passes. I think as you get older, home calls. You just feel you want to be there. I do very much so. But we've got our children here so we stay on. Sometimes I feel that if I were to buy a house in England I could just walk in and stay for the rest of my life.

Susan Eyres, who was sixty years old when she immigrated, describes the first months of her life after their reason for coming to New Zealand had evaporated.

We lived with our son for three weeks and we bought this house within five days of our moving into New Zealand. We deliberately put space between us because it would have been fatal to hang onto our son's coat tails, so that we depended on his friends for our friends. And so we didn't see much of them and whether that had a bearing on our not bonding, I don't know, but I don't think so. I would say this: we came for the wrong reasons. We came because we had a son living here, he was married, and we'd got two grandchildren. And in the first several months I just felt like getting on the next plane back to England. Finally, I came to realise that I had to solve my friendship problems. There was a church just around the corner and to be frank about it, I joined just to meet people. It's all been a progression from that.

The ambivalence of the participants in this thesis – expressing a desire on the one hand to “go home”, while on the other communicating overall satisfaction with their life

circumstances, is similar to that found by Bernard et al. in their interviews with elderly Bangladeshis and Punjabis in Bethnal Green and Wolverhampton. This is how they described these immigrants to Britain:

Bangladesh, and more especially their own particular village, was still a fundamental part of their memories and emotions. In some cases this was given particular emphasis for men and women who still had close relatives, in some cases children, in Bangladesh. For almost all, however, life in Bangladesh represented a powerful and anchoring force, when compared with the perceived limitations of their current existence. But memories were often contradictory: people had strong feelings about their place of birth on the one side; but also remembered poverty, the lack of health care, and the sense of a disordered society (Bernard, Ogg, Phillips & Phillipson, 2000: 209)

As with the Bangladeshis in Britain, the homelands of the immigrants in this thesis anchor them to the times of their youth when parents, grandparents and siblings formed an important part of their lives and the future was bright. Unlike the Maori and Cherokee participants whose homelands were lost to colonisers, the immigrant participants left the lands of their ancestors for reasons of war, personal safety, and economics. Whatever the reasons, however, the many comments made by Maori, Cherokee, and Europeans participants make it clear that in old age, their longing to return the lands of their ancestors is signally similar.

Although studies focusing on the effect of immigration on successful ageing are rare, there are a few that examine the special difficulties faced by elderly immigrants. Factors such as the breakdown of family ties brought about migration, loss of social roles, economic hardship, and homesickness were generally found to produce a higher level of stress, anxiety and depression in elderly immigrants when compared to non-immigrant elders (Remennick, 2003; Martinez, 2002; Silveira & Ebrahim, 1998; Gonzalez, Haan, & Hinton, 2001). In Australia, an interesting observation has been made of Australia's aged Dutch immigrant population. Even among those who had immigrated many years earlier and appear to have assimilated well into Australian mainstream society, the old age

stressors of illness, chronic disease, dementia, and loss of spouse and friends have created difficulties, including the loss of English language fluency (Dutch Care Ltd, 2003).

Migration at any age involves a surrender of social, cultural, and environmental ties; when it occurs in late adulthood, the process of acculturation may be lengthy and stressful. It has been suggested that among older migrants, even after the acculturation process has been successfully negotiated, and life in the new environment has long since settled into a satisfactory pattern of existence, traumatic events such as death of a spouse and serious illness can re-awaken new feelings of homesickness, loneliness, and maladjustment (Tropper, 1997; Heikkila, 2004; Valle, 1998). When this occurs, strong, positive relationships between elderly migrants and their children who live nearby may be particularly important in reducing feelings of alienation. However, ties between elderly people and their grown children are not always as strong as the parents had hoped they would be. This can be particularly galling if the older people have emigrated to be near their children and children.

Conclusions

Though there are commonalities in the life narratives of these immigrants – such as the disruption caused by World War II - there is much dissimilarity in their early experiences. Childhood and youth in their European homelands included a good education for at least two, but not the others. Some, but not all, had loving, affectionate parents; a few spent their childhoods surrounded by extended family members. At least two lived in small, closely-knit communities. One spent the years from nine to eighteen in public school some distance from his parents; and while most were healthy children, the childhoods of two were marred by serious illness. To understand the effect of emigration upon the ability to age successfully, early experiences such as these must be taken into account.

Well-being in old age is built not only on freedom from chronic disease and disabilities as suggested by the successful ageing concept, but also upon the tools and skills accumulated in earlier life stages, as for that matter is the ability to emigrate successfully. Different levels of advantage in early life have implications for the ability to assimilate into new environments successfully and for well-being in later life.

The participants discussed in this chapter have worked hard to overcome the challenges of emigration. They have coped with the loss of their old homes and the families and friends they left behind. They have established and maintained new social networks. Despite illness, institutionalisation, disappointing relations with their children, and loss of status, they manage to remain cheerful and purposeful. Nevertheless, by the standards of the successful ageing concept, they would still be seen as 'unsuccessfully' aged.

CHAPTER 10

PARTICIPANTS OF EUROPEAN DESCENT

The eight participants in this chapter are all women. They were born in the United States and New Zealand between the years of 1903 and 1929. In the years between their births and old ages, the world had changed in so many ways that it was difficult for me to comprehend the stories they told. Several were born into homes with no electricity, indoor plumbing, telephone, radio, or automobile. There were no ministers or doctors nearby to deliver babies and minister to the sick and dying. Antibiotics had not been discovered; there was no cure for polio, and vaccines were not widely available in rural communities. In the communities of their youths, elderly people were generally respected and valued. The term 'ageism' had not yet been coined, and in any event, from the stories they told of the elderly members of their families, it is doubtful that the term was needed. Compared with their childhoods, the old ages of these eight women was vastly different. They communicated by telephone with friends and relatives. They travelled comfortably in trains, buses, and their children's automobiles; several had travelled by plane. They used showers, toilets, refrigerators, and electric stoves; they slept on inner-spring mattresses, stayed warm in the winter and cool in the summer. The term 'ageism' had also been invented and each woman had experienced it. Nancy Robinson, when her skills as a minister were rejected in old age; Mabelle Armstrong who was institutionalised in old age against her wishes; Fanny Gage, whose son-in-law expressed that his opinion that "old ladies belong in nursing homes where they can't bother their families". Each of these women had stories that spoke of their experiences with prejudice against women, and later, of prejudice against older women. The lives of these women are in many ways, a mirror of the social changes that have occurred in liberal western societies over the past one hundred years.

New Zealand Participants

The six women who compose this group of participants are native New Zealanders born to descendents of settlers from the United Kingdom. They range in age from eighty-four to ninety-eight. Four had been born on North Island farms established by their grandparents; one had been born in a small town in the southern tip of South Island. They were all well acquainted with their family history. They knew where, when and under what circumstances their families had left the United Kingdom for New Zealand. They had each visited England at least once for the purpose of retaining the connection between themselves and their 'English' cousins and other relatives, and their English families had visited them in return.

They are long-lived, hardy women with many stories of life in rural twentieth-century New Zealand. As the oldest of the women, Mabelle Armstrong's memories included events of World War I. They all recalled the Great Depression and later World War II when, as young wives and mothers, their husbands left to fight in Europe and North Africa.³⁸

Mabelle Armstrong

Mabelle Armstrong was ninety-eight years of age when she agreed to participate in this study. Her grandparents had immigrated to New Zealand from Oxfordshire, England in the 1860s. The eldest of her parent's eight children, she was born in 1905 on a North Island farm which her family had occupied for forty years. Four of her seven siblings

³⁸ Sally Dickerson loaned me a book entitled *The land girls: In a man's world 1939-1946* (Bardsley, 2000), which she said was an accurate depiction of her own life during the War. Filled with fascinating accounts of the lives of some New Zealand women during the years of the War, it gave me a greater appreciation of the hardiness of these elderly New Zealand participants.

were still alive; their ages are 93, 94, 96, and 97. In Mabelle's family, such longevity is not unusual. Confirming research findings that exceptional longevity is a strong family trait (Perls, 2000), she reports that her grandparents, and her aunts and uncles "Mostly all lived for a very long while."

Mabelle had overcome several obstacles in the course of her life. Diagnosed with Parkinson's disease at the age of forty-eight, it had developed slowly, due in part to the effort she made to minimise the visible symptoms of the disease. When we sometimes walked together during my visits, Mabelle moved briskly and without the aid of a walker or cane, saying:

Several years after I was diagnosed with Parkinson's I began to notice that I was shuffling when I walked. I control that tendency by willing myself to step out and pick my feet up smartly.

Widowed at the age of sixty-three, Mabelle did not ask her children for financial help, she went to work. In fact, she took the train to her place of employment in a city twenty-five kilometres away from her home for almost twelve years. When she 'retired' at the age of almost seventy-five, she had paid off the mortgage on her home.

When my husband was in hospital, and he was there for quite a while, the government department he worked for asked me would I like to come and work for two to three weeks to help them through a busy time. And I said, 'Well, I haven't done office work for so long', but they said, 'Oh, you'll just be a dog's body, you'll do the banking and things like that. It would be a help.'

Mabelle now resides in a long-term care facility located almost fifty kilometres from her home. The events leading to her institutionalisation were a trip over a kitchen rug, a fall, and a broken hip. She was found several hours later, after her son, having made unsuccessful attempts to reach her by phone, called the neighbours and asked them to check on his mother. After surgery to repair her hip, Mabelle worked hard to walk again. She was determined to return to her home and garden, and to the meetings of the several clubs and organisations to which she belonged. Through her determination and

perseverance, at the time of our meetings, she was walking independently without a trace of a limp. In persevering over the obstacles of her life, Mabelle had learned to be resilient and adaptable. Until she was institutionalised at the age of ninety-five, Mabelle's successful return to work after decades out of the paid workforce, her payoff of the mortgage on the family home, and her battle against Parkinson's Disease, had actually increased her self-respect and in turn, her sense of well-being.

Sally Dickerson

Sally was born in New Zealand eighty-two years ago; her mother was the daughter of Glaswegian and Gloucestershire immigrants. She was unique among the women of this chapter in that she managed a career as a buyer for a large New Zealand company as well as marriage and motherhood. Her marriage ended when she was fifty-seven with the sudden death of her husband; her career ended with retirement at the age of sixty-two.

As a result of failed total hip replacement surgery, Sally could walk short distances only with the aid of a walker. Nevertheless, Sally described her life as happy and fulfilled. An enthusiastic communicator, she wrote letters and talked on the telephone with friends and family in both the North and South Islands. With good vision and hearing and a strategically located flat, she had many opportunities for meaningful communication, which helped to compensate for her immobility.

My son and daughter-in-law always come to see me on Sunday afternoons and I live for that. They are very special. I also have friends that go back to my childhood days. I also feel very much a part of it here, the church and the neighbourhood and all the people. The only thing is that I cannot walk any distance. I have someone who comes in one day a week and she does my big shopping. Rarely do I have less than a couple of visitors a day. Somebody is always popping in. I go to church every Sunday morning and Sunday evenings if my son and daughter-in-law have left for the day, and I always go to the Ladies Social on Wednesdays. I am secretary for the church missionary society and that puts me in touch with lots of people. I have so many friends and they're beautiful people.

As it had with Mabelle Armstrong, Sally's ability to remain independent in old age had increased her sense of well-being. Retirement allowed Sally to spend more time with her family and friends. After retiring from her job as a buyer, she regularly travelled by train to care for sick friends, to help her daughters-in-law, who, as she had been, were working mothers, and to simply relax with people she loved. However, Sally also put her experience and skill to work managing a series of 'church stores', raising money for her church and local community, and managing a "soup kitchen" for the homeless. In her old age, these tasks contributed to Sally's sense of worth. As members of a liberal western nation, Sally and Mabelle had been taught to love their family and to value productivity. In old age, these values remained important to them.

Fanny Gage

Fanny Gage was eighty-nine years when I first met her. She lived independently in a small flat in a community of elderly people. She was mentally alert, with excellent memory recall for events of eighty years ago and those of a week ago. Until she was well into her eighties, she was a Girl Guide leader and chairperson of a local woman's club, often driving her friends to shops and malls, restaurants, club meetings, theatre, and church. By the time of our meetings, the pattern of Fanny's life had become simple and regular, revolving around family and church. Her daughter Janet visited each day to prepare her evening tea. They often ate together, after which Fanny dressed for bed and Janet went home to prepare her husband's dinner. Each Saturday and Sunday, Janet arrived early to help Fanny prepare breakfast, bathe, dress, and do the laundry. Her two sons visited on the weekends, often bringing vases of fresh flowers from their gardens. In my many visits to Fanny, there was seldom a time when she did not have vases of fresh flowers in her small flat. Each Wednesday, unless she was not feeling well, with the help

of a friend or neighbour, Fanny walked the short distance from her flat to the church for the meeting of the women's club she had once chaired.

The following excerpt is from a letter Fanny wrote me while I was away on a trip. It demonstrates the well-being she derived from the love of friends and family.

Dear Jeanne,

What a wonderful surprise I got for my birthday. My family hired the hall and it was full with old friends and nearly all my family – so many of them. I did not know where to start. Janet had made me a cake and the tables were loaded with goodies and decorations. There was a special table for the little ones. My family got me a lovely new telly with a remote control. What a good surprise! I must go. Janet has just come in to get my tea. She is so good.

In very old age, Fanny Gage was no longer able to participate in the many of the activities that had once endowed her with a strong sense of well-being – driving her own car, taking friends to church and other activities, managing family affairs, Girl Guide leadership, and the chairing of her favourite club. Perhaps it was because she had lost so much that Fanny took special pride in her ability to live by herself. This pride was reflected in the care she took to keep her small flat clean and her garden well tended. Fanny also derived a sense of worth from the recognition she was given by the members of the club she had chaired for so many years. I attended the club meetings with Fanny for many months and on several occasions she received flowers and cards of appreciation. Beside the sofa in her flat she kept a scrapbook filled with pictures, letters, and mementoes of her years as a teacher and leader. In the last year of her life, when Fanny could no longer walk with me to club meetings, and she was too weak to look through her scrapbooks, her well-being came from the love and respect of her family.

Mildred Howard

Mildred Howard described herself in these words:

I'm nearly ninety-three, but I don't feel that old unless I've got to get up and around. My mind is as good as it ever was. I've still got my marbles with me and I can still count up my pennies.

Although she made no mention of it in the excerpt above, Mildred was blind. In her interviews, she related how, at the age of eighty-eight, she went to bed one night able to see, but was blind when she awoke the next morning; while she had slept, haemorrhaging into both eyes had caused irreversible eye damage.

Mildred was born in 1912 in a rural North Island community. Her parents lived with her paternal grandparents on a large sheep and cattle farm. She was their only child. When she was twenty-six, she married a young Scotsman from Glasgow who was also an only child. As she says:

I was an only child who married an only child and had no children. Instead of children, I grew a tumour. Mind you, it was unfortunate, but oh, my husband, he was a lovely man. I thought the world of him. We got on like a house on fire! We did everything together.

Mildred lived alone in the house she and her husband purchased a few years before his death. This was a great help to Mildred in adapting to blindness; because she could visualise every aspect of her house and garden, she was able to cook, bathe, dress and walk to the mail box at the end of her driveway without assistance. She spent most of her waking hours in a reclining chair that had been set on blocks so that she could get in and out of it easily. A telephone sat to the left of her chair on a small table; on her right was another table holding a clock, water, and her needlework.³⁹ Another table to her right held stacks of talking books delivered to her home by the local library and Services

³⁹ Mildred was well known locally for her beautiful needlework. I sat beside her several times and watched her attempt to knit. She made mistakes, which she could feel but was unable to correct. Frustrated with her product, she would put it down for a while, but pick it up to try again later.

for the Blind. These were particularly important to her, because they supplied not only story, but also the sound of a human voice. I arrived more than once and found her asleep in her chair with a talking book playing in the background, and although she laughed at herself for falling asleep, she said that the sound of a human voice in her empty home calmed and soothed her.

Although she could no longer drive, with the help of friends, Mildred continued most of the activities in which she had engaged before she lost her sight. She went to church each Sunday, to the weekly meetings of a local women's organisation, shopping with her neighbours, and to a mah-jong club, which she helped found years ago. When she fell in her home at the age of 92 and broke her left hip, Mildred's quality of life took a dramatic downturn.

When I first met Mildred, her partial hip replacement had failed and she was waiting for a second hip repair. For the first several months our friendship, intense pain, immobility, and the spectre of additional surgery kept Mildred drained and exhausted. Nine months after I met her, I visited her in hospital where she was recovering from a hip replacement and found her in a four-bed ward sitting up in bed chatting with the other patients in the room. Her appetite was good, the post-surgical pain was less than she had expected, and her outlook was bright. A few weeks later, we went together to a club meeting. It was her first post-surgical outing. Not long after, Mildred was playing mah-jong again and calling people who could provide transportation for her to and from club meetings. She was still blind and spending many hours alone in her home listening to talking books, but Mildred was again participating in life and she was deriving satisfaction and well-being from the contributions she was able to make. As she said:

I'm cooking my own meals again and I'm baking bread and cakes to give to my friends. I can get out of the house and go to meetings. I look after myself and do whatever I can do for myself without help.

Nancy Robinson

Nancy Robinson never married. Instead, from the age of sixteen until retirement at the age of sixty, she dedicated herself to the service of the church. In the early years of her retirement, Nancy was in good health. She enjoyed long walks and working in her vegetable garden. She also continued to work for the church.

For the first several years after I retired, I kept busy doing whatever needed doing. Its very important work and in a way I was doing what I had always done, except that I didn't have the responsibility of the Sunday sermons. Time has changed all that. I cannot physically handle responsibility like I used to, and of course, the responsibility of the church is no longer mine, it belongs to today's clergy.

Today, at the age of seventy-five, with diminishing physical resources and a heart condition, even pleasurable activities are becoming onerous for Nancy.

I have had about fourteen months of really struggling along and I've realized that I must cut back on the work I've been doing. I just can't cope. It is too much for me.

Despite the difficult circumstances of her old age, Nancy expresses a great deal of life satisfaction. She and her sister are confidantes, able to share and communicate on a very personal, intimate level, and she remains an important source of spiritual support for neighbours and members of the church who still perceive her as a minister of God.

I was converted when I was eight and since then I've always known I belonged to Jesus. I didn't do much about it until I was about fourteen. I'd been up to something which I shouldn't have been doing and I couldn't stand that. I went to Mum and Dad and talked to them and instead of being in trouble, my mother just gathered me into her arms and I caught a glimpse of God's love. Since that day, I have never turned back. I wasn't conscious of making a career choice; it was just that God had called me.

Spirituality was an important source of well-being for Nancy and many of her activities were expressions of her faith in God. She called in on her neighbours regularly with gifts from her garden; when they were ill she visited them at home and in the hospital. Each Sunday as she sat in church, she made a list of the members who were not present; by

Tuesday of each week Nancy would have called each absent member. More than once over the months of my participation in their lives, my phone rang on Sunday or Monday to inquire if I had not been at church due to illness, and could she be of any assistance. She was not unusual in this regard. My visits to Sally Dickerson, Susan Eyres, Maisie Harrison, Fanny Gage, and Mildred Howard often engaged me in trips to hospitals, long-term care facilities, and the homes of sick, elderly individuals whom these women wanted to visit. These women did not merely attend church, they were actively spiritual. Similarly, although I was not as actively engaged in their daily lives as I was with the women named above, Jacob Traub, Hannah Meyers, Annabelle Gregson, Agnes Schultz, Rose Winters, and Edna Holt spoke of the well-being that they derived from their faith in God.

Rose Winters

Seventy-eight year old Rose Winters was widowed. She lived in the home she and her husband occupied before his death. She had several age-related disabilities. She is a noncompliant diabetic, and freely admitted that she was occasionally ill as a result. She had a damaged knee, but refused to walk with a cane, or to have her name added to the surgical waiting list. Additionally, she had blurred vision, which was a source of great anxiety.

I've been to the hospital twice just recently because of my eye. My vision is blurry and the doctors tell me that I have a clot behind one of my eyes. This last time I went they took a picture behind and it appears to have cleared a certain amount, but they said there will always be that distortion there. Sadly, I call this one my best eye and that is the one that's been affected.

Rose was an extraordinarily self-sufficient individual. She explained the development of her self-sufficiency in this excerpt.

My husband was ill for a very long time. It was over twenty odd years before he died. He was only forty-eight when he first went down with Guillain Barre Syndrome. He never got better from it. I managed on my

own. We never had a district nurse or anybody like that. I never called friends. I learned to do the things that needed doing. I was the one who was always driving the car. He found he couldn't manage it, so I had to do it. Now I'm so very thankful that I can drive a car and do all the other things I do. That's sort of circumstances isn't it? It was sad that my husband was ill and I found myself having to do most everything, but it caused me to be self-sufficient and today I am able to carry on.

Over the months that I visited Rose, I came to understand that self-reliance was critical to her well-being. In fact, as she told me, her need to remain self-reliant frequently got her involved in "too many" activities. Except for Jacob Traub, Rose was more actively engaged in volunteerism than were any other of the participants. She was an artist; she painted and displayed her art at a shop for local artists, where she was also a volunteer sales person six hours a week. She was a member of a local support group for Girl Guide leaders; she attended church twice weekly and an every Wednesday evening home Bible study group, providing transportation for friends who could no longer drive. She took a weekly Yoga class, she lived next door to her daughter, and frequently baby watched her grandchildren, every other month she spent a week in her sister's home thirty kilometres away, and on alternate months her sister spent a week with her. Rose was so busy that it was necessary to make an appointment to visit her. I often wondered if non-compliance over her diabetic diet, which seemed inevitably to make her ill, was not a means by which she could call a 'time out' on her hectic lifestyle. Although she was the busiest, Rose's life was typical of the women in this chapter in the regularity with which they saw their family and friends (institutionalised Mabelle Armstrong is the exception). The self-reliance so important to their well-being had not resulted in isolation. They all had supportive, reciprocal networks of friends and those who could, called on their adult children as well.

The United States Participants

At the ages of 95, 101, and 102, the three women in this group are among the oldest of the interviewees. From birth through old age, they have lived in the Texas and Oklahoma region of the North American Southern Plains (Baker, Levacy, Gutierrez, Ochoa, & Retana, 1999-2000). Between the years of 1903 and 1911, when they were born, the American frontier era was drawing to a close, but large areas of the plains and prairies of western America remained undeveloped and frontier people lacked many of the basic comforts taken for granted by city dwellers. In their childhoods, these women lived in primitive, harsh environments far from the major events of the early twentieth century. However, despite the political and geographical isolation of the Southern Plains events in Europe touched their lives as their fathers, brothers, and uncles left to serve in the Great War of 1914 – 1918. A few years later, as young women, they experienced the American depression along with the rest of the country, but in addition, lived through the extremely difficult decade of the Dust Bowl.⁴⁰ These women were survivors.

Annabelle Gregson

When I met Annabelle Gregson at the age of one-hundred, she was living independently in the same small West Texas town in which Agnes Schultz and Hannah Meyers resided. The three women attended the same church and were acquainted, but were not close friends, and did not socialise with each other outside of church.

⁴⁰ The decade of the Dust Bowl has been described as the “most graphic environmental disaster in American history”. On May 11, 1934, one storm blew away an estimated three hundred thousand tons of topsoil. Hundreds of miles from its epicentre in the Great Plains, dust from the storm darkened the skies of Cleveland, Ohio, fell on Washington, D. C., and created a haze extending 300 miles beyond the Atlantic Coast (Etulain & Malone, 1989).

Born in 1904, Annabelle was the youngest of eight children in a Southern Plains farm family. Her life narrative is a tale of the physical hardships and emotional trials typical of the lives of Americans of that time. When she was three years old, her mother died; on the eve of her marriage, her father lost his sight in an accident at a lumberyard; her first child was stillborn and the second died, along with several hundred children and adults, in an explosion of the community school.⁴¹ In the last few years, she had broken a leg, hip, shoulder, and wrist, yet she had this to say about her life:

I'm just doing real well for my age and the bones I've broken. Before I started falling, I walked a lot. Then I had to be more careful, but I still walked every day and I loved it. I still walk outside. I eat the things I like, especially vegetables. I've never carried any weight.⁴² I've got this lift chair here and I used it for a few days and then I said I'm not going to use it until I need to, so I quit on it. I get out when my daughter takes me out in her car. I still have my car; I drove it until I was ninety-five, but then I broke my leg and that ended my driving. I go to church every Sunday, unless the weather is bad. I appreciate the church and I appreciate the life I've lived. I have been well taken care of. Some people get bitter, they forget to smile and they forget how to be happy. That hasn't happened to me.

Annabelle Gregson had actively cultivated happiness and a positive attitude in her old age. It had become an important component of her well-being. The same was true of all three of the elderly participants I interviewed in this remote West Texas town. Annabelle,

⁴¹ On March 18, 1937, in the oil community of New London, Texas, the Rusk County School, which was heated by natural gas, exploded and burned to the ground. 294 bodies were recovered, but it is estimated that a total of 425 teachers, children, school employees, and parents died in the explosion. This catastrophe led to the passage of a law requiring the addition of Mercaptan to give natural gas (which at the time was odourless and colourless) an identifying smell. In 1961, William Benson admitted to sabotaging gas lines under the school.

⁴² Annabelle's reference to "carrying no weight" is true of most of the interviewees. Her comments over diet are also typical of remarks made by other participants that they ate small servings of food. As a group, these elders were diet conscious and selective in what they ate.

Hannah Meyers, and Agnes Schultz verbalised feelings of joy and happiness that went beyond those expressed by any other of the participants – other than Neville Schuster, who expressed similar joy and happiness over his relationship with his wife and daughter. The community in which these women lived may have played a large part in making their late life happiness and well-being possible. It was a town of 4,000 people located in a remote area of the Southern plains. The inhabitants were mostly long-time residents. They went to church together on Sunday, worked with each other during the week; they looked out for each other's children and their old people. The three elderly women whom I interviewed for this chapter not only had the support of their families, but also that of the community. It was a testimony to the difference that can be made to the lives of elderly people when they live in a community that respects and cares for them.

Hannah Meyers

Hannah Meyers was a ninety-four-year-old widow who lived by herself in her own apartment. She was mentally alert and well oriented to the present, but had a great many physical disabilities, most of which were the result of arthritis and a right hip replacement she described as “botched.” She related unrelenting pain, which had left her incapacitated and homebound for the past seven years. My single interview with Hannah took place in her modest apartment, sited in a small housing complex for Senior Citizens.

Hannah was sixty-five when her husband died suddenly. She humorously related an offhand marriage proposal made to her two years into her widowhood.

About two years after my husband died, a friend of his said to me, ‘Hannah, you’re too young to live by yourself. I guess we’d better get married.’ I said to him, ‘That’s for the birds. I can live by myself.’ And, that is just what I’ve done. I’m right here, living on my own. I’ve managed on what money I had. All but my Social Security check has run out, but I make it through.

Hannah appeared to have no regrets over her decision not to remarry. She continued her comments above by saying:

Loneliness, the kind that comes from being on your own, hasn't been as hard for me as it is for some women, because my husband spent so much time in the fields. Sometimes he'd be gone four to five days, so we weren't wrapped up in each other, particularly the last several years. He died suddenly; he took sick one morning and died that evening. The way I look at it, suppose I had remarried. Right now I might have somebody sitting in that chair over there not able to take care of me, nor me able to take care of him. So where would we be? As it is, if I want to turn on the radio, loud or low, I can do it. I can do anything but get out and go somewhere and having a man here wouldn't change that.

Hannah perceived that marriage was not necessarily the route to well-being in her old age. She implied what Allison Turner had said when she commented, "society has it all wrong" in its ideas over marriage. Both had observed older women caring for sick, spouses and neither wanted that for themselves. Allison resolved the problem by breaking with tradition and marrying a younger man. Hannah's solution was to remain single. As a result, her well-being came from pride in her ability to "make it" on her own.

Agnes Schultz

Agnes Schultz was born on the Southern Plains of Oklahoma in 1903. She was the eldest of nine children. At the age of twenty, her mother died leaving five young children orphaned and alone in an Oklahoma farmhouse.

When my mother passed away, all I had to do was sign on the dotted line. She had everything ready. I knew I was going to take the children. She wanted me to keep them all together, which I did until they were grown. I raised four brothers and one sister. All through my life I just did what needed to be done. I didn't mind.

At the time of our interview, Agnes was one hundred years old; she and her ninety-three year old sister were the last living members of a once large family. Married once, she and her husband had two sons; one died in an automobile accident at the age of seventeen and the other died in Honolulu in World War II; her husband died ten days before their sixty-seventh wedding anniversary. When I met Agnes, she was living alone in the house that had been her home for decades. Each week a neighbour came to her house to take Agnes shopping and do the relatively few household tasks that Agnes could not do. Agnes was content with her life and derived a great deal of her well-being from the fact that she lived independently with a minimum of assistance.

Conclusions

The factors these women name as essential to well-being include independence: a theme that comes out very strongly in this chapter. As we have seen, these women derived satisfaction from being as independent as possible. With only one exception, these women were attempting to keep as well as possible. Striving for good health and social connectedness fits the mainstream gerontological concept of 'successful aging'. This is perhaps not surprising, since these women were all a part of liberal western nations.

Some of these women had been able to maintain relatively good health, whilst others were working hard to remain cheerful in the face of illness and disability, including overcoming pain. The 'successful ageing' concept does not mention cheerfulness in the face of adversity, even though, according to one participant, having a positive attitude appeared to improve general well-being. In a disturbing number of cases out of such a small sample, participants were suffering from the effects of hip operations that had gone wrong. The women had had surgery to improve their mobility and independence, but the outcome was worse than if they had not done so. The 'successful ageing' concept

evaluates elderly individuals according to the outcomes, but tends to ignore the role of others, such as doctors, in helping or hindering their efforts.

The second major theme that emerges is closeness to family and friends. Some of the women with the poorest health and the least capacity for independent living did report good quality of life and well-being because of close ties with families and friends. Social connectedness is a major theme in the 'successful ageing' concept too; but usually where the elderly person is contributing rather than receiving care. In some cases, the women were accepting help from their families, but nevertheless experiencing well-being.

Another theme raised by participants in this and other chapters, and one that appears to effect well-being in old age, is spirituality and religion. Many participants mentioned religion and church-based activities as contributing to their well-being. Although part of the benefit is undoubtedly the sense of community and social connectedness (which is included in the 'successful ageing' concept), spirituality has been overlooked by the 'successful ageing' concept.

This chapter concludes the introductions of the participants. The remaining chapters examine the range of factors that have contributed to or detracted from the well-being of their old ages.

CHAPTER 11

WELL-BEING IN OLD AGE: RESPECT

Introduction

This thesis began by pointing out that the mainstream gerontological ‘successful ageing’ concept does not include the subjective viewpoints and experiences of elderly people themselves – the ‘how it is for me’ of ageing – in its definition of the essential components of optimal old age. Instead, using laboratory-based studies of the responses of older people to stress, studies in the brain ageing of humans and animals, and other studies of older people, a research team of sixteen scientists formulated the definition of successful ageing (Rowe & Kahn, 1998: xi-xii). Thereby this definition passes by a rich source of data critical to a complete, encompassing gerontological concept of well-being in old age.

The successful ageing concept, the “new gerontology”, began as an attempt to direct the attention of gerontologists and geriatricians away from the diseases and disabilities of old age towards the positive factors that permit people to function effectively in old age (ibid). The successful ageing concept identified specific biological, psychological, and social factors it considered essential to a good old age: high cognitive and physical function, avoidance, or delay of the diseases and disabilities associated with old age and active engagement with life. However, because ‘successful ageing’ is a concept that has been defined largely by scientists rather than by older people, it is poorly positioned to consider the factors that elders themselves consider essential to well-being, many of which factors are social and cultural. Much of the focus of gerontology remains riveted on disease and disability. The ‘successful ageing’ concept does highlight the importance of remaining socially connected, but tends to place the onus upon elderly people themselves to maintain social networks, and overlooks the impact of age discrimination

and low income upon their ability to participate in social activities. The participants in this thesis identified a wide range of factors, including spirituality, sense of place, belonging to the land, safe good quality housing, and having respect, as essential to well-being in old age.

To become old in mainstream Western cultures is to become a member of a devalued social group to which are attached a great many negative stereotypes. Old age brings challenges such as the demise of partner, siblings, and friends, a post-retirement fall in socioeconomic status, and a declining ability to be independent and self-sufficient. In these circumstances, self-respect and confidence can be difficult to maintain (Robins & Trzesniewski, 2005; Stickle & Onedera, 2006; Katz, Joiner, & Kwon, 2002). Relationships that acknowledge an older person's wisdom and experience are particularly important to well-being because they help to restore self-respect and sense of worth (Torres, 2002; Lyyra & Heikkinen, 2006; Sheung-Tak & Chan, 2006). Except for the three who were institutionalised, the participants in this study had well developed relationships with friends and peers that provided a reassurance of their worth and a respect for their skills and abilities. However, they also looked to people outside their social age group for respect and value; in particular, they looked to their adult children.

Relationships with Adult Children, Respect, and Well-Being

The participants in this thesis had clearly defined notions of respect. They had been taught to respect older people, they had taught their children to do the same, and they expected respect for themselves. For these participants, respect had much to do with deference. Out of regard for their rights and feelings, in decisions pertaining to their personal lives, these participants expected their children to defer to their wishes. However, in several cases, quite the opposite occurred. For example, Robert Gordon, Mabelle Armstrong, and Theresa Landman expected their children to defer to their wish

to remain out of a nursing home, but their children ignored their wishes. Maisie Harrison and Susan Eyres expected to be treated as a valuable part of their sons' lives, but were not. Harriet Carey and Estelle Doherty expected to live in their daughters' homes in their old age, thereby honouring Cherokee tradition, but their daughters did not invite them and so they lived alone in senior citizen housing complexes. As the only surviving member of a once large Jewish family, Jacob Traub expected his daughter to respect him and to cherish their past; instead, she disposed of many of her father's mementoes.

However, other participants had much different experiences. They were honoured and respected and wherever possible, their children deferred to their wishes. The Maori participants were the most notably respected, but Fanny Gage, Sally Dickerson, Neville Schuster, Rose Winters, Annabelle Gregson, and Hannah Meyers, also occupied central positions within their families. Relationships with their children directly affected the participants' well-being. For some of the participants, the behaviour of their children helped increase their feelings of worth; for others the behaviour of their children served to decrease their feelings of respect and worth. As Mabelle Armstrong expressed it:

In my day, old people were treated with respect. When my father's mother came to visit, we were told, 'Grandma's coming. Be on your best behaviour; put a stool for her feet, put a rug on her knees and don't talk too loudly to her.' We looked on her as somebody precious; we worshipped her.

For the purpose of this discussion, the participants' adult children can be separated by their behaviour into three general categories: those who took control of their parents' lives, those who were uninvolved, and those who engaged in reciprocal relationships with their parents. The situation that existed between Simon Burgess and his children is an interesting exception that deserves to be discussed separately. Simon saw his relationship with his adult children as being unsatisfactory, but remarkably, they all

chose as adults to live under the same roof. When disharmony ensued, he did not attribute it to his children, but to his faulted behaviour as a young father. At the time I interviewed Simon, he was living in one section of the house, and his adult children occupied the other. The situation seemed tense, but they were still living under the same roof. As a kaumatua, Simon's calendar was full. His responsibilities required him to be involved in marae activities, whanau events, and civic organisations; they also contributed to his well-being.

I'm in a lot of organisations. I even carry a diary around to remind me who I've got to meet. I never refuse to meet with anybody. Students come here regularly and I tell them what they want to know. I feel good as an older man and I'm trying to pass what makes that happen on to the young ones.

Simon's perception of his positive influence on the lives of the young people of his whanau did not extend to his own children to the extent he would have liked. The excerpt below stands out in his interview data because it contrasted sharply with his comments regarding the overall satisfaction of his old age.

I am seeing on TV that we shouldn't be too strict with our children. When my children were young, I believed they might get into trouble with the law if I wasn't strict. Today, I can say that it was my strictness that kept them out of drugs, but I also can say that I'm not getting the degree of love I should be getting from them. It is my own fault because I never gave it to them when I was a young dad. As the chief, I am respected and copied by the young ones on the marae. From my own children, I get very little respect.

Simon looked back on his parenting with regret and concluded that he should have been less zealous in punishing his children and more loving towards them. When he was a young father, he used the harsh methods with his children that his father had used with him.

I had a hard life from my dad. If I didn't do the right thing I got the belt and that flowed down to me. My father and I never really got like this (he holds up his hand with two fingers intertwined), and my children and I – well I should have been doing a bit of this (here he demonstrates hugging) – and I didn't do it.

Both at home and at school, the harsh, physical punishment which Simon applied to his children, was once socially acceptable:

Corporal punishment is no longer acceptable in our schools and physical punishment of children by parents is frowned upon now. For many years, it was considered a parent's duty and a teacher's duty to punish a disobedient child. When I graduated from teachers college in 1967 many of my classmates bought a leather strap which they regarded as an essential piece of equipment to take with them to their new jobs in New Zealand (Selby, 1999: 3).

The well-being of Simon's old age was marred by the fact that his children did not love and respect him, as he would have liked. He attributed their attitude towards him to his strict, rather than loving parenting methods. However, as the above quote indicates, Simon was a parent of his times and corporal punishment of children at home and in school was practiced not only in Maori society, but in other societies as well. An example is this story told by eighty-five-year old London-born Neville Schuster.

I was introduced to discipline at the age of four. The tool of enforcement was a bamboo garden cane that my father kept in the potting shed. When I transgressed, I was dispatched by one of my parents to bring the cane to the house where I was commanded to kneel and bend over the bed, at which point the summary punishment was executed. Five years later I no longer lived at home for most of the year. I attended a preparatory boarding school for four years and then a public school for the following five. The enforcement tool at both was the same as that wielded by my parents. In prep school, our Latin Master utilised a somewhat less dramatic, but still painful, form of physical punishment. The erroneous declension of Latin verbs resulted in a call to his desk where the ear lobe of the unfortunate victim was twisted until he was able to recite correctly. I didn't punish my son in the same way. It would have upset my wife, who came from a culture, which did not physically punish children. Another reason was that my son was a completely different personality; he was very sensitive and easily wounded and certainly was not a candidate for physical punishment. Furthermore, my experience had made physical punishment abhorrent to me.

Simon's problems with his children were but one side of the relationships he had with them. Of his three adult children, two lived with him in the family home and were generally available to him when he needed their help. Regarding the positive influence

that their presence in the home had on the everyday quality of his life Simon commented:

I haven't married again, but as I say, I've got the family here. I think if my family left I would be very lonely. I wouldn't be as well as I am now. Loneliness is not good.

On the day of our taped interview, Simon invited several friends to attend and afterwards we were served afternoon tea by his daughter. The food she had prepared and the manner in which it was served supported both her father and traditional Maori hospitality. Nevertheless, Simon was unsettled by the relationships he had with his children; he believed he could rely on them as he became older and less self-sufficient, but he was not certain.

I hope that when I get to the age of eighty-five and am old and crotchety my children will look after me. That's why this house is here. It belongs to all of us. It's a family home. I don't want to go into a nursing home, I want to stay here and my children understand that. A lot of the ones my age have sold their homes and they're in kaumatua flats. From there they've got to go into nursing homes because there is no other place for them and they can't care for themselves.

For the purpose of this thesis, the important point to be drawn from Simon's discussion is his perception that his early parenting practices had established an enduring barrier to loving relationships between himself and his children, which in turn, had negatively affected his well-being in old age. Remembering the Maori model of health known as "whare tapa whā", in which each of the four ingredients comprising health – spirit, mind, body, and family – must be intact if well-being is to be achieved and maintained, it is understandable that Simon's unsatisfactory relationships with his children would diminish his sense of well-being. Elderly and widowed, Simon looked for a greater

degree of love from his children than they could give.⁴³ Although Simon's relationships with his children were a negative aspect of his late life, they were not the major subject of his interview. Instead, Simon was directing his energies to passing Maori customs, language, and traditions to the young people of his iwi.

Whatever the degree of involvement, the relationships between each of the participants and their families was an especially important factor in the well-being of their old age (excluding Mildred Howard who was the last living member of her family). Controlling and uninvolved family members impeded the ability of these elders to be self-directed and as a result did much damage to their self-respect and status and their sense of being loved and valued. Reciprocal relationships were an asset to well-being; operating on the belief that elders have the right to control their own daily lives, they supported the participants' independence. Consequently, these participants continued to contribute meaningfully to family and community.

Adult Children Who Controlled Their Parents' Lives

Not all participants were as fortunate as Simon Burgess. Mabelle Armstrong was a resident in a long-term care facility located almost fifty kilometres from the home in which she had lived for many decades. She relates the events that led to her move to the nursing home environment.

When it was time for me to leave the hospital, my children said to me, 'We've arranged for you to come out to a rest home for a bit to recover from your fall' and when I got here they said, 'This is it. You're here to

⁴³ As illustrated by Simon and his children, Selby found that the impact of corporal punishment on children was long lasting and painful. Referring to an older Maori whom she had interviewed, she said that he was a man who wanted to be a fluent speaker of te reo Maori but he "could not because of scars left from practices in his childhood – he was beaten for speaking Maori and was suffering life long pain and effects" (1999: 10).

stay; we've made all the arrangements.' I wasn't in favour of coming here. I didn't think I needed to live in a rest home because if I had gone home I would have had help. I had lived in my neighbourhood for forty years and I knew everybody. Before my fall, I was having help, they call it home help, a lady used to come two hours a week and I'd have the washing done and she'd hang it out; and then I could have had 'Meals on Wheels' if I had wanted. If I had straight away gone home from hospital, I would have been fine, but they had sold my flat and I had no place to live. I had to go to a home.⁴⁴

Unhappy with her new living environment and angry with her children for placing her there, Mabelle nevertheless tried to fit into the routine of nursing home life.

For the first six months I was here, I used to go in and participate in the morning crossword puzzle activity. It sounds a silly thing to say, but I didn't enjoy it. The other residents left it to me to do and the therapy lady knew it and she would say to me, 'Mabelle, why you don't you give the others a chance? Don't be so superior. Wait and let the others try.' I now feel happier not going in. I mean, they're good here, but at the same time they treat you as though you are inferior. They talk down to you. Even those who are in charge do it. I tried talking to my daughter about this and I got into trouble with her. She didn't want to hear it.

Mabelle faced her options. She could withdraw from life or adapt. As difficult as it was, she tried to adapt, looking for ways in which she could be content in the nursing home environment. She formed a friendship with Robert Gordon, who like herself, was in need of someone to talk to and she allied herself with the recreation therapist. She also derived great pleasure from reading:

Few of the books the library brings round are in large print, but now and again, there's quite a nice one. I have one that I've read for the third time. It's called "The Flame Trees of Thika." I never thought I would read a book for the third time, but it is so descriptive. The author doesn't just say a sun set, it's two pages describing the sunset – what it was like and what she thought while she was looking at it. You can read it over and over and you are not bored. Those are the kind of books I love.

⁴⁴ Mabelle had two children: a 74 year-old son and a 70 year-old daughter. They were both married; they and their spouses were retired. Her son lived fifteen minutes driving distance from the nursing home and her daughter five minutes. In contrast, Mabelle's home of forty years was located in a community more than an hour's drive from her children's homes.

Regarding the importance of television in the nursing home environment, she commented:

I was not a great television enthusiast, but here everybody's in bed by six o'clock and I have a television in my room, so I go in and watch it. A recent program called "Captain's Log" has been following the voyages of Captain Cook. There were some lovely scenes of New Zealand and the Sounds, close to where my husband and I used to go on holiday.

The facility's recreation therapist described Mabelle to me as her greatest success, saying that she had produced some beautiful crafts and pieces of art work that were for sale in the home's gift shop. Mabelle had this to say about the nursing home routine she has designed for herself.

When I get depressed and lonely, I pick up The Flame Trees of Thika, work on the crossword, talk to Robert and do a bit of walking in the corridors of the Home. I also help the therapy lady with whatever she's doing. After lunch today, she's going to make Christmas decorations and there will be two or three of them and myself to help, although sometimes I am the only person in there with her.

Difficult as her life was in the nursing home, through books and television and her relationships with Robert Gordon and the recreational therapist, Mabelle managed to adapt to her new environment. However, she could never accept the actions of her children in removing her from her home, and her neighbourhood friends, nor their changed attitude towards her.

When my family came to see me in my own home it was so different. I mean, they enjoyed coming to see me and showed it. But now, when they come here, they don't enjoy their visits. There's a very certain type of false chatter that goes on. They treat me more and more as though I am unable to carry on a conversation. It's the consistent contempt with which they treat me that injures the most. Straight away when I came here I was treated differently. When they came to see me in my own home they would say, 'Mum, what you think of this?' and 'What do you think about that?' Now they speak to me like an old person who doesn't know anything.

For Mabelle, it was not that the nursing home environment had proven too great an obstacle to her well-being, the source of her greatest sorrow was the loss of the love and respect her children once felt for her.

I was never lonely in my own home; I had a telephone and I was still connected with all my friends. And it gave me a real interest. I used to go to our church fellowship and I was often on the committee. I belonged to the Women's Institute and the RSA. They gave a celebration of those who had been in the RSA for over thirty years and I was one of them. I had been on committees and been vice-president during my time, and I was given a special plaque and a cake was made. I often think that it proves that to some people I have been of some importance. Now I am so lost because I'm just another old lady in a home.⁴⁵

Like Mabelle, Robert Gordon's relocation from his home to a long-term care facility came about as a result of an autocratic decision by his children. Also like Mabelle, his resistance to the move permanently damaged his relationship with them.

My children chose this nursing home as a place for me to die. I was in hospital and I'd got to leave there. I had fallen over backwards in my place and fractured my pelvis. As they saw it, the trouble in going back home was that I could bake a bit, but I couldn't cook. I never accepted that I couldn't cook for myself, but they moved me here anyway.

Robert realized that the balance of power was tipped against him in his fight to retain control of his life. He had a reputation for contrariness and stubbornness, and in trying to stay out of the nursing home, he had angered and alienated his children. They were therefore unwilling to assist him in his power struggle with the facility's manager for fear that he would be asked to leave the nursing home and they would be obligated to take him into their own homes. None of Robert's four children was prepared to have

⁴⁵ Mabelle Armstrong died in the fall of 2004, just a few days before her 100th birthday. Encouraged by the manager of the nursing home to "fight a little longer" so that she could celebrate her 100th birthday, she replied, "It is of no significance."

him in their homes, even for a brief time. As a result, he was circumspect in his battles with the manager and her staff; not only did they hold his future in their hands, but also, he depended upon their good will to keep his cat Mitten with him. However, the struggle itself was important to him.

Very few people here say what they think to the manager. I don't get asked by any of them what I think, but I tell them just the same and the more I do, the more trouble I get into. They may make me abide by their rules, but they can't rule my life. They make me obey, but I keep on protesting. I won't lie down.

Theresa Landman's children likewise took arbitrary action to place their mother in a nursing home. When Theresa relocated from South Africa to New Zealand, where her children lived, she came with the promise that she would live with her daughter; this was the case for the first six months after Theresa's arrival. However, Theresa had Alzheimer's disease, her memory was poor, she repeated herself almost constantly, and she required frequent reminders in order to complete the most basic of tasks. In addition, she was lonely. She missed the South Africa and her lifelong friends.

I had lovely friends until I left South Africa. Since I've been over here, most of the husbands have died and the wives have gone to live with children on the coast somewhere and I've lost touch because their kids don't know where I am. Anyway, after a time what are you going to write about? You can't keep up correspondence with people in another country, and all of you old. And so, I get no news from South Africa and I don't really want any because I'm not there anymore.

Theresa turned to her daughter to fill her need for friendship, emotional support, and friendship. Consequently, six months after her arrival in New Zealand, as Theresa's daughter and son-in-law were leaving on their annual holiday, they persuaded Theresa to stay 'temporarily' in a long-term care facility for that period of time. Theresa's memory was so poor that it took her almost a month to realise that her daughter and son-in-law's holiday must surely have ended and to wonder why she had not returned to their home. At that point, Theresa's daughter informed her that she had been permanently admitted

to the facility in order 'to be around people of your own age'. Theresa told this story with surprisingly little rancour, but her loneliness and disappointment were apparent.

It's nice in this home. They're very good to us. They try to put on a bit of entertainment and occasionally some musical people will come and play for us. Everything is comfortable and clean, but there is no one to talk to personally like you and I are doing now. I've tried to make friends here in the nursing home, and we all chat and talk, but everybody has their own life to live. They don't know South Africa. They are people who've grown up and spent their lives here. There is nothing for them to talk to me about.

Theresa continued to look to her children and grandchildren for companionship, love, and support. It was not as forthcoming as she would have liked, but when she spoke of her family, which she often did, she was always careful to balance criticism with appreciation.

I never go to the shops. I gave my daughter my power of attorney and she does the banking, draws the money, and goes shopping. I haven't been to any of the big drapers or anything here. My daughter says, 'Mom, you'll get too tired, I'll get it. What do you want?' That's all right. My children are very good to me and my grandchildren are great on listening. I don't see much of any of them because they work and they've got children at school. Anyway, it's all working out. I see my children as often as they can manage it. I mean, my son just phoned and he was around just last week. They're very good to me. I've got a lovely family.

Unlike elderly members of earlier generations of his Jewish family, Jacob Traub could not turn to his family for love and support. He was a widower and estranged from his daughter, an only child. The antagonism between Jacob and his daughter was the result of misunderstanding and a series of intrusions and interference on the part of Jacob's daughter in her father's affairs. The final break occurred while he was spending the nights in his wife's hospital room a few weeks before her death. Without consulting her father, Jacob's daughter led a group of people from the church they both attend into his house for the purpose of cleaning and organising it. When Jacob came home after the 'house-cleaning' party, he was shocked to discover that they had removed two dumpsters full of 'trash' from his house. What the house cleaners had considered trash

was to him priceless and irreplaceable. He was so angry that he severed his relationship with his daughter, his friends, and the church that he had attended for almost forty years. When I met Jacob a few months later, he was grieving over the death of his wife, the severed relationship with his daughter, the loss of his friends, and the loss of pictures and other mementoes that dated back to his move to the United States.⁴⁶

I am not out of focus now, but that event, occurring as it did at the time of my wife's death, disenchanted me with my church cohorts. The disaster of what happened to me was that those were people I considered to be my mentors and friends. Nor do I understand my daughter or her husband, either. I know now that when I die, they will throw out everything I have saved, everything I've got boxed in the house and in the basement. And the death of my partner? Well, it deprives me of somebody whom I loved much, much longer than anyone else.

Uninvolved Adult Children and Participant Well-Being

When Susan Eyres and her husband arrived from England, they moved in with their son and his family and began to look for a home in the neighbourhood in which he lived. Within a few days, they regretted their move to New Zealand. They had mistakenly assumed that their son would welcome them into his life. In fact, he was not eager to have his parents living close by and he told them so. He had made the move to New Zealand, he explained, in part to put distance between himself and his father and mother. Hurt and upset, lonely and homesick, Susan said, "I just felt like getting the next plane back to England." Equally hurt by their son's words, Susan's husband refused to return

⁴⁶ Jacob had no possessions from his childhood. They were destroyed during the Nazi occupation of Poland when seventeen members of his family lost their lives in Auschwitz. Included among the items his daughter and friends threw away were his mementoes from World War II and the early years of his life in the United States. With the loss of these items, not only did he lose his tangible link to the events of those years, but also his ability to share his past visually with others. It was an intense loss for Jacob (Clark, 2003).

to England and admit to their friends the truth of their relationship with their son and how misguided they had been to leave England. Instead, they quickly settled on a home in a small New Zealand town an hour's drive away from their son's home. At the time of our meetings, Susan had lived in that home for twenty years. Throughout those years, their son had remained cool and distant, consistently rebuffing his parent's efforts to develop a deeper relationship with him.

I will say this: we came to New Zealand for the wrong reasons. We lived with our son for three weeks, and then, although we stayed in the country, we deliberately put distance between them and us. As a result, we didn't see much of them. It's no different today. Three weeks can go by before my son will drop in to see me. He usually comes on his own, stays a few minutes and leaves. My grandson lives very close by. Actually, he couldn't be any nearer. I never see him. I've told my family that if they don't want to come see me, I don't want them to come. I don't want them to come because it's their duty.

Because Susan had polio in infancy, walking had never been easy and she understood the serious effects that the inability to walk would have on her quality of life. At eighty-four, widowed⁴⁷ and living alone, she had become increasingly frail. She was losing the fight to walk even short distances and she thought seriously about how she would manage immobility without her son's help. Although she did not understand the reasons for his lack of participation in her life, having cared for her own mother for twenty-five years, she understood that participation could be stressful.

I do not want to be a burden on my family. They have their own lives to lead and I know from when I was working it is pretty difficult. My husband and I, we had my mother living with us and his father living about three-quarters of an hour away and I used to go every Sunday to see him knowing that my washing hadn't been done and my ironing hadn't

⁴⁷ I met Susan shortly after the death of her husband. Over the three years I interviewed her, I observed Susan's transition from a lonely, burdened caregiver to a woman who regularly attended theatre, dinner, church, and club meetings with friends. Sadly, during those two years, her health declined significantly.

been done and I was back to work on the Monday. I am determined not to get into that mindset.

After years of estrangement, the last four of which she spent caring for her terminally ill husband with no help from her son, his offer to have her live in his home was meaningless.

I have just had a security system installed in my house because I believe it will help me maintain independence. I did this despite the fact that I've actually been invited to go and live with my son. In fact, there's a flat being prepared for me just in case I change my mind, but the way I feel now, I'm not going to change my mind because there's nothing up there for me. I couldn't even use my scooter because there are no pavements, there are only country roads and I wouldn't feel safe. In any case, there would be nowhere to go. I could go outside and have fresh air, but that would be it. Basically, you're on your own in this life and you've got to draw on your own inner strengths.

Nor were retirement communities or nursing homes an option. From Susan's perspective, life in these environments was incompatible with her well-being; they were, she said, like 'chalk and cheese'.

When you live in a home, you're not independent and you've not got the same self-esteem. Self-esteem enters into it because some nurse comes in and talks to you as though you're a two-year-old. 'Time to have your bath now,' and 'Are you ready dear?' You might rebel for the first twelve months or so, but in the end, it's easier to give up. I've rejected that, and as far as retirement communities are concerned, when I see the adverts and that, people on the bowling green and them swimming – you know you probably see a dozen people dotted around, but how many are in the confines of their own homes not knowing what their neighbours are thinking? I don't know whether I'm right or wrong, but I think that retirement villages would be very lonely places.

Maisie Harrison's son and his family lived within a twenty-minute drive of her flat, but they were almost completely lacking in interest in Maisie's well-being.

I usually see them about once in six weeks for about two hours. The last time they visited, it was a pouring wet Sunday and they just came walking in the door. I said, 'Oh hello, you've arrived.' 'Yes', my son said, 'You're lucky to see us. If it was dry, we would have been away at the cricket field, but it was so wet we decided to come and say hello.' They won't phone me. I've told them, please phone me if you can't come or phone me if you will come. They say, 'What's the sense of that? We don't know

what the weather is going to be.' So, I wait at home every Saturday and Sunday so as not to miss them. It hurts sometimes.

Their disinterest had led Maisie to look to neighbours, church friends, and faith in God for emotional and social support. Although she claimed to have dealt with the emotional bleakness of her relationship with her son and his family, her words indicated otherwise.

I would so like for them to say one day, 'Mom, we're going to a concert. Would you like to go with us?' But they've never ever done that. They did promise before I moved here that they would take me places with them and that I could go down and stay overnight. It has never happened. It is hurtful, but there's no sense me killing myself because of somebody being like that. I've got to get over it and look down on it rather than look up to it. I think it does you good from time to time to talk about things, but I wouldn't dwell on it. Don't think for one minute I would let it bother me in the slightest. I've had to put a shield around me over that kind of thing.

Allison Turner, then at the end of her battle with congestive heart failure and end-stage emphysema, appeared to accept that the relationship she had with her children would not change.

Our son has gone to Australia for good. I know I shall never get there to see him. I can't do too much now. As far as our daughter and granddaughter are concerned, well, we see them every month or six weeks, but we would like to see them much more often.

Anika Struthers, for fear of severing the remote relationship she had with her daughters, put emotional distance between herself and them.

If I have something I need to talk about I don't go to my daughters, I go to a friend. I do not want to constantly talk about myself or tell them about my worries. It would get so boring and then they would start disliking me. I don't want to think they are saying to themselves or to others, 'Oh there she is on the telephone again moaning about things.'

Reciprocal Relationships and Participant Well-Being

Fanny Gage's daughter Janet was an outstanding example of an adult child who on the one hand was a hands-on caregiver for her mother (with outside help from a paid home health aide), but on the other hand, left her mother free to manage her own affairs. Janet supported her mother's decision to live alone in her own flat and helped to make it

possible, even though she herself was unsupported by her husband, who espoused the belief that the “easiest thing for us all” would be to have his mother-in-law placed in a nursing home. Janet never gave in to that pressure and as a result, Fanny experienced a great deal of satisfaction and well-being from living in her own home, surrounded by memories and pictures of her past. She also trusted Janet and although her decisions were independently made, she seldom made a decision without listening to Janet’s appraisal of what was best.

My daughter is marvellous. I don’t know what I’d do without her. I’d have to go into a home. It’s nice being able to stay here. I’ve had lovely neighbours and we’ve had a lot of fun. You know, they have all been so nice. There was an English couple and a Dutchman who lived right next door – he was quiet, but he was a good neighbour. The English couple and I had a lot of fun. We used to go to meetings together – yes, I’ve had a lot of fun here in my little flat.

Like Simon Burgess, Edna Holt found that being Maori meant greater social involvement in her old age, and a very much reduced likelihood of having to enter a rest home. When Edna recovered from her husband’s death, she became engaged once more in family responsibilities. She began by inviting an adult granddaughter to live with her. A result of this living arrangement has been the development of a warm and caring relationship between the two women that has increased Edna’s sense of well-being. Edna describes their love in words that are far different from those she used to describe her pain and loneliness after the death of her husband:

When I haven’t been well, she’s always been there for me. She loves me and looks after me. I turned seventy-seven not long ago. I went to bed the night before and never thought about my birthday, because I don’t think about age anymore. I got up early in the morning and my granddaughter and the two young ones that live not far away, they were already up and they were acting strange. I had to stay out of the kitchen until they called me to come. Well, the kitchen was all decorated with “Happy Birthday Mum” banners and cards. They had baked a cake and made breakfast, too.

In addition to the relationship she cultivated with her adult granddaughter, Edna also became extensively involved with her daughter's two young children; she brought a loving stability and consistency to their lives, which because of their mother's drug addiction, they lacked. In turn, they provided a new sense of purpose to her existence:

I'm not really ready to go yet. Sometimes I feel ready, but I want to be here for these two mokopunas. I want to be here in case something happens with my daughter. It happens – it has happened. I haven't had the kids for a couple of days, I'll get a call from them, and they'll say, 'Nanny, we need to come down.'

When problems of physical frailty, short-term memory loss, and transportation made it difficult for Edna to attend the marae as frequently as she once did, she turned her home into a happy, busy meeting place. In fact, the taping of her interview was an event attended by cousins, grandchildren, old friends, and several neighbours. At the end of the interview, she summarised her life and expressed satisfaction with its outcome:

You know, the Maori in my age group were poor. We had nothing, but we made our own fun. No one was better than the other; we were all mixed up together as though we were one. My husband I had but one child of our own. She died. She died as a baby and so we adopted six children. My life hasn't all been good. There were bad times, but I can put it this way: I've been happy.

Sarah Hunter was also a Maori woman. Also like Edna, Sarah was a key figure in the lives of her children and grandchildren. Widowed for two years, she was not a stay-at-home, lonely widow. Her life was full of activities and responsibilities; it required a high level of stamina, endurance, and determination. Our meetings were held over a three-month period during which she was caring for a sick daughter, that daughter's eight-year-old daughter, and managing their home, doing the cooking, cleaning, and laundry. She had returned to the North Island for this purpose, leaving Australia and the home of a son whose troubled relationship with his teen-age son had led to a crisis in their family. Shortly after our last meeting, she departed for the home of another son whose nineteen-

year-old daughter called to say her grandmother was needed there. Sarah's responsibilities should not be misconstrued as mere care giving or childcare activities; she was carrying on the traditional role of grandparents in Maori society, and she was a figure of authority in the way that her grandparents had been before her.

I was brought up by my grandparents. I was disciplined. The things they taught me served me well as I grew into my teen-age years. Several of my friends got pregnant; but I was taught never to be immoral. My grandmother taught me about how my body would change and my grandfather taught me the man's point of view. What they taught was good for me. I must also tell you this: we worked hard. My grandfather had pumpkins, corn, and kumuras that went for miles and his grandchildren were the workers.

As Sarah grew older, her mana increased.⁴⁸ This was so much the case that when disagreement occurred between Sarah and her children, Sarah's views prevailed. Maori individuals have traditionally reached the peak of their value to society at the end of their life course. Imbued with mana granted to them by the roles of kuia and kaumatua, and by the fact that their advanced age places them in close proximity to the ancestors, for generations Maori elders have enjoyed increased rather than diminished respect and honour. This was the position Sarah occupied.

I am that person who keeps the grandchildren on track. I try not to step on my children's toes, but we clash at times because I am a buffer for the grandchildren. I say they need grandparents like those that I had when I was growing up. A few years ago, at a gathering of the whole family, I said to my grandchildren – in the presence of their parents – if you ever need anything, I'm only a phone call away. That phone has hardly stopped ringing over the years. If anyone wants to ring me, I'll be there. No, I don't tread on my children. They say I'm needed; only I can fix the problems.

⁴⁸ Mana, defined as prestige, power and dignity (Robinson & Williams, 2001), is not static. It grows or diminishes as a result of the actions of an individual and as a result of the attitudes of other people towards that person (Middleton, 2003).

In her role as a grandmother, Sarah had counselled and taught fourteen inquiring grandchildren. From her they had learned their whakapapa and obtained their knowledge of Maori history; as their grandmother and the oldest living member of her family, she was a storyteller and a link to their ancestors. In her life review, Sarah talked about her well-being in old age:

I'm not ashamed of being old. I've seen things in my lifetime that were good. I've also seen it when it was bad, but the bad times were a learning process. I learned how to get through them and taught my children and grandchildren not to fall into the same thing. For me now, I'm happy I'm old. I'm seeing the results of my work and I enjoy it. I see it going on in my children and my grandchildren. No, I don't mind being old. It's like going to a movie. I see a kaleidoscope just in front of me – the things I did wrong, and those that I did right. I see my children growing up and I am proud. I see my grandchildren, the image of what I once was, and that sometimes makes me cringe, but it also makes me happy. I can see a part of me in all my fourteen grandchildren.

At the age of one-hundred years, Annabelle Gregson spoke of her family in a way that left no doubt of its importance to her well-being.

On the television set over there is a picture of my oldest sister; it was handed out at her 100th birthday party and I was able to go. We sisters stuck together for a long time. We all had such a good life and enjoyed each other. My oldest sister passed away at the youngest age. She was eighty-six. My youngest sister lived to be ninety-one, and another sister lived to be a hundred and one. We all lived in different places but we all just had a wonderful time together. They would come here and I would go see them. Now, I have my daughter. We never have had any trouble getting along. We can see things alike. She really takes good care of me. She lives close by and comes nearly every day. On Sunday someone always takes me to church. I have happy memories and I have good dreams. I often dream about my husband. We had a good life together. I dream about my family, too. I'm happy to be alive and to be my age.

When I met eighty-two-year-old Sally Dickerson she was living in a small flat in a retirement enclave thirty kilometres from the home in which she had lived for thirty years. Her move from the family home to a flat in a new community had been influenced, but not forced upon her, by her two sons and daughters-in-law. Unlike Mabelle Armstrong and Robert Gordon's children, who had taken charge of their

parents' lives, Sally's two sons presented their reasons for believing she should move into a smaller home, located closer to where they lived, but they left the decision itself to Sally, reassuring her that they would support whatever decision she made in the matter.

I had been lying in hospital for a long time when one of these flats came up and the manager of them came to see if I would take it. I told him to put my name down and I would talk to my sons and daughters-in-law about it. Which I did, but then I changed my mind. I had a big house and I did not see how I could pack it up, or get rid of the terrific amount of stuff that would not have fit into this small flat. However, unbeknownst to me, the manager later rang my son and he, my daughter-in-law, and my best friend went and looked at this flat. The next day they came to see me to say that they had decided that it would be good for me to take it. I thought about it for several weeks and came to believe that they were right in advising me to sell my house and move. Fortunately, the flat was still available. My sons quickly made arrangements for two people to come around and clean up the flat from back to front. They measured up for carpets and had the curtains shortened. They just took over. They did all the work, they did the lot. They thought that I'd be better off here and they were right. This is where I've been now for over twelve years and I love it. I love the people here.

The Importance of Social Support to Respect, Worth, and Well-Being

Without exception, the participants talked about the importance of friends and family as a means of achieving and maintaining well-being. Some spoke of the happiness they derived from the support of their families and friends; others of their lack of familial support; they all expressed a deep need to be of worth, to be respected, and to play a significant role in the life of someone dear to them. The participants' descriptions of social support, and its importance to their well-being, are similar to those of researchers. For example, Bowling, Farquhar, and Browne describe social support as an interactive process by which individuals are able to obtain emotional, instrumental, and financial aid from their social network (as cited in Bernard, Ogg, Phillips, & Phillipson, 2000: 26). Cobb's description of social support, written thirty years ago, is particularly pertinent to the participants' perceptions. First, Cobb states, social support leads individuals to feel loved and cared for. Secondly, it causes individuals to believe that

they are valued and esteemed, and thirdly it informs them that they are members of a network of communication and mutual obligation. Cobb further agrees with the participants' statements regarding the critical nature of social support by suggesting that it can protect people in crisis, reduce the amount of medication when it is required, accelerate recovery, and facilitate compliance with healthy lifestyles (Cobb, 1976). Although social support is not directly included in the definition of successful ageing, Rowe and Kahn do address the subject in their book. They have this to say:

Social support carries many meanings, including such factors as information, trust, care, love, esteem network membership, and mutual obligation. In general, two kinds of support are important for successful aging: so-called socioemotional support and instrumental support. Socioemotional support includes direct expressions of affection, liking, love, esteem, and respect. Instrumental support involves hands-on assistance in some activity, such as care when ill, help with household chores, providing transportation, loans or gifts of money, and the like. The first kind of support – emotional – is extremely important for successful aging. The second is sometimes less so ... (Rowe & Kahn, 1998: 158).

This passage identifies a link between successful ageing, social support, respect, and worth. Very similarly, the participants confirmed a link between well-being, social support, respect, and worth. The major difference between the concept of successful ageing and the participants regarding the importance of social support to the quality of life of older people relates to the degree of significance attached to it by each. The focus of the concept of successful ageing is the avoidance of disease and disability, placing the greatest emphasis on variables relating to physical health.⁴⁹ In doing so, it effectually

⁴⁹ The book *Successful Aging* confirms the significance the concept of successful ageing places upon physical health in old age. In chapters entitled "The Structure of Successful Aging", "Usual Aging", "Nature Versus Nurture in Aging", "Avoiding Disease and Disability in Late Life", "The Role of Exercise and Nutrition in Maintaining Health, Beyond Exercise: Strategies to Maintain and Enhance Physical Performance in Old Age, and Productivity in Old Age", a Western doctrine of 'successful' old age through health and productivity is promoted.

reduces the importance of social support, and thus, of respect and worth to 'successful' ageing. The focus of the participants, on the other hand, was upon establishing and maintaining strong, positive social relationships as a means of securing respect, worth, and well-being. While they strove to achieve the highest level of health possible, given their circumstances, their well-being was not mostly defined by their physical conditions.

Until her transfer to a nursing home at the age ninety-eight, Mabelle Armstrong had strong social support. A member of the RSA (Royal New Zealand Returned and Services' Association), she had been publicly honoured for thirty years of work and leadership, she was active in several clubs, and had a circle of friends with whom she attended clubs, theatre, dinner parties and church. And then, institutionalisation removed Mabelle from the source of her social support and it had a devastating effect on her well-being. Looking back on her old life Mabelle said, "So I got by on the money I earned and I was quite happy." Of her present life in the nursing home she says, "When I came here I didn't know anybody. I was so very lonely. I still am. I miss my old life and my friends." Robert Gordon's position paralleled Mabelle's. His placement in the nursing home isolated him from his social support system. Old friends could visit only rarely, and he was cut off from former activities. During the years that I visited Robert, he never once left the nursing home. Except for Mabelle, he lived among severely demented residents whose babble he commented once, "drives me crazy."

In their interviews, Edna Holt, Sarah Hunter, and Simon Burgess spoke of the depression they experienced immediately after the deaths of their spouses; but they were Maori and they had continued to have important responsibilities to family and tribe, which as older people, only they could discharge. In fulfilling these responsibilities, they left their depression behind and felt themselves as being respected, worthwhile members of their communities. Simon's life at the time we met was a confirmation of research findings that social support and participation can protect people in crisis, accelerate recovery, and reduce the need for medication. He described his life following the death of his wife as aimless and unhealthy; he had two emergency hospitalisations and began taking prescription drugs to prevent further episodes. However, Simon saw the challenges on his marae – young men and women were looking for leadership – and he responded to the call of those challenges. During his interview, he told how he no longer needed medication for survival, he had recovered from the health problems that had hospitalised him, and being no longer depressed, Simon was able to counsel and help others.

There was a stark contrast between the social support of the Maori participants, which is composed primarily of family and tribe, and that of non-Maori participants such as Maisie Harrison, Anika Struthers, Susan Eyres, Jacob Traub, and Estelle Doherty, who received little support from their families. Although Anika reported that her relationship with her daughters was improving, she was careful not to talk to them about her health problems and her loneliness, or about the fact that she had recently begun a romantic relationship with a neighbour. Anika said, "My daughters would not understand. If I talked about these things it would drive them away." Anika was able to keep the circumstances of her life hidden from her daughters because they lived a considerable

distance away. On the other hand, Maisie and Susan each had a son, and Estelle and Jacob each had a daughter living within a few kilometres of them who were poorly informed of the circumstances of their parents' lives because they chose not to be involved. Because Anika, Maisie, Susan, Jacob, and Estelle could not rely on their children for social support, they had built strong social support systems for themselves through membership in church and senior citizen organisations and by involvement in community activities. Active engagement in church, clubs, and community provided them with networks of friends; these networks were reciprocal and they supplied the respect and worth necessary for their well-being.

The Importance of Social Engagement to Respect, Worth, and Well-Being

There is general agreement among researchers that continued active engagement with others ameliorates the imposed losses and changes that occur in late life (Baltes and Baltes, 1990; Rowe and Kahn, 1998; Vaillant, 2002). The successful ageing concept attempts to promote social engagement by assigning to older people relevance, responsibility, respect, and worth (Fisher & Specht, 1999; Kaye, Butler, & Webster, 2003; Bambrick & Bonder, 2005; Okamoto & Tanaka, 2004) – the very qualities that define the mana of the Maori elders in this study. However, these are qualities not generally assigned to elderly people in Western societies. As explained by modernisation theory, relevance, respect, and worth of elders occur when society, by collective opinion, values and esteems them. Many years after his fieldwork amongst the Galilean and Golan Druze, Gutmann made these comments regarding the relevancy of the elderly:

... I learned that – contrary to the claims of Cumming and Henry (1961) – disengagement is not the natural condition of the elder but an aberration brought on by the secular nature of advanced societies. Where there is a traditional consensus alive among the people, the elders will be its

spokesmen and its living face; they do not disengage. Instead, they sponsor, in special ways, the social engagement of the younger adults (Gutmann, 1997: 65)

There is a major distinction between Western and Maori ideas regarding engagement in old age. The Maori participants are so important to the well-being of their families that they are obligated to be engaged in community affairs (Durie, 1999), whereas a majority of the Western participants, being deprived of a meaningful role within their families have had to look outside their families for meaningful social engagement. This is the same difference noted by Robinson and Williams (2001: 54-56) when they compared European and Maori concepts of social capital, the resources available to individuals through their membership in social networks. In Maori society, the foundation of social capital was obligation to the extended family based upon shared ancestry and cultural rules that oblige individuals to behave in the ways defined by Maori protocols. In contrast, in European society the foundation of social capital were organisations and networks outside the family characterised by rules rather than obligation. Thus, in Maori society, elderly individuals are obligated by tradition to lead and younger generations are obligated by tradition to respect and esteem them, while in Western society, elderly persons must often look to voluntary, community organisations unconnected to their families for social capital.

The effect of these cultural attitudes upon the respect, worth, and well-being of older people is clearly stated throughout the interview data, but particularly in the data provided by Simon Burgess, a Maori, and by Mabelle Armstrong, a participant of English descent. Simon, on the one hand, ascribed the mana of his old age to his role as a kaumatua, saying simply, "I'm busy and I'm happy with my life and that keeps me going." Mabelle, on the other hand, ascribed her unhappiness to the lack of a meaningful role within her family, saying, "When my children placed me in this institution, they

stripped me of all usefulness and I became obsolete". In other words, Simon was respected and esteemed, and his life had worth; Mabelle was not respected and she felt her life to be of little worth. Keeping in mind Simon's simple comments regarding the happiness he was experiencing in old age, Mabelle's words provide a further contrast.

We were brought up to treat old people with great respect. I taught my children the same thing, so I can't understand why I am being treated with such contempt. Not long ago I tried talking to my son about this. He got a very strange look on his face and he said to me, 'You're a silly old woman.'

Mabelle had a brother who married a Maori woman. One day as she spoke to me about his life she contrasted the place she occupied within her family, with her brother's position in his family. This is what she said:

I have a brother whose life is very different from mine. Forty years ago, he married into a Maori family and now that he is old, they respect and value him. The Maori people are wonderful to their old people. Not long ago he wrote to me and he said, 'I think often of you. I could not do what you are doing. I'd rather stay in my own home where I am loved and respected and I know you would have preferred to also. I think I can understand what you have given up in order to live there'.

Strong social support was critical to the well-being of the participants in this thesis. It is central to this thesis. Social support was directly related to the participants' perceptions that they were important to their families and communities, that they were respected, loved, and valued, and that their lives – despite disease and disability – were worthwhile.

Conclusions

The introduction to this chapter suggested that the concept of successful ageing lacks a critical source of data – the viewpoints and real life experiences of elderly people. The discussions in this chapter are the result of statements made by individuals whose perspectives were influenced by their Jewish, Maori, Cherokee, European, New Zealand, American, and immigrant backgrounds. 'Successful ageing' was conceptualised by scientists in western, liberal nations of the twentieth century. It defines 'successful

ageing' from a Western perspective. Thus, it lacks input not only from elders, but also from other cultures.

The difference between the participants' inclusive, and the successful ageing concept's exclusive treatment of respect and worth to well-being in old age, and of the role of adult children, social support, and social engagement in helping older people experience a sense of respect and worth, is therefore not surprising. The participants have related their personal struggles to retain respect and worth; the successful ageing concept relies on the knowledge of scientists and researchers, many of whom have not experienced old age personally. As a result of not being attuned to what elderly people have to say about old age, the successful ageing concept often misses the significance of factors such as familial relationships, social engagement, and social support which contribute to respect, worth and well-being. The following two excerpts from *Successful Aging* demonstrate this point. First, the quote below is an acknowledgment of the importance of social support to 'successful' ageing:

In the domain of human relationships, MacArthur and other research has validated, and in its own way deepened, the insights of everyday life. The linking of social relationships to longevity, the discovery that social support lies at the core of those relationships, and the special role of social support in aging have been gradually, but unmistakably, demonstrated (Rowe & Kahn, 1998: 152-153).

However, the primary theme of the successful ageing concept – the avoidance of disability and disease in old age – is so important to the overall concept that other factors of equal or greater significance to well-being are diminished. The following excerpt, taken from a discussion of the components of successful ageing illustrates this point.

Although active engagement with life is included as a component of 'successful' ageing, the critical component is clearly the absence of disease and disability. The absence of disease and disability makes it easier to maintain mental and physical function. And maintenance of mental and physical function enables (but does not guarantee) active

engagement with life. It is the combination of all three – avoidance of disease and disability, maintenance of cognitive and physical function, and sustained engagement with life – that represents the concept of successful aging most fully. Furthermore, each of these components of successful aging is itself a combination of factors. Avoiding disease and disability refers not only to the absence or presence of disease itself, but also the absence or presence of risk factors for disease and disability (Rowe and Kahn, 1998: 39).

Successful ageing, the ‘new gerontology’, which began with a goal of redirecting the focus of gerontology away from disease and disability to the factors that permit people to function effectively in old age, has reached a stalemate. It has limited its range of effectiveness by applying only Western values to its definition of optimal old age. It has handicapped its ability to see great significance in factors others than those that relate to avoidance of disease and disability; and it has discounted essential ingredients of well-being – respect, worth, social support, and social engagement – because it ignores what elderly people have to say.

CHAPTER 12

INDEPENDENCE AND WELL-BEING IN OLD AGE

Introduction

Independence and the value placed upon it are culturally defined and accepted by many older individuals in mainstream liberal western societies (Stephenson, Wolfe, Coughlan, & Koehn, 1999; Cardol, DeJong, & Ward, 2002). The 'successful ageing' concept regards independent older people as the most successful. However, there are also strong social norms for providing care for older people even if the receiving of care is against their will. Thus, the ability of elderly people to remain independent is affected by cultural norms and individual circumstances (Schulz & Heckhausen, 1999). The experience of Lydia Nichols, an elderly widow relocated from her home to a long-term care facility in the city where her son lived, is a case in point. Lydia's relocation occurred as a result of community-wide complaints to her son that she was wandering late at night in the small town in which she was living. Eventually, under continued community pressure that he take action to protect his mother, he removed her from the home in which she had lived for forty-five years and placed her in a long-term care facility. During the time of my visits to the facility, Lydia was refusing to take her medication, to eat her meals in the dining room, and to participate in recreational therapy. She was not thriving. Lydia's removal from her home is a dramatic example of the importance of independence to the well-being of many elderly citizens of liberal western societies.⁵⁰ It was certainly a major theme in this study. Independence (in the

⁵⁰ In the introduction to his insightful book *Dependence and Autonomy in Old Age: An Ethical Framework for Long-Term Care*, Agich makes the comments below. They point out the complexities involved on the one hand, in loving and keeping frail elders safe,

sense of not being in a care home) was seen as valuable, by each of the participants. For the Maori people who took part, it was interdependence that was valued, as they saw themselves as actively involved in their whanau. The West Texas participants who were respected and admired, were those who despite their very advanced ages, were most independent. In the United States, the Florida Policy Exchange Center on Aging, an organisation that supplies policymakers with information on policies, programs and services for older Americans, emphasises the importance of autonomy to maintaining a sense of self in old age:

Why is autonomy important? What is the rationale for the claim that autonomy has primacy among the values we use to shape long-term care policy and practice or any other policy involving vulnerable persons? What is autonomy for? I would argue that autonomy is an essential condition for the sense of self(ness) in modern society (Florida Policy Exchange Center on Aging, 1997).

As Lydia's experience informs us, and studies in liberal western nations confirm, the loss of independence, personal responsibility, and control over daily life choices,

and on the other hand, protecting their sense of self, and need for autonomy. They are particularly pertinent to the circumstances of Lydia Nichols, Mabelle Armstrong, Theresa Landman, and Robert Gordon who were each institutionalised against their wishes when their children decided for reasons of safety, that they could not live alone.

Autonomy and long-term care are a remarkably paradoxical conjunction. Individuals need long-term care because they suffer illnesses and incapacities that compromise their ability to function independently or to choose rationally. Yet the standard concept of autonomy in bioethics stresses the ideals of independence and rational free choice, ideals that appear ephemeral in the face of the wide range of impairments that cause individuals to need long-term care. No doubt such individuals are vulnerable and so might benefit from the protection afforded by various autonomy-derived rights such as noninterference. The paradox is that the underlying concept of autonomy involves a view of persons as robust and independent, whereas the reality of long-term care shows individuals who need support and companionship, needs that seem inimical to this ideal (Agich, 2003: 1).

decreases well-being in old age, (Dacey & Newcomer, 2005; Sabin, 2005; Aud & Rantz, 2005; Denby & Godfrey, 2004). To understand the participants' definitions of independence and its importance to their well-being, we turn first to Anika Struther's interview data.

Defining Independence

Anika Struthers was born and educated in Holland. Her definition of autonomy was shaped by her experiences as a young girl during World War II when movement was restricted and dangerous; and after the war, by the limitations placed on her freedom of movement because of her status as a single, young woman teaching primary school children in The Hague. When I met Anika, she was in good health but because of very poor vision, was prone to stumbling and falling. Although her falls had not resulted in serious injury she was worried about the negative impact that broken bones and immobility would have on her lifestyle. As we see from the following excerpts, Anika's definition of autonomy included the ability to move about freely and easily.

My biggest fear is to break a leg and be forced to stay at home. If I could drive, I would just get in my car and go see my old friends, people that I still keep in touch with, but haven't seen for years. I had a bad fall the other day and I was dead happy that nothing happened to me, that I didn't break a leg. I've had a few falls since I came into the village three years ago and every time I came out of it with nothing wrong. The footpaths are a bit uneven and I'm not always watching where I am going. The fact that I do not drive is for me a great problem. I get a lot of lifts, but I wish I could just pop into my car and go anywhere I like. That is my biggest trouble.

Eileen Richards' comments reflect the loss of choices and opportunities for a social life once independence is gone. Eileen's life had been characterised by independence. It had been an inherent part of every stage of her life course: as a young girl, she had participated with her parents in family decisions; as an adult, she had never married, and instead made her own way through life; in very old age, she remained fiercely independent. Furthermore, self-sufficiency was so important to Eileen's concept of well-

being that she had little respect for the dependent, helpless women who lived in her retirement community.

I think that life experiences throughout our years play quite a big part in the shaping of our old age. Where you have people who have been obliged, through the experiences of earlier years to take control of their own lives and possibly to look after others, there you have a background of mental, emotional and psychological development that leads away from the mental laziness, which is tantamount to a death sentence mentally. I can give you instance after instance of women who have been widowed fairly late in life who literally do not know how to write a check and haven't any concept of how to live because a husband has babied them from the word go.

Eileen's comments reflect the lack of respect endured by older women in particular, if they are not independent. Unlike older married men, who can regard it as normal to be provided with meals, washed clothes, and clean sheets, for women there is shame attached to being a care receiver.

The Role of Mobility in Retaining Independence

The importance of mobility to independence is a major theme of Susan Eyres' interview data. Having battled physical disabilities since infancy, Susan understood what the loss of mobility would do to her well-being.

I know that my mobility might let me down shortly. I'm not being pessimistic. The only method of transport I am using now is my scooter, getting in and out of most cars is too difficult. It's not only my balance, I am walking with much difficulty and thinking of ways to make my everyday life better if I am to stay in my own home. I hope that I can get the help I need. I'm quite prepared to pay for it, but I'm not very sure of my finances at the moment. Yes, I can see the time when I will probably have to be taken into care, but I'm going to stay here for as long as possible.

For Susan, there were vital connections between mobility, independence, and well-being.

My determination is to stay here. This house is paid for. It's within my means. The daily running of it, the monthly outgoings, they're within my means. So why would I change? That doesn't mean to say that I'm not a bit scared of the future. I'm not saying that. But I'll deal with the future

when it comes. Right now, I'm simply doing everything in my power to keep myself independent.

When Maisie Harrison's health deteriorated to the point that she could no longer walk the one kilometre from her home to the village shops, she purchased an electric scooter. When she did so, she acquired a new set of problems, not the least of which was mastering the use of an unfamiliar machine. Maisie's flat did not have a garage, and because her scooter was likely to be stolen if she left it outside, she drove it around to the back of the house and into her bedroom through a sliding glass door. This procedure secured the scooter, but in such a way that, in order to exit with it, she had to turn it around in a small room filled with furniture. Using the scooter was therefore no small undertaking. First, she had to repeatedly back up and turn until it faced away from the bedroom and towards the sliding glass door – a procedure made more tortuous by chronic back pain.

I haven't been able to get out lately on my scooter because I haven't been well enough. You see, I've got to have the strength to start it and bring it around and get it out the door. If it's too much to one side, I start again and do another wee bit and carry on like that back and forth getting it out.

Maisie's usual outing on the scooter consisted of going into the village to visit the post office, pharmacist, market, and village park to feed the birds. To reach the village, she had to cross the major thoroughfare leading into town. Traffic was heavy and fast-moving and there were no traffic lights at which she could cross; neither was there a safe crossing zone nearby. Maisie typically crossed the first lane and entered the turning lane in the middle of the road where she remained until a break in traffic occurred and she could safely complete the crossing. Because her scooter had stalled out several times, she was especially fearful that one day it would do so in the process of crossing the busy thoroughfare.

One day I called the scooter company to tell them I was having trouble with my scooter and the next day a big gentleman from the scooter

company came to my door. He must ha' been six feet tall, weighing fifteen stone, and he said he understood I was having trouble with my scooter stalling out and not starting. 'Well, he said, 'We can't have you spread like mince meat all over the road out there, can we?' I didn't think this was an appropriate remark; he just glossed over my problem, didn't he? Anyway, he got on the scooter and it started up right away. So then he said, 'Let me show you how easy it is to get this scooter out your bedroom door.' So he picked up the front of the scooter, aimed the wheels and steering bar at the glass door and drove through it. What a useless demonstration. I mean, I don't weigh seven stones, I am not even five feet tall and I have a bad back. It only made him look big and strong and me old and weak.

On two occasions, the scooter had broken down in the village. The first time, she had been rescued and taken home by a local mechanic. The second time, her scooter stopped five or six times during the trip back home; it took her an hour to traverse the one kilometre between the village shops and her apartment.

Maisie's experience may be an extreme example of the problems that electric scooters present to their elderly owners; she had far more difficulties with her scooter than Susan Eyres who, because of polio, has been using a mobility scooter for more than twenty years. No two people are the same in terms of age, physical condition, mechanical aptitude, and driving experience. Scooters are by no means a complete or problem-free solution to immobility. In Maisie's community, for example, an elderly woman on a scooter had been hospitalised after being struck by an automobile. Local merchants had complained about the congregation of elderly people outside their shops talking and visiting with each other on their scooters, and about the parking of scooters on sidewalks in front of their shops. Because of their complaints, the local council was considering a petition calling for the banning of scooters from village sidewalks and footpaths.

In modern western societies, mobility has become so synonymous with driving, that in nations such as New Zealand and the United States, where public transport is inadequate, people of all ages who do not drive face a big problem in mobility. The automobile has become so important that with the loss of the ability to drive, the lives of independent,

highly mobile, and autonomous elders can be quickly transformed into isolated dependency. Eighty-six-year-old Jacob Traub is an example. Widowed and estranged from his only child and from his church friends, his automobile was the primary means by which he was able to remain a part of the world outside his home. With his automobile he reached museums and libraries, searched for a new church home, met friends for lunch, and continued his volunteer activities; without a car, he would be isolated and alone. At the time of our interviews, Jacob had recently received a series of tickets for driving violations: speeding in residential areas, weaving in and out of lanes, failing to stop at a stop sign, and driving under the speed limit on the freeway. His driving skills were apparently deteriorating, but he could not acknowledge his declining ability to drive.

Thanks to the local police, I've racked up almost the limit of points on my driving license. Any more tickets and I'll lose it. I don't know why the cops think I'm such a lousy driver. Why don't they concentrate on taking the criminals off the road instead of stopping a guy like me who pays his taxes, doesn't hurt anybody and only tries to help society? If they try to take my license away, I'll take them to court.

At some point in the ageing process, many western elders find themselves confronted with a continuing need to drive, but an inability to navigate the fast moving traffic and the distances they must drive in order to reach shops, markets, doctors, and social services. When this dilemma results in the loss of their automobile and driving license, it can have a demoralising impact on the way they view themselves and the way they are viewed by others. In addition, when it is accompanied by decreased sensory perception, disease, weakness, and lack of endurance, many fulfilling activities and necessities of daily living are made difficult and even impossible. Younger friends and family members, who are active and busy with midlife activities, may forget that the elderly man or woman sitting home alone is dependent upon them for simple needs. When they do remember, it may be easier for them to pick up the milk and bread and deliver it, not

realising that they have fulfilled the basic need, but not the emotional, psychological need of the old for companionship, an interlude in the world of independence they once occupied.

Theresa Landman, an eighty-eight year old South African woman who moved to New Zealand three years ago, talked about the events that led up to the loss of her driving license. As she told the story those two losses were followed by further loss in independence.

I had a car for twenty years and then one day three men tried to throw me out of it. They got really vicious you know. I was only saved because other motorists saw what was happening and stopped to help me. Well, the kids were living in New Zealand, and my husband had been dead for some years and they said to me, 'Mom you're not to stay there anymore. We're all here. If you get sick or you are injured we can't come out to South Africa you know.' So I decided to sell up and come here. Now I am so bored. I don't have a car and I can't walk very far now. You know, I think all we do in this nursing home is to eat.

As defined by the Euro-western participants in this thesis, autonomy included freedom of movement, freedom of choice and action, and freedom from external control. Their definition, and the high value they placed upon it, reflects the opinion held by a majority of citizens in the western societies in which they live (Higgs, Hyde, Wiggins, & Blane, 2003; Torres, 2002; Westerhof, Katzko, Dittmann-Kohli, & Hayslip, 2001; Davies, Ellis, & Laker, 2000). In these societies, where old age is often accompanied by a loss of social status and respect, retaining freedom of action and independence despite advanced age becomes especially important to well-being. As Mabelle Armstrong said about her loss of autonomy,

My children treat me more and more as though I am unable to carry on a conversation. Their talk is so false; I mean, it is nothing like the conversations we used to have when I had my own home. And the people who work here, well, they treat me as though I am inferior. They talk down to me. Even one or two who are in charge do it. You see, I have been used to people, if they are going past, recognising me, whereas here, they just act as if they don't know me. I used to hear people say, 'Never get old,' but I never thought it would be like this.

In comparison to the Caucasian participants, the Maori people who took part did not link independence to well-being. Instead, their sense of self, identity, and well-being, was drawn from the interdependence that characterises traditional Maori society. Throughout the life course, as children, adolescents, young and middle-aged men and women, their families and tribe had encouraged and sustained them, and they in turn, sustained their families. As Emma Parker said, Maori females have kinship and marae duties to fulfil at every age of life. Thus, at whatever life stage they are in, within Maori society they are both supported and supportive. This is the interdependent nature of Maori society, which the event of old age does not end.: indeed, their mana tends to increase. As the needs of Maori individuals change with age and the type of support they require changes, just so their responsibilities change and often grow with age. Maori elders have social responsibilities, which only they can fulfil.

The attitude of the two Western Cherokee women participants towards autonomy was ambiguous and the meaning they placed upon it more difficult to describe. They valued kinship and interdependence, but it was not a part of the world in which they had experienced their adulthood. They had childhood memories of their extended families; they remembered that their grandmothers were respected clan leaders, healers, and storytellers. They realised what has been lost, but there was no way to retrieve it because their kinship ties had been severed. In the real world of their old age, autonomy was preferable to dependence upon those who represented mainstream culture. If they had lost their capacity to live independently, their only option would have been a move into a Medicare long-term care facility. For this reason, the ability to reach shops, banks, doctors' offices, and chemists, was particularly important to both Harriet and Estelle; mobility allowed them to remain in their own homes. When Estelle's fifteen-year-old automobile had recently broken down, she was so concerned that lack of transportation

might end her ability to live alone that she borrowed \$2500 from several friends and acquaintances to buy another automobile. With a monthly income of only \$500, Estelle's debt repayment consisted of infrequently written checks of five to ten dollars. Fortunately, Estelle's friends had generally been patient and understanding of her circumstances.

'Independence' in old age is very often obtained with medical assistance. However, medical and social service providers have been inconsistent and often slow in providing services that help to minimise immobility and dependency. Mildred Howard waited nine months for a hip replacement; and the hours of her home health aide were cut during that period of time. Profoundly deaf Fanny Gage waited a year for a hearing aid. Nancy Robinson waited three months to be seen by a cardiologist after she was admitted through the emergency room of the local hospital for chest pain, and she had been waiting almost a year for dentures; Maisie Harrison and Susan Eyres could not utilise the public bus system because the buses in their community have no wheelchair lifts. As regards her failed hip surgery, Sally Dickerson told this story:

It's still a nightmare for me. I can't bend down and getting down to my bedside to pray, and my walks on the beach have been taken from me. It is all gone. Those are the things I miss most of all. The orthopaedic surgeon has signed the papers that it was medical misadventure. He replaced the wrong hip you see and he cut the nerve while he was doing it. People ask me why I don't go after him for money, but look, I couldn't do that. I wouldn't feel good. He didn't set out to cripple me. No one does these things, not deliberately.

At the suggestion of her nephrologist, Maisie Harrison called to see what help she might be able to access from New Zealand social services. This was her account of her meeting with the social worker.

As it had been suggested by the specialist that I needed more help, a social worker came to ask me how I was getting on. She never entered the rooms or anything. She just came in and sat down. She asked me this, asked me that, and how was I getting my shopping done. So I told her that I had to ask the home health aide to take me. 'Och well', she says, 'just

continue asking her and then get a taxi back after you've got all your groceries. That will save you carrying them. Also, you could always phone up the store around the corner and they'll deliver. They're a wee bit dearer, but it's either you pay them or you pay the taxi. You have your choice. I don't think you need any more help. We'll get in touch with you again later.' Ten minutes and she was back at my door again. I had to sign a paper that she had been to reassess me. That was her reassessin' me. Wasn't much good was it? I got absolutely nothing out of it. To take a taxi down and back is eight dollars each way, but I've got taxi chits and I can get it for four or five dollars each way. Still, its money that I need to put to something else. So och, she wasn't the least bit caring.

In one of our taped meetings Mildred Howard told this story of her wait for hip replacement surgery:

The best thing I can do to ease the pain in my hip and leg is to sit as still as possible for as long as possible. Last week I called my doctor and told him that I am in a great deal of pain and I asked him to contact the surgeon to see if he could see me sooner, because my appointment is not for another six weeks. Well he did try, but he called to say that he was unable to get my appointment moved forward. So now he has prescribed pain pills which sometimes I think help a bit and at other times I don't think they do any good at all. Now the ACC has notified me that the hours of my home help have been cut back from four to three hours a week. I don't know how I will manage; it's hard managing now with four hours of help. I depend on the home health aide for bathing, dressing, shopping, and cleaning. I cannot dress myself completely. Putting on socks is impossible and getting into sweatpants is almost as difficult and extremely painful.

These excerpts from Maisie and Mildred's interviews may not be typical of the experiences of other elderly people with health care and social services providers; they may represent extreme examples of a flawed system. Furthermore, it is necessary to remember that the excerpts are subjective memories of what happened. However, because I was visiting Maisie and Mildred regularly during this period of their lives, I witnessed the effect of these events upon their well-being and consequently introduced them as topics of interview discussions. These excerpts are also not intended to portray social workers, doctors, and nurses, as people who do not care about their elderly clients; professional providers work within the limitations of the systems of which they are a part. This discussion is intended to convey the sense of frustration felt by needy elderly

people when community and social services fail to give them the help they seek. Fortunately, for some of the participants in this study, there was another, brighter side to their experiences with service agencies, the home health aide.

In contrast to the experiences related above, the home health aides assigned to Mildred Howard, Fanny Gage, Harriet Carey, Maisie Harrison, Annabelle Gregson, and Sally Dickerson made important contributions to the quality of life of these disabled elderly women. The relationships between Mildred Howard, Fanny Gage, and Annabelle Gregson, and their home health aides were especially close. Mildred had given her aide a key to her house; Fanny was regularly visited by her aide's husband and children; and Annabelle and her two aides read the Bible together at bedtime each night. It was not unusual for these home health aides to work more hours for their clients each week than they were paid for, to visit them on their days off, and to take them to church, to doctors, clinics, shops, and markets. A New Zealand study with similar findings, states the following regarding the caring nature of homecare workers and the services they perform:

The emotional contribution of homecare workers and the personalised, day-to-day needs assessments they undertake tend to be minimised, and the extent and importance of the social contact for clients are not fully ascribed. All research involving interviews with homecare workers about their job suggests that these tasks are almost always part of the caring role, and sometimes done outside the hours for which they are contracted. The same result was found in this study (Burns, Dwyer, Lambie, & Lynch, 1999).

This work is carried out mainly for old women by other women, often not much younger themselves and for extremely low pay. It provides essential assistance with independent living, but the low pay reflects the value placed on it by the social system.

Conclusions

It would be difficult to overstate the challenge that dependency presents to the quality of old age in Western societies and therefore to well-being (Stone, 2005; Covinsky et al.,

2003; Schank & Lough, 1990). Precisely because 'independence' is so highly valued in liberal-western cultures, loss of independence so often means a reduction in status, choices, and dignity. However, this is mediated by variables such as gender, ethnicity, and class. Even a small-scale study such as this one provides illustrations of the intersection of old age with these other factors.

For wealthy older people who can afford staff (for example, a driver), loss of status in old age may not be a major issue. Being able to pay for assistance is very different from being forcibly given rationed resources and made to comply with rest home regulations. None of the participants in this study was wealthy. Most were female, and women have lower lifetime incomes than men. Their incomes varied, but most were poor, some extremely so. Poverty, chronic disease and disability, loss of free movement and autonomous decision making, expiry of a driving license, and institutionalisation, sometimes bring unnecessary and unwanted interference from family and society into the lives of elderly people (Powell, Bray, Roberts, Goddard, & Smith, 2000; Saxton, 2005). As confirmed by several of the participants in this thesis, independence is as important an influence upon well-being as is health and illness (Higgs, Hyde, Wiggins, & Blane, 2003; Hyde, Wiggins, Higgs, & Blane, 2003; Baltes & Smith, 2002; Grewal, Nazroo, Bajekal, Blane, & Lewis, 2004). However, despite the importance of independence, medical and social service providers have been inconsistent in providing services that help to minimise immobility and dependency.

The claim is made that social services are organised around the needs of elderly women (Kaye & Crittendon, 2005). Interestingly, the men in this study, Robert Gordon, Jacob Traub, and Simon Burgess did not have cause to access public assistance during the course of this study. However, the treatment of the female participants in this thesis indicate that, whatever the situation with men, health, community, and social services

often failed them in the timely delivery of services and that, because of this failure, well-being was diminished. From the perspective of these women, many of the obstacles to successful aging were generated by deficiencies in health and social services systems.

In the United States the problems faced by poor elderly people such as Harriet Carey and Estelle Doherty in accessing the health care necessary for independence are comparable to those in New Zealand. A 2004 review of the barriers to health care access among elderly people in the U.S. stated:

These data show that income is a strong predictor of access to health care in the elderly, independent of race. Should [Medicare] reform result in more out-of-pocket expenses, it will surely decrease an older person's ability to be treated by a physician. It follows that rather than saving money, such a system would incur far greater expenses, as untreated conditions and lack of prevention would lead to greater severity of disease, which would promote more emergency visits and longer hospital stays (Fitzpatrick, Rowe, Cooper, Ives, & Robbins, 2004).

Interestingly, although the intersection of gender and class meant that poor women of European descent were particularly vulnerable, the Maori participants in this study fared relatively, apparently because of the value attached to elders in Maori culture. This appeared to offset the effects of higher levels of poverty amongst Maori than in the general New Zealand population. Also, for some of the other participants in this study, there was another, brighter side to their experiences with service agencies, the home health aide. However, this came at a cost to the caregivers, who were at the time of writing extremely underpaid, although in New Zealand efforts were being made by their union to secure a pay increase similar to that gained by nurses.

CHAPTER 13

THE ENVIRONMENT AND WELL-BEING

Introduction

The literature on successful ageing and the participants interviewed for this project are in agreement that the environment – the how and where of living – of old age is important to well-being in old age. However, the points they emphasise about environment are considerably different. As a consequence of being in poor health, of having attained old age ‘unsuccessfully’ because of chronic diseases and disabilities, the participants did not focus on biomedical solutions to improve their well-being. This is not to imply that they ignored their health, for they did not. They continued to visit doctors and clinics, to take their medications as prescribed, and to choose carefully what they ate and drank, but they did not seek well-being in the offices of medical practitioners. Instead, they looked for solutions to problems created when the neighbourhoods in which they resided were polluted and unsafe, the homes in which they lived were not those they preferred, and the societies in which they lived obstructed cognitive and physical well-being in old age.

In *Successful Aging*, Rowe and Kahn have this to say about the relationship of the environment to successful ageing:

... as we grow older, genetics becomes less important, and environment becomes more important. The likelihood of being fat, having hypertension, high cholesterol and triglyceride levels, and the rate at which one’s lung function declines with advancing age are, by and large, largely not inherited. These risks are due to environmental or lifestyle factors. How we live, and where we live, has the most profound impact on age-related changes in the function of many organs throughout the body, including the heart, immune system, lung, bones, brain, and kidneys (1998: 30).

However, unlike the participants, the successful ageing concept does not focus on problems of environment. It concentrates instead on biomedical solutions to lifestyle and on personality factors that could enhance the chance of remaining free from chronic

disease and disability. The successful ageing concept envisions the “emergence of a physically and cognitively fit, nondisabled, active elderly population” (Rowe & Kahn, 1998: 18). It is a vision of wonderful biophysical old age but as this thesis has emphasised, it is incomplete in several respects. First, because it does not listen to what elderly people have to say, it misses essential elements of well-being. Secondly, because it places the burden of responsibility for ageing ‘successfully’ upon the elderly, it fails to recognise the influence of society in shaping the experience of old age. And thirdly, because it fails to address the social barriers to ageing ‘successfully’, it is irrelevant to all but a privileged few of the world’s population of old people. Among the participants in this thesis, Estelle Doherty, Harriet Carey, and Nancy Robinson entered old age with multiple, chronic ailments acquired over a lifetime of hard work and penury. The backs, knees, hips, arm and shoulder joints of Susan Eyres, Maisie Harrison, Edna Holt, Rose Winters, and Anika Struthers, were damaged by the hard physical work of caring for their spouses. Before they were institutionalised, Robert Gordon, Mabelle Armstrong, and Theresa Landman shopped, travelled, and entertained their friends, in modest terms, as they wished. Once they entered long-term care, their nursing home expenses consumed their pensions.

The ‘Concept’ of Successful Ageing versus the Lived Experience of Old Age

The elderly participants in this thesis have given me a different perspective on the role of environment in the well-being of old age. Until they taught me otherwise, I thought I understood the importance of environment. I had worked in long-term care institutions and seen the results of institutionalisation. Before I walked with Harriet Carey and Estelle Doherty through their neighbourhoods, I believed that living in one’s home – ageing in place – was more desirable than living in an institution. After walking with

these women, however, I understood why ageing in place is not always the best choice. The safety of a nursing home may be preferable to the dangers of inner city housing projects. Before this study, I understood that the loss of a driving license and automobile was a life-changing event. I had talked with institutionalised elders who told me how the loss of transportation had led to isolation, loss of independence and self-esteem, confinement, and finally to institutionalisation. However, Fanny Gage, Eileen Richards, and Theresa Landman, Allison Turner, and Annabelle Gregson gave me a fuller understanding of the link between driving and environment. One by one, as they were forced to discontinue meaningful activities for lack of the ability to drive, I observed at firsthand how their worlds grew smaller, and their environments became narrowed to the small homes in which they lived. From my walks with Maisie Harrison, Susan Eyres, and Anika Struthers, who lived in a small New Zealand village plagued with the problem of 'boy-racing', I learned how dangerous navigating the streets and sidewalks on foot can be for elderly women. While full comprehension of the circumstances of another person's life is not completely possible, I agree with the comment Katarin Jurich has made about the knowledge she gained from her fieldwork on the Lakota Indian Reservation of South Dakota:

I didn't get it from watching or from interaction per se, but from an existential position of being in the world, engaging in practices of reservation life (Jurich, 2000).

As did Katarin Jurich, I became deeply engaged with the New Zealand participants in this research project. I once stood with Susan Eyres waiting for a bus to the shops. When it came, I watched her struggle to reach the lower step. I observed her frustration when she realised that the bus had stopped on an incline that made it impossible for her to board with her polio-damaged legs. When the bus driver and passengers became impatient with her efforts to board, Susan turned in defeat and walked back to her house.

I had agreed beforehand to go with Susan as an observer, not her helper, because she wanted me to see firsthand the struggles she faced in living in her own home. I had not realised how difficult it would be to feel so helpless.

Similar incidents with others over a period of three years taught me that in old age, environment permeates every aspect of well-being. Robert Gordon, Mabelle Armstrong, and Theresa Landman, gave me an insight into the monotony and boredom that results from living in a long-term care environment among severely demented and disabled people. With few visitors from the outside, their physical and mental abilities were wasting away and my visits were at best, brief respites. From Simon Burgess I learned the effect of the environment on the health of people who ate fish from polluted waters in order not to abandon the traditions and ways of their ancestors. From Maisie Harrison, with whom in the early days of our friendship, I was able to walk to the neighbourhood shops, but later could not because of her increasing frailty, I learned something of the isolation that occurs when increasing fatiguability makes walking further than one's mailbox impossible. These are matters of environment. Many elderly people live in communities that have not been designed or made safe for elderly people. The shops, markets, doctors and social services offices, chemists, and clinics are sometimes a considerable distance from where they live. Public transportation, as I learned from my experience with Susan Eyres can be inadequate; and, in company with Maisie Harrison one day, the two of us learned that neither powered nor manual wheelchair users could board the local buses.

The Environment of the Institution and Well-Being

Speaking of the nursing home environment Rowe and Kahn make these comments:

Most people fear being confined to a nursing home, and the limitations of such life are undeniable. But only 5 percent of people over the age of sixty-five live in nursing homes, and that percentage has been falling for at least ten years. The rest live in the community at large, and fewer than

5 percent of them need help with the basic activities of daily living (1998: 43).

This is reassuring information for politicians and policy makers and for the 95 percent of individuals over the age of sixty-five who are not confined to an institution and do not need help to live independently. However, for people like Robert Gordon and Mabelle Armstrong, who lived in a nursing home populated mostly by older people with dementia, Rowe and Kahn's comments would have offered no personal hope of change. One day, as I walked home after a visit with Robert and Mabelle, I sat on a park bench and made the following entry in my diary:

Robert and Mabelle live in the same nursing home. They are lonely, isolated, and unhappy in this environment. They are quite possibly the only two residents whose cognitive powers are intact. Both Robert and Mabelle have reported to their children incidents of being spied upon, lied to, patronised and talked down to in front of other people. In my many visits to the nursing home, I have personally witnessed such incidents. I have myself become uneasy inside the home. Robert, Mabelle, and I are frequently under scrutiny by the manager and her staff as we sit and talk. Our interviews, conducted in the small library (seldom occupied by anyone other than Robert and Mabelle) are subject to staff interruption. A closed door is almost always opened by a staff member, and a staff member frequently appears to remind us that lunch or tea time is approaching, or that crafts and games will soon be under way. Sometimes a staff member will simply stand in the doorway and listen for a while. Interview privacy is difficult to achieve. I wonder if the manager and her staff are uncomfortable with my frequent visits with the two residents most capable of reporting how they are being treated. I ask this question because in contrast, my visits with Theresa Landman – who is also resident in this nursing home, and whose short-term memory deficit causes her generally to forget my visits and the contents of our conversations – are seldom interrupted by staff members. On the other hand, I have learned from conversations with Robert and Mabelle's children that they fully support the manager's policies and her actions. I think that surely, these children would protect their parents from the kind of indignities being reported to them, but I am not certain because it is the children who have forced Robert and Mabelle to live in this nursing home. In fact, I ask myself, how are these two elderly people actually being treated? The home is clean and well-maintained. Meals are served punctually: breakfast occurs at seven in the morning, morning tea at ten, lunch at noon, afternoon tea at two in the afternoon and evening tea at five o'clock. The food is nutritious, nicely presented, and ample. Chair exercises and crossword puzzles take place every morning and art classes each afternoon. These activities are interspersed periodically by

entertainment from the outside. Staff members are generally polite to residents and visitors. Robert is allowed to keep a bottle of Scotch in his room and his cat Mitten roams freely throughout the facility. There is no apparent abuse and no obvious cause for complaint on the part of the residents. Nevertheless, there is a troubling, disturbing sense that everything one does inside this nursing home is observed and reported to the manager. Further, that any behaviour that deviates from facility policies, on the part of staff or residents, will not be tolerated. Each time I visit this nursing home, it is a relief to walk back into the sunshine of the outside world. The lack of freedom inside the home, and the disadvantaged elders who are enduring their fate without recourse or hope of change disturbs me. The unimpaired are treated as though they are impaired, and the impaired are pressed to behave as though they are unimpaired. In the absence of physical abuse, this nursing home can be described as a beneficent concentration camp.

In view of these reflections, and if the participants in this project are typical, Rowe and Kahn are exactly correct when they state that most people fear being institutionalised in old age. Robert Gordon, Mabelle Armstrong, and Theresa Landman were institutionalised when I met them and they remained unhappily in that circumstance throughout my visits; their worst fears had come true. Robert said of his children, "They put me here to die" and Theresa longed to be out of the chill nursing home and back into the heat of the South African coast where her former friends had retired; Mabelle, who was bored and unhappy, described the nursing environment in these words:

There is little to think about in this place except the past. There is nothing fresh happening. The people who live here do not talk much. Some of them sit all day in dead silence. I find if I try to make conversation, they are apt to say, 'Who are you?' I miss my friends. I have not seen them in over a year because they live so far away, they are elderly, and they cannot just come to see me here. A few months ago, I was well enough to go for a walk. I did quite a bit of walking and it helped, but now my heart is acting up and I'm unable to walk as I did. Also, having only one little room that is your own is very limiting. You can't really sit in there. The staff come in and get you or they pop in to change the towels or something else. So, I just let them.

Simon Burgess and Susan Eyres fear that institutionalisation will be their fate. Jacob Traub has planned for institutionalisation by purchasing long-term care insurance which he hopes will enable him to reside in the high quality nursing home of his choice. Eileen

Richards and Anika Struthers have planned for dependency by purchasing a home in a retirement village where, as they become needier, they can move from independent to semi-dependent to full-time care units in the community where they now reside. Those who own their own homes, and have strong social support – Edna Holt, Rose Winters, Annabelle Gregson, Sarah Hunter, Neville Schuster, Allison Turner, and Agnes Schultz – are the least worried about institutionalisation. However, all the participants realise that an unexpected event, most particularly a fall, can change their circumstances suddenly and dramatically. This was the experience of both Mabelle and Robert, who lived independently in their own homes until they fell, Mabelle at the age of ninety-seven and Robert at age ninety-two. There is another type of threat to the well-being of elderly people, which as I discovered from my several visits to the homes of Harriet Carey and Estelle Doherty, is the result of aging in place in low-income, high crime, inner city neighbourhoods.

Unsafe Neighbourhoods, Substandard Housing and Well-Being

Demonstrating the critical nature of the environment, the neighbourhoods in which Harriet Carey and Estelle Doherty lived were deplorable. The interior of their apartments were small and dark and accessed by passing through a doorway leading to a vestibule shared by all the tenants in their buildings. (Although the two women lived in different cities, the public housing complexes they lived in were mixed family/elderly units laid out similarly). The fact that Harriet and Estelle lived in public housing projects, rather than projects designed for the elderly increased their exposure to crime and violence. In the United States, projects specifically for the elderly are typically sited in neighbourhoods where a high percentage of residents are over the age of sixty-five and the incidence of crime relatively low, whereas family public housing, as in the cases of Harriet and Estelle, is typically built in poverty ridden, racially segregated

neighbourhoods (Gibler, 2003). In Harriet's building, prostitution was practiced in the apartment above her, and in Estelle's building drugs were sold from the apartment across from hers. The outer doors of the buildings the women lived in were key locked as was, of course, the doors into their apartments. Locking is a necessary precaution in high crime neighbourhoods, but it presented special problems for these two elderly women. The door to Estelle's apartment was difficult to unlock. I tried several times unsuccessfully to do so; Estelle was able to, but not quickly. Harriet's apartment door unlocked easily, but she had arthritis in her hands and she struggled to hold the key, put it into the lock, and turn it. The exercise of unlocking two doors to enter their apartments placed the women for a period of time in unsafe circumstances. While entering her apartment one day, Harriet was accosted by a middle-aged man who believed he was entering the apartment above. Harriet responded by beating him with her cane, pushing her door open, locking herself inside and calling the police. She did well. The man was found by the police outside Harriet's door in a drunken sleep and taken off to jail. Harriet was so frightened by the experience that she did not leave her apartment for several days. Estelle had no similar experience, but she worried about her physical safety because she had called the police several times to complain about the drug trafficking taking place in the neighbouring apartment. She had been threatened by the men selling the drugs, and was very cautious when leaving and returning to her apartment in the evening.

In New Zealand, four participants – Sally Dickerson, Fanny Gage, Nancy Robinson and Maisie Harrison – received government subsidised accommodation benefits which helped them pay the rent on the small apartments in which they lived. Although there are areas which are unsafe for elderly New Zealanders (such as South Auckland), none of the New Zealand participants in this study lived in such neighbourhoods; the communities in

which they resided were largely populated by elderly people like themselves, and also by families with low to modest incomes. Where they lived, crime was not widespread;⁵¹ the greatest danger to physical safety was fast moving traffic on the major thoroughfares with few safe crossing points, and speeding and racing in the village streets. Vision and hearing impaired, slow-moving elderly people living in the village were understandably frightened of crossing the streets, and those who were able to walk were discouraged from doing so.

Issues of environment negatively affect the ability of elderly people to age with well-being. The successful aging model recognises the profound effect of environment upon the experience of old age, but focuses its attention on data which indicate that the vast majority of elderly people are making it on their own, interpreting it to mean that because they are not receiving assistance, they do not need it. In this way, the successful ageing concept fails to engage what Agich has referred to as the “messy deep reality of being old and frail” (Agich, 2003: 5), and Laslett the “final dependence” of the fourth age (Laslett, 1989: 4).

Ninety-six percent of older people are ‘community dwelling’ as the Census puts it; they live in private homes, usually on their own or with family. Among those community-dwelling elders, fewer than 5 percent say that they need help in the basic activities of daily living, such as dressing, bathing, and eating. More than 95 percent take care of these things for themselves. Independence in such efforts means that these

⁵¹ While I was living in the community, an exception to this statement was the beating of Maisie Harrison’s neighbour by an ex-boyfriend. Maisie heard the screaming and commotion and called the police. The man was caught trying to flee the scene; the young woman who had been attacked was treated at the local hospital and released. Maisie took her into her home while she recovered, and afterwards, to a meeting of her woman’s church club where the young woman became a devoted attendee.

people are functioning mentally as well as physically (Rowe & Kahn, 1998: 126).

Mildred Howard and Maisie Harrison are two such individuals. They are making it on their own – barely. They echo the sentiments of their friend Allison Turner who says, “I get through it by constantly telling myself I can do it.” Several of the participants in this study live in environments that are not of their choosing for reasons of safety and mobility. The successful aging model acknowledges the importance of environment and focuses its attention on the solution of medical problems caused by diseases such as hypertension, high cholesterol levels and lung function. Such a focus is of little use in resolving the issues of environment created by factors of unsafe housing, poorly designed communities and public transportation systems, and institutionalisation.

The Tendency to Fall and Its Affect on Well-Being

Elderly people fall. They fall in all sorts of environments: in their homes, as patients in hospitals, in nursing homes, in day care centres, in shops, and in parking lots (Nadkarni, Iyengar, Dussa, Watve, & Vishwanath, 2005; Wellbery, 2005; DiFabio, Zampieri, Henke, Olson, Rickheim, & Russell, 2005). Among non-ambulatory elderly people tips and falls from wheelchairs is a common form of accident resulting in fractures, lacerations, and contusions (Gavin-Dreschnack et al., 2005). Fall-induced injury is a primary reason for hospitalisation and a major cause of accidental death among elderly people (Jansson, 2005; Kannus, Parkkari, Niemi, & Palvanen, 2005). Among elderly people falls are not isolated, one-time events. Regardless of their environment, having fallen once, an older person is at substantial risk of falling again; having fallen and fractured a bone, older people are highly likely to break a bone in subsequent falls (The RECORD Trial Group, 2005).

The problem is not just that the frequency of falls increases with age, but age- or disease-related changes to an older adult's physiological system leave them more susceptible to injuries. Older adults function at a much

lower level of their physiological reserves in all organ systems. These changes increase the older adult's susceptibility both to falling and being injured in a fall. A loss of balance may be a result of slower reaction times, loss of muscle strength, loss of bone mineral density, and a loss of postural stability. Older adults with dementia and physical disabilities have an even greater susceptibility to injury and falls because of a decrease in safety awareness and impairments in balance and independent mobility (Diener & Mitchell, 2005)

Many studies on aging, including the MacArthur Studies, reveal the tendency of elderly people to fall. Rowe and Kahn prescribe exercise to help prevent falls.

The facts are that exercise dramatically increases physical fitness, muscle size, and strength in older individuals. Besides rejuvenating muscles, resistance exercises (pumping iron) also enhance bone strength, limiting the risk of osteoporosis and fractures of the hip, spine, and wrist. Exercise also improves balance, thereby decreasing the risk of falling, a common and life-threatening problem in older persons (Rowe & Kahn, 1998:27).

Rowe and Kahn's recommendation of exercise to improve strength and balance as a means of reducing falls is a standard medical response to patients who have fallen, or who display an unsteady gait and a tendency to fall. Physical exercise has proven to be of such great benefit in strengthening the muscles of older people and in improving their balance (Shrier, 2003; Steadman, Donaldson, & Kalra, 2003; Diener & Mitchell, 2005) that doctors frequently write prescriptions for their older patients to be evaluated by physical therapists for exercise therapy. The solution to reducing falls among older people appears to be simple: inform them of the need to exercise, explain the benefits, put them in touch with physical therapists who will design an individualised exercise program, and in a few weeks, these older people will enjoy improved muscle strength and tone, balance and mobility. However, the generation interviewed for this study did not characteristically go to gyms to keep fit; instead, they relied on work and walking to maintain their physical well-being.

The current poor results of fall prevention programs speak of the difficulties involved in decreasing falls among elderly people for whom a work-out with a 'personal trainer' or

therapist is a novel (and expensive) experience. Neville Schuster had a serious fall during the time we were meeting for taped interviews and spent a night in a hospital emergency room. After a CAT scan revealed no concussion, the doctors released him with a referral to a therapist for gait and walking aid evaluation. Neville did not see the physical therapist and gave several reasons for not doing so. He was recovering from the flu and did not feel well. He did not believe that a physical therapist would be able to improve the steadiness of his gait and was therefore unwilling to commit to the several visits he would be expected to make to the therapist. He was not open to using a cane or walker; and transportation to and from the therapist's office was a problem. Diener & Mitchell (2005) used a multifactorial approach in designing their fall prevention program, which included physical therapy assessment, home and behavioural hazards assessment, and fall prevention education. Although at the end of the three months they had succeeded in reducing the fall rate of the participants, they were left with many unanswered questions. First, several participants were uncooperative and reluctant exercisers, and the question became how to motivate them to walk faster, increase weights, and attempt more challenging balance exercises. Secondly, there was reason to believe that identification of home and behavioural hazards and the use of fall prevention educational material among the participants was as important to fall reduction as the physical exercise program. And finally, a follow-up six months later on the medium-term results of the program revealed that the gains from participation in the program had been lost, indicating a need for ongoing exercise, hazard identification, and education. Hill and Schwarz report that, despite an increase in the number of fall prevention programs, falls remain a major cause of death and disability for Australians over the age of sixty-five and they point to compliance as an important factor influencing outcomes:

...compliance has been relatively poor in the use of hip protectors, acceptance of home modifications, some forms of exercise, and long-term reduction of psychotropic drug use. Medical and allied health practitioners have a key role in providing ongoing support to facilitate commencement and longer-term involvement by individual patients in successful interventions (Hill & Schwarz, 2004).

Other researchers speak of the need to incorporate exercise as a part of lifestyle “well before the age of fifty and to maintain it for as long as possible in order to produce the desired preventive effect” (Lynch, 2004: 295). They suggest that exercise intensity is also important – the lifting of heavier rather than lighter weights – asking, “...what proportion of older people, especially frail elders, can or will, perform such intense exercise” (ibid). Regarding the effect of Tai Chi in retarding bone loss and in improving muscle strength, Jaffe agrees with its benefits, but summarises the difficulties in motivating elderly people to exercise regularly by saying,

We all know that *exercise* is effective for the treatment and the prevention of osteoporosis and the prevention of *falls*, but trying to find simple, nontaxing recommendations for patients can be more challenging (Shrier, 2003).

Eleven of the participants in this project are prone to falling; all have injured themselves in their falls, suffering broken bones, skin tears, contusions, lacerations, and external and internal head injuries. Their falls have led to hospitalisation and for two of them subsequent institutionalisation. As a direct result of a fall, Fanny Gage was first hospitalised and then transferred to a long-term care facility where she died two weeks later. Mildred Howard, Agnes Schultz, Annabelle Gregson, and Hannah Meyers became homebound from falling; their environments narrowed to the walls of their small homes.

Following Mabelle Armstrong’s hospitalisation for a broken hip and Robert Gordon’s for a broken pelvis, both incurred as a result of falls, Mabelle and Robert’s children had their parents placed in a long-term care facility for protection against further falls. This

is not an unusual occurrence. Falling frequently leads to institutionalisation. While there are other causes for institutionalisation – wandering behaviour, incontinence, living alone, visual impairment, dementia and confusion – being judged as at risk for falls, having a history of falls, having sustained a fall during hospitalisation, and unsafe gait rank highest on the list (Aditya, Sharma, Allen, & Vassallo, 2003; Richmond, Kauder, Strumpf, & Meredith, 2002; "To Avoid a Nursing Home," 1998). Institutionalisation of elderly people as a protection against future falls is ironic. There is an incongruity between the expected and the actual results of institutionalisation, which a little research by Mabelle and Robert's children would have revealed: institutionalisation provides little protection against falls. Rao (2005) reports that 30 to 40 percent of community-dwelling adults over the age of sixty-five fall each year, but that among nursing home residents and hospitalised elders the incidence of falls are even higher. In fact, long-term care facilities are notorious for the falls that occur within them (Sieri & Beretta, 2004; Kerse, Butler, Robinson, & Todd, 2002; Warnke, Meyer, Bender, & Muhlhauser, 2004; Hamer, Gulpers, & Strik, 2004).

In their words and in their behaviour, the participants convey their fear of falling. They move slowly and cautiously, referring often to their need to walk carefully. Those who have fallen remember the pain, long convalescence and loss of autonomy. Those who have not fallen, have friends who have broken arms, legs, and hips in falls. These participants are well aware that in old age a fall, particularly one which results in a broken hip, could be the event which would move them from the independent lifestyle so important to their well-being into dependency (Rogers, 2005; Lee & Mihailidis, 2005; Hart-Hughes, Quigley, Bulat, Palacios, & Scott, 2004). In elderly people, falls are a major cause of diminished health, self-sufficiency, self-confidence, well-being, depression, and social isolation (Steadman, Donaldson, & Kalra, 2003; Kell, Bell, &

Quinney, 2001. For families and the communities in which old people live, the care and maintenance of elders disabled by falls is an enormous task (Daley & Spinks, 2000; Kannus, Parkkari, Niemi, and Palvanen, 2005; Kannus, 2005; Nadkarni, Iyengar, Dussa, Watve, & Vishwanath, 2005).

Avoiding Institutionalisation

As discussed earlier, the majority of the elderly men and women in this thesis included independence and autonomy as a critical component of well-being. Put another way, the majority of participants feared that if they lost their independence, they would be forced to live in a nursing home. Speaking one day about her struggle to remain independent, Susan Eyres made the following comments about nursing homes and isolation:

People talk to me about my position and how I should go into a nursing home. But what kind of life would I have in a place where people are sat in a chair and there's nobody talking. Now you would think that they would talk and draw strength from one another, but they're all locked into their own little private world. I have no idea why that is, but I think that with the best will in the world it puts them under the heading of institutionalised.

In order to stay out of nursing homes, the participants attempted to retain a high level of self-sufficiency. Minimal assistance from other people was critical to remaining in their own homes, and was in turn crucial to avoiding dependency and institutionalisation. Each of the participants were keenly aware that immobility could lead to institutionalisation. They all had friends and neighbours who, who like Mabelle Armstrong, Lydia Nichols, Theresa Landman, and Robert Gordon, had been moved into long-term care facilities because immobility brought about by advanced chronic disease, disability, sensory loss, dementia, and frailty put an end to independence in activities of daily living and thus an end to independent living.

A few qualifying statements can be made regarding the Maori and West Texas participants. First, the four Maori participants led an independent lifestyle. Edna Holt

was the frailest, but she remained able to walk to the village shops and to her friends and family's homes; to reach destinations farther afield, she relied on her granddaughter without reservation. At the age of seventy-seven, Sarah Hunter was the only participant in the group who can be described as having no apparent chronic diseases and disabilities. Her physical and mental capacities were remarkable and she was fully capable of arranging whatever transport she needed and she had many people to call on to provide it; like Edna, she had no reservations about doing so. As she spent a portion of every year with each of her four children, contributing to the running of their households, Sarah expressed no anxiety about isolation and loss of autonomy. Simon Burgess managed his tribal responsibilities without difficulty; and at age sixty, Emma Parker was completely independent. Secondly, because of their mana, the elderly Maori participants occupied positions of authority in their whanau and on the marae which were unrelated to independence and dependency appeared to be less an issue for them than it was for many of the elderly participants who were not Maori. Simon Burgess, who, in his work as a kaumatua observed what he described as a growing trend for children to place their aging Maori parents in long-term care facilities, expressed some anxiety about his own future, but felt generally confident that his mana and his children's traditional upbringing would protect him from institutionalisation. Despite the possible portent of future institutionalisation on a wider scale amongst Maori (as envisioned by Simon), the Maori participants generally spoke little about a need to be independent and not at all about institutional isolation. Sarah Hunter lived with her children, Edna Holt's granddaughter lived with her, Simon Burgess's adult son and daughter shared the family home with him, and Edna Parker planned to retire to housing provided for the elderly on the marae of her childhood. The Maori participants were deeply involved with their families and communities. They were not isolated and they did not express a fear of

immobility and isolation. This certainly was in notable contrast to many parallel situations in the other New Zealand communities in which I interviewed participants.

As regards the three very aged West Texas participants, they were confined to their homes and had been for years. Nevertheless, their morale was high; they expressed little anxiety about their future independence and little dissatisfaction with their present circumstances. One-hundred-two-year-old Agnes Shultz had no family members living nearby, but she received strong support from the community and her church. One-hundred-year old Annabelle Gregson had two home health aides, a daughter, and church friends who watched over her carefully; and at the age of ninety-four Hannah Meyers was visited and telephoned regularly by her two sons, old friends and concerned members of the church to which she belonged. In their interviews Annabelle, Agnes, and Hannah each expressed happiness and contentment with their current lives.

Agnes made this comment: I'm fine. I have never felt better in my life.

Although she was immobilised by arthritis, Hannah conveyed the great pleasure she derived from living independently in her apartment, saying:

I can do anything but get out and go somewhere. I take care of my own business. I take my own medicine. I said I was going to make it and I have!

And Annabelle summed up her circumstances by saying:

I'm just doing real well for my age and for the bones I've broken. I have a happy life and I'm very happy to be alive.

Several factors may contribute to the well-being of these three participants. The small West Texas town in which they lived was a tightly knit community. Neighbourhoods were populated by families who had lived in their homes for decades and sometimes for generations. Many people had lived in the town their entire lives. Situated on the plains of West Texas and surrounded by irrigated farms producing cotton, grain sorghums, and vegetables, few people moved in from the outside. It was also located in the

geographical region of the United States known as the 'Bible Belt', an area populated largely by fundamental Christians, among whom the elderly are highly respected. These factors may have contributed to the sense of well-being that existed among these very elderly women. There is another factor which has been reported with regard to the old and which may apply to Agnes, Annabelle, and Hannah: compared to younger elders, centenarians and very aged individuals are usually positive about their lives despite reduced independence and physical limitations (Callen & Wells, 2005; Yi & Vaupel, 2002; Yi, Vaupel, Zhenyu, Chunyuan, & Yushi, 2002; Martin, Long, & Poon, 2002).

Except for the Maori and West Texas women, immobility was a great concern for many of the other participants. To continue living in their own homes they needed to remain autonomous. In sharp contrast to the Maori and West Texas participants, these individuals receive very little support from their families. Several were immigrants; their siblings and other family members who were still alive were back in their places of birth, sometimes in other countries. For these, their children represented their only family support system, yet those of Susan Eyres, Maisie Harrison, Anika Struthers, Jacob Traub, Estelle Doherty, and Harriet Carey, none of them Maori, were uninvolved in the routine daily lives of their parents. Consequently, when these participants needed help, they turned to friends and neighbours, churches and service agencies. For example, Jacob told me that because of her past behaviour towards him, he would "under no circumstances" ask his daughter for help; Anika feared that her daughters would view her as "old and complaining" if she were speak to them of her loneliness; and Susan said,

If I were to call on my son now, after all these years of him not being a helping part of my life, he'd straight away figure that I must be in a bad way. I'd be out of my house and in care before I would know how I got there. So no, I'll not ask my son for help. I have a young friend, she's

only in her fifties, who I could ring anytime, even in the middle of the night, and she would come immediately.

Harriet Carey had this to say about her daughter's lack of involvement in her life.

My daughter has said to me more than once, 'Mom, if you ever need help, I'll be there for you. All you have to do is call and I'll come.' I do not believe her. If she cared, I wouldn't have to call her. She knows how old I am, that I can't walk any distance without help, that I have trouble getting my groceries, getting to the bank, and getting to the doctor. She never calls or comes when I am trying to find a way to get to these places. Right now, I have medicine that needs to be picked up at the drug store and no way to get there. I stopped asking my daughter for help a long time ago, and I won't start again now.

Conclusions

There is an ironical outcome to the eventualities that sometimes overtake the very elderly. Out of fear that they will be seen as weak and incapable of living independently, they avoid asking their children for help. Not asking for help, however, requires them to conceal their problems, to say that all is well with them. A result of this course is that having concealed the difficult realities of their lives, the gap between themselves and their adult children may be further widened and the circumstances of their lives further aggravated. Robert Gordon's children did not realise that their father was no longer able to cook until he fell and ended up in hospital, where in addition to a broken pelvis, he was diagnosed with malnutrition. When he recovered from surgery, they placed him in a nursing home. One wonders if Robert had been open with his children over his need for help with meal preparation, he could have avoided malnutrition, a fall brought about by weakness, and a brittle, broken pelvis – in short the very series of events that eventually resulted in the institutionalisation he desperately wished to avoid. Mabelle Armstrong's story is similar. She had controlled her Parkinson's disease for many years, but after she fell and broke her hip at the age of ninety-seven, her children, worried that Parkinson's would cause her to fall again, had her admitted to a nursing home. When Estelle Doherty's car broke down, her children refused to help her buy another, believing that

she was no longer a safe driver. To stay in her own apartment and out of long-term care, Estelle borrowed money from friends and bought an old automobile without their knowledge. As a result, she was still navigating fast moving city roads, in a car with no air conditioning, well-worn tires, and little gas in the tank, all of which was exacerbating her asthma and coronary heart condition. When her children inquired over her well-being, Estelle replied that she was “fine.”

In this study, when crisis revealed to uninvolved adult children the realities of their parents’ lives, they acted to remove their parents from the environment in which the crisis occurred. With a history of non-involvement in their parents’ lives, these adult children did not work reciprocally with their parents to resolve the challenges; they arbitrarily made the decision to move them into nursing homes. The elderly themselves, being in crisis and fearful that the very thing they had struggled to avoid was about to occur, fought the move. The tenuous relationships between the elderly individuals and their children were severely strained and altered, and nursing home residency began with resentment and unhappiness. The counter to this scenario is that it was an unlikely situation for participants such as Nevelle Schuster, Fanny Gage, Annabelle Gregson, Sarah Hunter, Edna Holt, Sally Dickerson, Allison Turner, and Rose Winters. These individuals had close, loving relationships with their children. Their relationships being based on reciprocity, changes in the well-being of elderly parents were quickly discerned and resolved mutually.

CHAPTER 14

SPIRITUALITY AND WELL-BEING

Introduction

Studies indicate that religion and spirituality are important to the sustained well-being of older people, particularly those dealing with physical illnesses (Langer, 2004; Koenig, George, & Titus, 2004; Meraviglia, 2004; Emery & Pargament, 2004; Robinson & Nussbaum, 2004). Several of the participants in this study used spirituality to cope with the stresses and losses of old age. Thirteen attended church services at least once weekly⁵² and their closest friends were elderly church members like themselves. They expressed their spirituality and religious convictions in various ways. Jacob Traub, who had converted from Judaism to Christianity, worked as a nursing home volunteer and Sunday School teacher. Nancy Robinson, a retired minister, called on the sick and homebound with gifts from her garden. Sally Dickerson immersed herself in baking projects to raise money for church missionaries. Annabelle Gregson read the Bible to her home health aides each evening; and Agnes Schultz used her joy as a centenarian to testify to the value of faith in old age. Their faith in God, and the social connectedness they experienced from church attendance, was critical in seeing them through illness, sadness, and loneliness. When participants who were active in church had problems of any sort, they turned first to their church friends for help rather than their children. As Maisie Harrison said, "Its others with faith like yourself that can understand best what you're going through when you are old."

⁵² In the United States, ABC news recently reported that 60 percent of Americans over the age of sixty-five attend religious services at least once a week compared with 28

Participants' Expressions of Religion and Spirituality

Jacob Traub was one of the thirteen individuals for whom religion was an important means of dealing with the difficulties of old age.

When I need support to get through the day, I turn to my God. I have been an elected and ordained elder and deacon in the Presbyterian Church for sixty-five years. I have been a focussed Christian. I think my spiritual life as a Jew was very significant. My grandfather was not a particularly observing Jew. He went to synagogue, but nothing much more than that. It was from my mother that I learned my spirituality and it was because of that spirituality that the step from being a Jew to a Christian was a logical and easy step to take.

Sally Dickerson had been devout Christian most of her life. In old age, most of the activities in which she engaged were church related.

My mother was a Scottish Presbyterian, a beautiful pianist and a teacher of the old hymns. I was born in South Island in a place that had no churches. The minister would come once a month and hold a meeting in the waiting room at the railway station. After I married, my husband was in government and we moved a lot, but I always went to church. When my husband died, I had the Church and I had my family. I've always believed that it's not what you do, it's the way you relate to people that is most important. Each of us needs do to do something positive for the world we live in.

Nancy Robinson, who had become an ordained minister, echoed Sally's convictions. In old age, her faith was strong. She did not express any doubts that the course of her life had run as it had been meant to run.

I didn't like church when I was a young girl. To me, wet Sundays were always the best, because if it was pouring with rain, we didn't have to go to church. I had the whole day to read. Of all the family, I was the least one you would have thought would go into the ministry. I loathed going to church. The rest of the family always called me a sinner because of this. Later, when I made my decision to become ordained, I knew I was going to establish my own way. I tore down the idea of marriage, said good-bye

percent of 18 – 30 year-olds. Among women over the age of 45, the percentage of weekly church attendance was 68 percent (Abcnews.com.go, 2006)

to my sister and my mother and never looked back. I never doubted that I had responded to God's call.

Robert Gordon, Mabelle Armstrong, and Allison Turner were unique among the participants for making no statements referring to faith or spirituality in their interviews. Neville Schuster was also unusual among the participants. He addressed spirituality and religion and rejected them as a means of achieving happiness and life satisfaction. This is what he said on the subject of religion and life after death.

I do not believe in the notion of God and eternal life. The idea of a God who rewards 'good people' with heaven, and punishes the 'bad' with eternal hell seems fantastical to me. This is in contradiction to the teachings of my youth, when I prayed each night before I went to sleep, thanked God for my food, and at prep school attended church three times a week. I stopped believing in God as an adult many years ago. The happiness in my life results from treating other people in a way that does not make their lives worse for having known me and from the love I feel for my wife and daughter. I do not believe in life beyond death and because of this, I understand how important it is to live each day well. This life is all we have so we need to do the best we can for as long as we are alive.

Neville refuted religion. However, he had addressed spiritual issues – the meaning and purpose of living. He had examined his life, determined the factors that gave it meaning, and proceeded to act in harmony with what he believed to be true. His conclusions did not lead him to a religious community or cause him to seek others who believed as he did. Neville was satisfied with the life he and his wife and daughter shared and they supplied him with the support and social connectedness that other participants sought through their church affiliations and friendships (Dulin, 2005).

Discussion

A significant proportion of the participants, most of them women, in this thesis were active church members. They went to church every Sunday, attended weekday Bible classes, prepared church suppers, visited nursing homes, and hospitals, supported community outreach programs, and participated in special events throughout the year.

They were among the most faithful and dependable of their church's members. They were also among the most spiritual. In deep old age, they felt the imminence of their death; they also felt closer to God. Maisie Harrison told me one day that she was looking for someone who would give her cat a kind and loving home. I was surprised because I knew she loved her cat dearly. She said:

It's no good me being ruled by my heart. It is my head now that must make the decisions. I know I will soon be flying away and then who will look after my cat? If I were going to be here longer, I could let my heart decide, but before long, I will be with my mother and father and my brothers and sisters who have already flown away. Soon I won't be praying to God, I will talking directly to him.

Church attendance supplied these participants' need for friendship, for a social support network, and it kept them socially active. They hosted Bible classes, potluck dinners, and birthday parties in their homes. Women like Maisie Harrison and Susan Eyres, who had disappointing relationships with their sons, cultivated satisfying relationships with older women in similar situations. Eileen Richards' minister referred to her as a "national treasure" because of her commitment to teaching. When she went to church each Sunday, Estelle Doherty escaped the squalid conditions of the public housing complex in which she lived. Because I spent so much time with the participants, I saw them in their homes and at church and I witnessed the positive effect of religion and spirituality upon the quality of their lives. At the time I met them, it is doubtful that Susan Eyres, Maisie Harrison, Mildred Howard, Annabelle Gregson, Hannah Meyers, or Agnes Schultz would have been living independently in their own homes if it had not been for the ministers, priests, deacons, elders, and church friends who gave them hands on aid when they needed it. Ram Dass has suggested the following:

One of the reasons that old age is so disconcerting to many people is that they feel as if they're stripped of their roles. As we enter old age and face physical frailty, the departure of children, retirement, and the deaths of loved ones, we see the lights fading, the audience dwindles, and we are

overwhelmed by a loss of purpose, and by the fear of not knowing how to behave or where we now fit in this play (Dass, 2000: 82).

The participants in this chapter were not without their struggles. However, they were not overwhelmed by loss of purpose or a fear of not knowing where they fit into the world. In deep old age, they carried on with the responsibilities that related to friendship and faith. Their belief systems gave their lives meaning and purpose. When they acted in faith and friendship, they became essential and valuable to others; their sense of worthlessness decreased and their self-esteem increased. Their church membership strengthened the spiritual dimension of their lives and added deep meaning to their old ages.

Conclusions

Well-being from spirituality and religion comes partly from the sense of social connectedness that occurs in shared worship and related activities. The women in this chapter cooked for the poor of their community, they knitted blankets for the homeless, and they visited the sick and homebound. They engaged in these activities as a group and met weekly to encourage each other in their work. They became steadfast friends and their old ages acquired deep meaning. The successful ageing concept acknowledges the importance of social connectedness. However, it does not mention the role of spirituality in 'successful' ageing, whereas most of the participants talked a great deal about the importance of spirituality to well-being in old age. As Sally Dickerson expressed it, "I'm so grateful to God for what I've got."

CHAPTER 15

CONCLUSION

Introduction

The concept of successful ageing is currently used internationally as a tool to promote well-being amongst older people. However, this thesis concludes that the mainstream concept of successful ageing is unlikely to produce well-being for most old people. In earlier chapters, I discussed the reasons for this. The main reason identified in this thesis is that advocates of 'successful ageing' do not ask elders themselves what provides (and detracts from) a sense of well-being. The research project conducted for this thesis was an attempt to begin remedying this by conducting in-depth interviews with elders in two nations and from a number of ethnic groups. Their responses about what provided well-being in their lives showed some overlap but also many important differences from the concept of successful ageing.

As we have seen, the components identified by the participants as essential to well-being were respect, spirituality, loving meaningful relationships with others, independence, and a safe living environment. In contrast, the successful ageing concept cites avoidance of disease and disability, maintenance of cognitive and physical function, and sustained engagement with life.

Unlike the successful ageing concept, the participants in this study did not define well-being in terms of health and function. Although good health was important to them – for example, they were careful what they ate, and few were overweight – health was not an overriding factor in their definition of well-being as it is in the concept of successful ageing. The participants were also engaged, active and productive. However, they did not exercise in gyms or health clubs, and they did not participate in activities in order to be “actively engaged with life, or to be “productive”. They chose activities that were

meaningful to them. They collected food for the poor, cooked meals for the sick, knitted blankets, socks, mittens, and sweaters for the homeless, and those who drove transported their friends and neighbours.

As we have discussed, the concept of successful ageing regards physical and mental functioning as essential to successful ageing. However, chronic disease and disability did not place well-being beyond the reach of the elderly people in this study. Disease and disability made well-being more difficult to achieve, but not impossible. The participants' definition of well-being is much broader than the successful ageing concept; it goes beyond mental and physical function, embracing factors of the human spirit, love, respect, and value. The interview data contains no inferences on the part of any participant that disease and disability in old age signals failure.

A Critique of 'Successful Ageing'

The concept of successful ageing provides a prescriptive model for the education and enlightenment of those about to embark on the journey to old age. People are instructed to keep fit and healthy and maintain social networks, so as to become 'successfully aged', and it is implied, have well-being. The concept of successful ageing places primary responsibility for ageing well on lifestyle choices made by the individual. There are several drawbacks with this view. One is that it fails to take account of social inequalities based on race, gender, and class, and their implications for health in later life. Low income and status have a negative impact upon health, and working class people are more likely to have poor health in old age than more privileged middle class people are. Middle and upper class people are better able to pay for assistance and for private health care. A 'successfully aged' person is therefore likely to be a member of the middle or upper class, who does not need to make demands on the public health system or state welfare.

Women live longer than men live in almost all nations; they are the majority of the very old, and the gender balance of participants in this research project reflects that. However, women are more likely than men are to suffer from long-term, chronic, and often disabling conditions, such as arthritis, which can make it extremely difficult to keep fit. Women are also the majority of those on low incomes, partly as a result of having performed years of unpaid work. Amongst participants in this project, it was women who in middle age had become caregivers for their parents, and in old age, for their husbands. Since most of the women were poor as well, they could not afford to pay nurses, aides, and orderlies to help with the bathing, toileting, lifting, and moving of those in their care. Some had chronic diseases and pain that were the direct result of injuries they sustained as caregivers. These were not, as the successful ageing concept suggests, the result of unwise lifestyle choices. Nevertheless, by the definition of the successful ageing concept, these women, would not be regarded as 'successfully aged'. Membership in an ethnic minority, especially a First Nation group, carries with it an increased risk of poverty, poor health, and early death, in both New Zealand and the United States. Interestingly, however, the Maori participants in this study reported high levels of well-being. These appear to have been the result of the higher levels of respect given to older people in traditional Maori culture. The Maori elders who took part in the research experienced a strong sense of interdependence between themselves and their extended families: of being needed rather than being needy. It is likely that this would have been overlooked in the successful ageing concept, as collective approaches to old age do not figure largely in the concept. In general, the mainstream successful ageing has been criticised for being mono cultural and Eurocentric: this was similarly a finding in this research. The liberalism and individualism inherent in the successful ageing concept is one example of its liberal-western heritage.

A further problem with the concept of successful ageing is that it presents a picture of healthy middle age rather than old age. Most people (unless they die without living their full life span) experience physical and mental decline from old age and everyone eventually dies. The normal processes of ageing are presented as aberrant, avoidable failings, capable of being delayed indefinitely. True old age is not squarely addressed. In short, 'successful ageing' is ageist. It is likely to make poor, sick, lonely, and disabled old people feel unsuccessful as well.

Overlaps between 'Successful Ageing' and Well-Being in Old Age

There were some areas of overlap between 'successful ageing' and well-being in old age as identified by the participants in this study. In common with the successful ageing concept, many of the participants placed high value upon independence. However, this was mainly true of the participants who were of European descent, who had been raised in cultures that value independence and individual self-reliance, whereas the Maori and Cherokee participants stressed the value of interdependence.

The participants of European descent, both those in New Zealand and the United States, dreaded the idea of being put in a nursing home against their wishes. As we have seen, this had happened to some of them, and their experiences of loss of freedom and choice illustrate the reasons why elders generally prefer to avoid institutional care wherever possible. Much of what they did, therefore, was aimed at helping themselves and their friends remain in their own homes. For the Maori participants, this was not an issue since even those who had difficult family relationships did not expect to be placed in a nursing home.

For participants of European extraction, being able to stay independent and out of a nursing home was critical to their sense of well-being. Nevertheless, independence had a negative side, which affected their well-being. For those who succeeded in remaining

at home, but had poor health, loneliness was often a major issue. For example, during the months that Mildred Howard was confined to her home with a broken hip, her loneliness and pain were major problems. She often called her friends for help. “I am lonely”, she would say, “Come and spend some time with me and if you can’t come, talk to me on the phone”; and fortunately, they did – during the months that she was homebound, Mildred had a daily telephone call or visit from one of her friends.

Another area where there is a degree of overlap relates to spirituality and religion. A high proportion of the participants in this study (and of older people more generally) regularly attend religious services and other church-related activities. According to the successful ageing concept, this is a way of being socially connected, and it is certainly one social outlet that many of the participants in this study appeared to find beneficial. However, the notion of spirituality itself is absent from the successful ageing concept, as indeed is the question of why so many older people seek comfort from religion.

In general, however, there were many differences between ‘successful ageing’ and self-report well-being in old age. This was particularly true for the Maori participants, for whom well-being included the health of the land, and a responsibility to care for the earth: a consideration entirely absent from the concept of successful ageing. For all the participants, a sense of being valued and respected was crucial to their well-being. For these participants and others like them, who would have been considered ‘unsuccessfully aged’, the concept of successful ageing would achieve exactly the opposite of a sense of being valued and respected.

Towards Well-Being in Old Age

This study concludes that the successful ageing concept does not promote well-being in old age. It congratulates elders who have good health and social activities, whilst relegating those who are housebound and in poor health to the status of ‘unsuccessfully

aged'. Further, it has neglected to ask what elderly people have to say about the factors that *do* produce optimal well-being. The greatest failing of the successful ageing concept is that it for the most part ignores the voices of the elderly who know most about what contributes to and what detracts from well-being in old age. This statement brings us full circle back to the overriding lesson learned from this thesis: the elderly participants were frequently able to define well-being for themselves and their friends. They had a range of valuable insights into what was necessary to promote the best possible old age. The problem was that few people were listening to them; lacking an audience, their needs went unmet.

This leads me to suggest that many of the challenges which elderly people present to twenty-first century liberal western societies could be resolved if we listened to the solutions *they* propose. This is no simple statement; neither is it an easy solution to the challenges presented by demographic changes. Listening requires that attention be paid to the individual who is speaking. This cannot happen in single community meetings between political leaders and older constituents. After three years of meaningful communication with my elderly participants, I am still learning from what they had to say to me about a good old age. Furthermore, in community meetings, many of the elderly whose viewpoints we need to hear, if we are to create a successful social strategy for ageing, may not be present. It is not enough to develop a strategy *for* older people. Strategies for ageing should be designed in cooperation *with* our elders. Policy makers may provide the energy and the expertise to execute strategies for ageing, but older people - those who belong to ethnic minorities and those who do not, the sick and the well, the well-educated and the less educated - in other words, elderly people from *all* strata of society should be included in any national strategy for ageing.

In its current state, our system for delivering services to elderly citizens does not allow adequate time for service workers to talk meaningfully to their clients. It allows even less time for the ideas and insights of older people to be transformed into better practice and policy. Maisie Harrison's comments about her social worker, "She wasn't the least bit caring", refer in part to the fact that the ten-minute assessment of her needs did not include listening to anything she had to say. A frequent complaint of nurses for example, in hospitals, skilled nursing facilities, and long-term care facilities is understaffing which leads to quick rounds, brief hellos, and unsatisfactory communication between health care providers and their clients.

Through interviews and observations over a prolonged period of time, of a small number of elderly people in order to discover what gives them a sense of well-being, this study has begun to remedy the problem,. The experiences of the participants may not be typical of a majority of the elders in their societies; in addition, my personal beliefs about old age have influenced the examination and interpretation of the interview data. Nevertheless, the study is valuable for its in-depth comparison of the concept of successful ageing with the concept of a good old age as defined by a diverse group of elderly people. The participants raised a number of issues that contributed to their well-being, which the successful ageing concept overlooks. Love, respect, meaningful relationships, and feeling valued increased the well-being of these participants. Their physical environment – whether they had access to transport, affordable, safe housing, and whether pavements were well maintained, also affected their sense of well-being. All these factors were things socially created and impossible for one elderly person to achieve alone. This research raises questions that could be usefully explored by further

research. For example, how widespread are the views of these elderly people? Once we know, what can be done to promote well-being amongst older people?

Arguably, the next task should be to see what could be done on this and other research findings to promote the good old age defined by older people. That is beyond the scope of this thesis. It is a truism that we have an ageing population. Social policies will therefore have a major impact for better or worse upon the health and well-being of an extremely large proportion of the voting population. At present, there are rising concerns on the part of policy makers about the health and welfare costs associated with the ageing population. However, promoting well-being in old age as defined by elderly people may or may not necessarily be more costly than promoting 'successful ageing'. At this stage, we do not know. However, to promote well-being in old age, and as a mark of respect, it is vital that we move away from categorising older people as successfully or unsuccessfully aged, and instead ask them this question: what promotes well-being for them?

REFERENCES

- 109th U.S. Congress (2005-2006). (2005). *H.R. 2629: Positive Aging Act of 2005* [Data File]. Available from GovTrack.us, <http://www.govtrack.us/congress/bill>.
- 50plus.com. (2005). *CARP and Human Rights Commission to fight ageism* [Article by Keith Norton]. Available from 50plus.com, <http://en.50plus.com>.
- AARP. (2005, June 1). *Beyond 50.05* (A report to the nation on liveable communities: Creating environments for successful aging). Washington, DC: AARP Public Policy Institute.
- ABCNEWS.com. (2006). *Who goes to church?* [Report]. Available from ABC News, www.abcnews.go.com
- Achenbaum, W. A. (1995). *Crossing frontiers: Gerontology emerges as a science*. Cambridge, England: Press Syndicate of the University of Cambridge.
- Across the Boundaries Project. (2002). *Keeping jobs and raising families in low-income America: It just doesn't work* (Report conducted by the Radcliffe Public Policy Center and 9to5National Association of Working Women). Cambridge, MA: Harvard University.
- Adams, B. (2006, May 7). Area teachers are retiring in droves. *Times Leader*, p. N/A.
- Aditya, B. S., Sharma, J. C., Allen, S. C., & Vassallo, M. (2003). Predictors of a nursing home placement from a non-acute geriatric hospital. *Clinical Rehabilitation*, 17, 108-113.
- Age Concern England. (2005). *Making more of life* [Data File]. Available from Age Concern: Staying Active, <http://www.ace.org.uk>.

- Age Concern England. (2005, May 4). *The Gray vote - UK elections 2005* (Interview with Neil Churchill, Communications Director, Age Concern England). Washington, DC: AARP Policy & Research.
- Age Concern New Zealand. (1999). *Policy Manifesto 1999* [Data file]. Available from Age Concern New Zealand, national.office @ageconcern.nz.
- Age Concern Northern Ireland. (2001). In Ageing Population Panel (Ed.), *Northern Ireland Ageing Population Panel Report* (Report 2001). Belfast, Ireland: Age Concern Northern Ireland; Department of Enterprise, Trade and Investment; Foresight Northern Ireland. Retrieved May 2, 2006, from Age Concern Northern Ireland Web site: <http://www.ageconcernni.org>.
- Age Concern. (2006). *Ageism Campaign* [Policy & Campaigns]. Available from Age Concern, <http://www.ace.org.uk>
- Agich, G. J. (2003). *Dependence and autonomy in old age: An ethical framework for long-term care*. Cambridge, England: Press Syndicate.
- Ahdar, R. (2003). Indigenous spiritual concerns and the secular state: Some New Zealand developments. *Oxford Journal of Legal Studies*, 23(4), 611-637.
- Ainsworth, P. (2000). *Understanding depression*. Jackson: University Press of Mississippi.
- AJN. (1999). Ageism in medicine. *American Journal of Nursing*, 99(5), 10.
- Allen, P. G. (1997). Indian Summer. In M. Pearsall (Ed.), *The other within us: Feminist explorations of women and aging* (pp. 233-238). Boulder, CO: Westview Press.
- Alliance for Aging Research. (2003). *Ageism: How healthcare fails the elderly* (Hearing of the U.S. Senate Special Committee on Aging) [Electronic version]. Washington, DC: Alliance for Aging Research.

- Alpass, F. M., & Neville s. J. (2005). Suicide ideation in New Zealand older males (1991=2000). *International Journal of Men's Health*, 4(2), 277-286.
- Alter, D. A., Chong, A., Austin, P. C., Iron, K., Williams, J. I., Morgan, C. D., et al. (2006). The relationship of socioeconomic status and health: Status to outcomes following heart attack. *Annals of Internal Medicine*, 144(2), 142.
- Alves,D., & Cleveland, P. (1999). *The Maori and the Crown: An indigenous people's struggle for self-determination*. Westport, CT: Greenwood Press.
- Ambitious Federal elder justice proposal developed by Sen. Breaux. (2005, June/July). *National Center on Elder Abuse*, 4(11-12), 1-3.
- American Association of Retired Persons. (2005). *Public policy priorities: Economic security* [Public policy bulletin]. Available from AARP, <http://www.aarp.org/issues/policies>.
- American Psychological Association. (2000). *Resolution on poverty and socioeconomic status* (Resolution). Washington, DC: American Psychological Association. Retrieved May 12, 2006, from APA Online Web site: <http://www.apa.org>.
- Anchorage Senior Citizens Advisory Commission. (1999). *Successful aging in Anchorage* (Final Report) [Electronic version]. Anchorage, Alaska: Municipality of Anchorage.
- Anderson, K. (1997). *Changing woman: A history of racial ethnic women in modern America*. New York: Oxford University Press.
- Andrews, G., Clark, M., & Luszcz, M. (2002). Successful aging in the Australian Longitudinal Study of Aging. *Journal of Social Issues*, 58(4), 749-765.
- Andrews, J., & Manthorpe, J. (2004). Older community nurses: Perspectives and prospects. *British Journal of Community Nursing*, 9(7), 274-280.

- Annan, K. (2000). *Secretary-General's message marking International Day of Older Persons* (SG/SM/7560OBV/161) [Electronic version]. New York: United Nations.
- Anti-aging or successful aging? (2001, April). *Tufts University Health & Nutrition Letter*, 19(2), 1.
- Appelbaum, S. H., Patton, E., & Shapiro, B. (2003). The early retirement incentive program. *Journal of European Industrial Training*, 27(1), 22-35.
- Ariza, R. P. (2002, April). *Aging on the World Stage*. Perspectives for the media on longevity with world experts on population aging presented at the United Nations Second World Assembly on Ageing, Madrid, Spain.
- Armstrong, M. J. (2003). Is being a grandmother being old? Cross-ethnic perspectives from New Zealand. *Journal of Cross-cultural Gerontology*, 18, 185-202.
- Aruguete, M. S., Yates, A., & Edman, J. (2006). Gender differences in attitudes about fat. *American Journal of Psychology*, 8(1), 183-192.
- Asahara, K., Momose, Y., Sachiyo, M., Okubo, N., & Magilvy, J. K. (2001). The relationship of social norms to use of services and caregiver burden in Japan. *Journal of Nursing Scholarship*, 33(4), 375-381.
- Asai, M. O., & Kameoka, V. A. (2005). The influence of sekentei on family caregiving and underutilization of social services among Japanese caregivers. *Social Work*, 50(2), 111-118.
- Ashton, T. (2000). New Zealand: Long-term care in a decade of change. *Health Affairs*, 19(3), 72-85.
- The Assembly Line. (1996, June). *Inventor of the Week Archive, Henry Ford*. Retrieved June 1, 2006, from Lemelson-MIT Program Web site: <http://web.mit.edu/invent>.
- Atchley, R. C. (1980). *The social forces in later life*. Belmont, CA: Wadsworth.

- Atchley, R. C. (1989). A continuity theory of normal aging. *The Gerontologist*, 29, 183-190.
- Atchley, R. C. (1999). *Continuity and adaptation in aging: Creating positive experiences*. Baltimore: The Johns Hopkins University Press.
- Atchley, R. C., & Barusch, A. G. (2004). *Social forces & aging* (10th ed.). Belmont, CA: Wadsworth/Thomson Learning.
- Atkinson, A. B. (2004, November). *The future of social protection in a unifying Europe*. Lecture presented at the First Kela Lecture delivered in Helsinki, Helsinki, Finland.
- Attwood, B., & Magowan, F. (Eds.). (2001). *Telling stories: Indigenous history and memory in Australia and New Zealand*. Crows Nest, NSW: Allen & Unwin.
- Aud, M. A., & Rantz, M. J. (2005). Admissions to skilled nursing facilities from assisted living facilities. *Journal of Nursing Care Quality*, 20(1), 16-26.
- Australian Department of Health and Ageing. (2005). *The National Strategy for an Ageing Australia* [Data file]. Available from Australian Department of Health and Ageing, <http://www.gov.health.au>.
- Australian Department of Health, & Ageing. (2004). Quality information on ageing for all Australians. In *Home Page* (Online Health). Canberra, Australia: Australian Department of Health & Ageing. Retrieved August 11, 2004, from Home Page (Online Health Web site: <http://www.seniors.gov.au>).
- Austrian, S. G. (2002). *Developmental theories through the life cycle*. New York: Columbia University Press.
- Avorn, J. (1984). Benefit cost analysis in geriatric care: Turning age discrimination into health policy. *New England Journal of Medicine*, 310, 1294-1301.

- Ayres, M. M., & Woodtli, A. (2001). Concept analysis: Abuse of ageing caregivers by elderly care recipients. *Journal of Advanced Nursing*, 35(3), 326-334.
- Baird, A. L., & Grieve, F. G. (2006). Exposure to male models in advertisements leads to a decrease in men's body satisfaction. *North American Journal of Psychology*, 8(1), 115-121.
- Baker, W., Levacy, J. H., Jr., Gutierrez, M. A., Ochoa, E. Z., & Retana, M. B. 1999-2000. Cowboys of the Americas: Argentina gauchos and North American Southern Plains cowboys. In W. Baker, J. H. Levacy, Jr., M. A. Gutierrez, E. Z. Ochoa, & B. B. Retana (Series Eds.) & TTU International Cultural Center & Lubbock City-County Library (Vol. Eds.), *Texas Tech University Southwest Collection* (pp. 1-60). Lubbock: Museum of Texas Tech University.
- Baltes, P. B. (2006). Facing our limits: Human dignity in the very old. *Daedalus*, 135(1), 32-40.
- 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* (pp. 1-34). Cambridge, MA: Cambridge University Press.
- Baltes, P. B., & Baltes, M. M. (1998). Savoir vivre in old age. *National Forum*, 78(2), 13-19.
- Baltes, P. B., & Smith, J. (Eds.). (2002). New frontiers in the future of aging: From successful aging of the young-old to the dilemmas of the Fourth Age. In P. B. Baltes & J. Smith (Eds.), *Max Planck Institute for Human Development Berlin*, Germany: Max Planck Institute.
- Bambrick, P., & Bonder, B. (2005). Older adults' perceptions of work. *Work*, 24(1), 77-84.

- Barber, B. R. (2005). Dreamers without borders: What happened to the EU treaty looks a lot like what happened in America last year. *The American Prospect*, 16(8), 39-43.
- Barber, D. (1998). The dawning of "The third age." *New Zealand Management*, 56(5), 46-48.
- Bardsley, D. (2000). *The land girls: In a man's world 1939-1946*. Dunedin, New Zealand: University of Otago Press.
- Barnett, R. C. (2005). Ageism and sexism in the workplace. *Generations*, 29(3), 25-30.
- Barnett, R., & Barnett, P. (2004). Primary health care in New Zealand: Problems and policy approaches. *Social Policy Journal of New Zealand*, 21, 49-66.
- Bartlam, B., Bernard, M., & Biggs, S. (2004). *New lifestyles in old age: Health, identity and well-being in retirement communities* (Keele University Centre for Social Gerontology). Keele, England: Keele University. Retrieved May 2, 2006, from Keele University Centre for Social Gerontology Web site: <http://www.keele.ac.uk>.
- Baskett, J. (2000). The four cornerstones of well-being in a multicultural society. *Age and Ageing*, 29(5), 465-466.
- Bass, S. A., Caro, F. G., & Chen, Y. P. (Eds.). (1993). *Achieving a productive aging society*. Westport, CT: Auburn House.
- Bass, S. A., Caro, F. G., & Chen, Y-P. (Eds.). (1993). *Achieving a productive aging society*. Westport, CT: Auburn House.
- Battiste, M., Bell, L., & Findlay, L. M. (2002). An interview with Linda Tuhiwai Te Rena Smith. *Canadian Journal of Native Education*, 26, 169-201.
- Batty, D. (2004, October 11). Old age 'treated like an illness'. *The Guardian*. Retrieved May 2, 2006, from The Guardian Web site: <http://politics.guardian.co.uk>.

- Batty, D. (2005, August 2). Charity urges human rights protection for older people. *Society Guardian*. Retrieved June 27, 2006, from Society Guardian Web site: <http://www.society.guardian.co.uk>.
- Bauman, S., Adams, J. H., & Waldo, M. (2001). Resilience in the oldest-old. *Counselling and Human Development*, 34(2), 1-20.
- Bearon, L. B. (1996). Successful aging: What does the "good life" look like? *The Forum for Family and Consumer Issues*, 1(3). Retrieved November 15, 2001, from North Carolina State University Family and Consumer Sciences Web site: <http://www.ces.ncsu.edu>.
- Becker, E. (1971). *The birth and death of meaning*. New York: Free Press.
- Becker, E. (1973). *The denial of death*. New York: Free Press.
- Becker, E. (1975). *Escape from evil*. New York: Free Press.
- Beedon, L., Southworth, L., & Gist, J. (2006). The state of 50+ America 2006. In *The health quality of older Americans* (Research report). Washington, DC: AARP Policy & Research for professionals in aging.
- Beehive.govt.nz. (2005). *Address to government superannuitants conference* [Address by Dr. Michael Cullen]. Available from beehive.govt.nz, <http://www.beehive.govt.nz>.
- Beehive.govt.nz. (2005). *More cataract and joint operations* [Official website of the New Zealand government]. Available from beehive.govt.nz, <http://www.beehive.govt.nz>.
- Ben-Zira, Z. (1991). *Regression, stress, and readjustment in aging: A structured, biopsychosocial perspective on coping and professional support*. New York: Praeger Publishers.

- Berger, B. R. (2004). "Power over this unfortunate race": Race, politics and Indian law in United States v. Rogers. *William and Mary Law Review*, 45(5), 1957-2053.
- Bernard, M. (2004). Overcoming ageism, one student at a time. *Geriatrics*, 59(12), 11.
- Bernard, M., & Phillips, J. (2000). The challenge of ageing in tomorrow's Britain. *Ageing and Society*, 20, 35-54.
- Bernard, M., Ogg, J., Phillips, J., & Phillipson, C. (2000). *The family and community life of older people: Social networks and social support in three urban areas*. New York: Routledge.
- Besser, A., & Priel, B. (2005). Interpersonal relatedness and self-definition in late adulthood depression: Personality predispositions, and protective factors. *Social Behavior and Personality*, 33(4), 351-382.
- Best, E. (1954). *Spiritual and mental concepts of the Maori* [Electronic version]. Wellington, New Zealand: R. E. Owen, Government Printer.
- Bhattacharya, M., & Smith, R. (2001). Aging and productivity among judges: Some empirical evidence from the High Court of Australia. *Australian Economic Papers*, 40(2), 199-213.
- Biggs, S. (2001). Toward critical narrativity stories of aging in contemporary social policy. *Journal of Aging Studies*, 15(4), 303-317.
- Binstock, R. H. (1983). The aged as scapegoat. *The Gerontologist*, 23, 123-143.
- Binstock, R. H. (2002). In memoriam: Bernice L. Neugarten. *The Gerontologist*, 42(2), 149-151.
- Binstock, R. H. (2004). Advocacy in an era of neoconservatism: Responses of Nation Aging organizations. *Generations*, 28(1), 49-54.
- Binstock, R. H. (2005). Old-age policies, politics, and ageism. *Generations*, 29(3), 73-77.

- Birren, J. E. (1959). Principles of research on aging. In J. E. Birren (Ed.), *Handbook of aging and the individual* (pp. 2-42). Chicago: University of Chicago Press.
- Bissell, K. L. (2004). What do these messages really mean? Sports media exposure, sports participation, and body image distortion in women between the ages of 18 and 75. *Journalism & Mass Communication Quarterly*, 81(1), 108-123.
- Bjorn, A., & Strang, V. R. (2001). Family caregiver respite and leisure: A feminist perspective. *Scandinavian Journal of Caring Sciences*, 15, 74-81.
- Black Irish. (1989). In *Oxford English Dictionary* (Second ed.). Retrieved May 28, 2005, from Oxford English Dictionary Online Web site:
- Blaikie, A. (1999). *Ageing and popular culture*. Cambridge, England: Cambridge University Press.
- Blodgett, L. J., Boyer, W., & Turk, E. (2005). No thank you not today: Supporting ethical and professional relationships in large qualitative studies. *Forum Qualitative Social Research*, 6(3). Retrieved October 10, 2005, from Forum Qualitative Sozialforschung/Forum Web site: <http://www.qualitative-research.net/fqs-texte/3-05/05-3-e.htm>.
- Blomqvist, P. (2004). The choice revolution: Privatization of Swedish welfare services in the 1990s. *Social Policy & Administration*, 38(2), 139-155.
- Blum, V. (2005). Becoming the other woman. *Frontiers: A Journal of Women's Studies*, 26(2), 104-131.
- Blundo, R., & Bowen, D. E. (2005). Aging and older men: Thoughts, reflections and issues. *Journal of Sociology & Social Welfare*, 32(1), 3-8.
- Blundo, R., & Estes, T. (2005). The peculiarities of men aging: A collection of anecdotes. *Journal of Sociology & Social Welfare*, 32(1), 61-70.

- Boas, M., Braathen., E., & Saether, G. (2000). *Ethnicity kills? The politics of war, peace, and ethnicity in Subsaharan Africa*. Houndmills, England: Macmillan Press.
- Bochin, H. W. (1990). *Richard Nixon: Rhetorical strategist*. New York: Greenwood Press.
- Bode, H. A. Eykerman., P., & Verhoeven, R. J. (2005). Getting Belgium back to work. *Mckinsey Quarterly*, 1, 26-29.
- Bonn, D. (1999). Never too late to tackle serum cholesterol. *Lancet*, 354(9178), 575-579.
- Boost.com. (2005). *The Importance of Interaction* [Interview with Dr. Kahn]. Available from Novartis Medical Nutrition, <http://www.boost.com>
- Borchelt, M., Jopp, D., Maier, H., & Smith, J. (2002). Health and well-being in the young old and oldest old. *Journal of Social Issues*, 58(4), 715-732.
- Borowski, A., Encel, S., & Ozanne, E. (1997). *Ageing and social policy in Australia*. Cambridge, England: Cambridge University Press.
- Boruassa, S. C., & Strong, A. L. (2002). Restitution of land to New Zealand Maori: The role of social structure. *Pacific Affairs*, 75(2), 227-263.
- Boston University School of Medicine. (2000). *The New England Centenarian Study (Overview)* [Report]. Available from Boston University School of Medicine, <http://www.bumc.bu.edu>
- Boston University School of Medicine. (2003). *New England Centenarian Study (Summary Report)*. Boston: Boston University. Retrieved April 7, 2003, from New England Centenarian Study Web site: <http://www.bumc.bu.edu>.
- Boston, J. (1993). Reshaping social policy in New Zealand. *Fiscal Studies*, 14(3), 64-86.
- Bowling, A. (1999). Ageism in cardiology. *British Medical Journal*, 319, 1353-1355.
- Bowling, J., Hill, R. D., Morrison, A., & Thorn, B. L. (Eds.). (2002). *Geriatric Residential Care*. Mahway, NJ: Lawrence Erlbaum Associates.

- Braithwaite, V. (2002). Reducing ageism. In *Ageism: Stereotyping and prejudice against older persons* (pp. 311-337). Cambridge, MA: MIT Press.
- Breen, N., Snipp, M., & Thornton, R. (1992). *The Cherokees: A population history*. Lincoln: University of Nebraska Press.
- Breitkreuz, R. S. (2005). Engendering citizenship? A critical feminist analysis of Canadian welfare-to-work policies and the employment experiences of lone mothers. *Journal of Sociology & Social Welfare*, 32(2), 147-166.
- Brennan, F. H. (2002). Exercise prescriptions for active seniors. *Physician & Sports Medicine Online*, 30(2). Retrieved August 6, 2005, from The Physician & Sports Medicine Online Journal Web site: <http://www.physsportsmed.com>.
- Brickey, M. (2001). The extended life: Four strategies for healthy longevity. *The Futurist*, 35(5), 52-56.
- Brougham, A. E., Reed, A. W., & Karetu, T. (1996). *The Reed book of Maori proverbs*. Auckland, NZ: Reed Publishing. (Original work published 1963)
- Browne, C. V. (1998). *Feminism and aging*. New York: Springer.
- Brubaker, D. L., & Thomas, R. M. (2000). *Theses and dissertations: A guide to planning, research, and writing*. Westport, CT: Bergin & Garvey.
- Brundtland, G. H. (1999). *Active ageing makes the difference* (Introduction presented at the World Health Day 1999) [Electronic version]. Geneva, Switzerland: United Nations.
- Buller, W. L. (1882). *Address of Dr. Buller as counsel for Ngati Apa in the Native Land Court* (Address presented at the Native Land Court). Wellington, New Zealand.
- Bureau of Indian Affairs Statement of Responsibility*. (2004). Retrieved June 8, 2004, from United States Department of the Interior Web site: www.doi.gov-bureau-indian-affairs.html.

- Burgess, E. W. (1954). Social relations, activities, and personal adjustment. *American Journal of Sociology*, 59, 352-360.
- Burgio, L. D., Allen-Burge, R., Roth, D. L., Bourgeois, M. S., Dijkstra, K., Gerstle, J., et al. (2000). Improving communication between nursing assistants and nursing home residents during care routines. *The Gerontologist*, 41(4), 449-460.
- Burns, J., Dwyer, M., Lambie, H., & Lynch, J. (1999). *Homecare workers - A case study of a female occupation* (A research report commissioned by the Ministry of Women's Affairs). Wellington, New Zealand: New Zealand Ministry of Women's Affairs.
- Burstow, P. (2005). Speech - Care home concerns: The fight for rights. In *Relatives and Residents Association Conference* (Speech ed.) Folkestone, England: Ian Munro.
- Bury Metro Executive Committee. (2005). *Positive Ageing Strategy* [Data file]. Available from Bury Metro Executive Committee, <http://burydem.bury.gov.uk>.
- Bury, M., & Holme, A. (1991). *Life after ninety*. New York: Routledge.
- Butler, R. N. (1969). Ageism: Another form of bigotry. *The Gerontologist*, 9, 243.
- Butler, R. N. (1993). Dispelling ageism: The cross-cutting intervention. *Generations*, 17(2), 75-79.
- Butler, R. N. (2001, July). *Longevity and healthy aging: Evidence and action*. Paper presented at the International Association of Gerontology's 17th World Congress of Gerontology, Vancouver, Canada.
- Butler, R. N. (2002). Written testimony of Robert N. Butler, M.D. In *Testimony before the U.S. Senate Special Committee on Aging*. New York: International Longevity Center.
- Butler, R. N. (2002a). Image of aging in media and marketing. In *FDCH Congressional Testimony* (Vol. 09/04/2002) Washington, DC: Senate Special Aging Committee.

- Butler, R. N. (2002b). The study of productive aging. *Journals of Gerontology: Social Sciences*, 57B, S323.
- Butler, R., & Fillit, H. (2006). Gerontology. In *Encyclopedia Americana*. Retrieved June 15, 2006, from <http://ea.grolier.com.ezproxy.appolibrary.com/cgi-bin/article?assetid+0174580-00>.
- Buttersworth's Publications. (2003). *Laws of New Zealand* [Data file]. Available from Buttersworth Online: <http://www.buttersworthonline.com>.
- Bynoe, A. J. (2000). Social welfare effects of structural adjustment in Trinidad and Tobago. *International Advances in Economic Research*, 6(3), 593-594.
- Byrne, G. J. A., & Raphael, B. (1997). The psychological symptoms of conjugal bereavement in elderly men over the first 13 months. *International Journal of Geriatric Psychiatry*, 12, 241-251.
- Bytheway, B. (1997). *Ageism*. Buckingham, England: Open University Press.
- Bytheway, B. (2005). Ageism and age categorization. *Journal of Social Issues*, 61(2), 361-374.
- Cadigan, T. (2001). Land ideologies that inform a contextual Maori theology of land. *Ecotheology*, 6(1, 2), 123-137.
- Calasanti, T. (2005). Ageism, gravity, and gender: Experiences of aging bodies. *Generations*, 29(3), 8-12.
- Calasanti, T., Slevin, K. F., & King, N. (2006). Ageism and Feminism: From "et cetera" to center. *NWSA Journal*, 18(1), 13-30.
- Callahan, C. M., & McHorney, C. A. (2003). Successful aging and the humility of perspective. *Annals of Internal Medicine*, 139(5), 389-390.

- Callen, B. L., & Wells, T. J. (2005). Views of community-dwelling, old-old people on barriers and aids to nutritional health. *Journal of Nursing Scholarship*, 35(3), 257-263.
- Callow, M. (2004). Identifying promotional appeals for targeting potential volunteers: An exploratory study on volunteering motives among retirees. *International Journal of Nonprofit and Voluntary Sector Marketing*, 9(3), 261-274.
- Canadian Intergovernmental Conference Secretariat. (2005). *Federal-Provincial-Territorial Ministers responsible for seniors share commitment to working together for seniors* [Data file]. Available from Canadian Intergovernmental Conference Secretariat, <http://www.scics.gc.ca/>.
- Caraley, D. (1996). Dismantling the federal safety net: Fictions versus realities. *Political Science Quarterly*, 111(2), 225-259.
- Carden, G. (1994). The Southeast. In C. F. Taylor (Ed.), *Native American myths and legends* (pp. 13-25). New York: Smithmark Publishers.
- Cardol, M., DeJong, B. A., & Ward, C. D. (2002). On autonomy and participation in rehabilitation. *Disability and Rehabilitation*, 24(18), 970-974.
- Carlson, T. (2002, Spring). Vital information. *Good Age Newspaper*. Retrieved August 1, 2004, from Amherst H. Wilder Foundation Web site: <http://www.wilder.org/goodage>.
- Catalyst. (2002). *The challenge of longer life - economic burden or social opportunity* (ISBN 9 904508 02 2). London: Central Books.
- Cato Institute. (2004, September 9). *Mandatory retirement age rules: Is it time to re-evaluate?* (Presented to United State Senate Special Committee on Aging). Washington, DC: Jagadeesh, G.

- Centres of Excellence for Women's Health. (2002). In C. Reid (Ed.), *A full measure: Women's occupational status and health* (Research Bulletin, Volume 2, Number 3). Winnipeg, Manitoba: Centres of Excellence for Women's Health.
- Cerrato, I. M., & deTroconiz, M. I. (1998). Successful aging: But, why don't the elderly get more depressed? *Psychology in Spain*, 2(1), 27-42.
- Chapleski, E. E., Lichtenberg, P. A., Dwyer, J. W., Youngblade, L. M., & Tsai, P. F. (1997). Morbidity and comorbidity among Great Lakes American Indians: Predictors of functional ability. *The Gerontologist*, 37(5), 588-598.
- Chappell, N. L., & Driedger, L. (1987). *Aging and ethnicity: Toward an interface*. Toronto, Canada: Butterworth's.
- Cheal, D. (1996). *New Poverty: Families in postmodern society*. Westport, CT: Praeger Publishers.
- Cherline, A. (1983). A sense of history: Recent research on aging and the family. In M. W. Riley (Ed.), *Aging in society: Selected reviews of recent research* (pp. 5-24). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Cherokee. (2002). In *Wikipedia* (Vol. 1.2). Retrieved June 8, 2004, from Wikipedia Web site: <http://www.en.wikipedia.org/wiki>.
- Chipperfield, J. G., & Havens, B. (2001). Gender differences in the relationship between marital status transitions and life satisfaction in later life. *The Journals of Gerontology: Series B: Psychological and Social Sciences*, 56B(3), 176-177.
- Chipperfield, J. G., Perry, R. P., & Menec, V. H. (1999). Primary and secondary control-enhancing strategies: Implications for health in later life. *Journal of Aging and Health*, 1(4), 517-539.
- Choi, & Sharpe, D. L. (2005). Transition to poverty among the elderly. *Consumer Interests Annual*, 51, 43-53.

- Chopra, D., & Simon, D. (2001). *Grow younger, live longer*. New York: Harmony Books.
- Chou, K-L. (2002). Successful aging among the young-old, old-old, and oldest-old Chinese. *International Journal of Aging & Human Development*, 54(1), 1-15.
- Christiansen, C. (2000). Defining lives: occupation as identity. *American Journal of Occupational Therapy*, 53, 547-558.
- Clark, D. (2003). Jewish museums: From Jewish icons to Jewish narratives. *European Judaism*, 36(2), 4-22.
- Clarke, K., & Neuwelt, P. (2003, July). *Community participation in primary health organisations: A framework based on Tikanga*. Conference paper presented at the Public Health Association Conference 2003, Hamilton, New Zealand.
- Classic Reader. (2005). *Idylls of the king: Lancelot and Elaine* [Classic literature]. Available from Classic Reader, <http://www.classicreader.com>
- The Cleveland Foundation. (2004). In R. Batyko (Ed.), *The Cleveland Foundation's successful aging initiative becomes role model for cities facing surging population of older adults* (Press Release). Cleveland, OH: The Cleveland Foundation. Retrieved May 3, 2006, from Successful Aging Initiative Web site: <http://www.successfulaging.org>.
- The Cleveland Foundation. (2005). *Successful Aging Initiative* [Data File]. Available from the Successful Aging Initiative, <http://www.successfulaging.org/>.
- Cobb, S. (1976). Presidential address - 1976: Social support as a moderator of life stress. *Psychosomatic Medicine*, 38(5), 300-314.
- Coffin, J. G. (1998). 'Homework in comparative perspective'. *Labor History*, 39(4), 423-426.

- Cohen, R. (1984). Age and culture as theory. In D. I. Kertzer & Keith J (Eds.), *Age & anthropological issues in biological gerontology* (pp. 234-249). Ithaca, NY: Cornell University Press.
- Cole, S. L. (1999). Missing Alice: In search of a mother's voice. In *Figuring age: Women, bodies, generations* (pp. 336-339). Bloomington, IN: Indiana University Press.
- Cole, T. R. (1986). The "Enlightened view of aging": Victorian morality in a new key. In T. R. Cole & S. A. Gadow (Eds.), *What does it mean to grow old?* (pp. 117-130). Durham, NC: Duke University Press.
- Cole, T. R. (1993). The prophecy of senescence. In K. W. Schaie (Ed.), *Societal impact on aging: Historical perspectives* (pp. 165-181). New York: Springer.
- Coleman, P. G. (1993). *Adult development and aging* (2nd ed.). Oxford, England: Oxford University Press.
- Collings, P. (2001). "If you got everything, it's good enough": Perspectives on successful aging in a Canadian Inuit community. *Journal of Cross-cultural Gerontology*, 16(2), 127-156.
- Collings, P. F. (1999). Our elders come first: Human development and aging. *Dissertation Abstracts*, 1, 1-205. (UMI No. 9940830)
- Collins, C., & Jones, R. (1997). Emotional distress and morbidity in dementia carers: A matched comparison of husbands and wives. *International Journal of Geriatric Psychiatry*, 12, 1168-1173.
- Comfort, A. (1977). *A good age*. London: Mitchell Beazley Publishers.
- Condliffe, J. B. (1959). *New Zealand in the making*. London: Allen & Unwin.

- Cooper, J. E., & Ah Nee-benham, M. (Eds.). (2000). *Indigenous educational models for contemporary practice: In our Mother's voice*. Mahway, NJ: Lawrence Erlbaum Associates.
- Costa, D. L. (1998). The evolution of retirement: Summary of a research project. *American Economic Review*, 88(2), 232-236.
- Coughlin, T. A., & Zuckerman, S. (2005). Three years of state fiscal struggles: How did Medicaid and SCHIP fare? *Health Affairs*, 24, 385-399.
- Coupland, J., & Nussbaum, J. F. (2004). *Handbook of communication and aging research*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Covinsky, K. E., Palmer, R. M., Fortinsky, R. H., Counsell, S. R., Stewart, A. L. Dresevic., D., Burant., et al. (2003). Loss of independence in activities of daily living in older adults hospitalized with medical illnesses: Increased vulnerability with age. *Journal of The American Geriatrics Society*, 51(4), 451-458.
- Craig, S. (1999, February). *"Torches of freedom": Themes of women's liberation in American cigarette advertising*. Paper presented at the Gender Studies Division Southwest/Texas Popular Culture Association, Denton, TX.
- Crowther, M. R., Parker, M. W., Achenbaum, W. A., Larimore, W. L., & Koenig H. G. (2002). Rowe and Kahn's model of successful aging revisited: Positive spirituality - the forgotten factor. *The Gerontologist*, 42(5), 613-620.
- Cuddy, A. J. C., & Fiske, S. T. (2002). Doddering but dear: Process, content, and function in the stereotyping of older persons. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 3-26). Cambridge, MA: MIT Press.

- Cuddy, A. J. C., Norton, M. I., & Fiske, S. T. (2005). This old stereotype: The pervasiveness and persistence of the elderly stereotype. *Journal of Social Issues*, 61(2), 267-286.
- Cumming, E., & Henry W. (1961). *Growing old: The process of disengagement*. New York: Basic Books.
- Cumming, E., Dean, L., Newell, D., & McCaffrey, I. (1961). Disengagement tentative theory of aging. *Sociometry*, 23, 23-25.
- Cunningham, C., & Stanley, F. (2003). Indigenous by definition, experience, or world view. *Student BMJ*, 11(October), 352-353.
- Cunningham, W. R., & Brookbank, J. W. (1988). *Gerontology: The psychology, biology, and sociology of aging*. New York: Harpercollins College Division.
- Cushman, J. H. (1986, July 8). Soldiers bid a farewell to smoking. *The New York Times*, p. Archive.
- Cushner, K. (1998). *International perspectives on intercultural education*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Czerny, A. (2006). Government's workplace health plan 'lacks cohesion'. *People Management*, 12(1), 10.
- D. A. Neugartern. (Ed.). (1996). *The meanings of age: Selected papers of Bernice L. Neugartern*. Chicago: University of Chicago Press.
- Dacey, M. L., & Newcomer, A. R. (2005). A client-centered counseling approach for motivating older adults toward physical acitivity. *Topics in Geriatric Rehabilitation*, 21(3), 194-206.
- Daley, M. J., & Spinks W. L. (2000). Exercise, Mobility and Aging. *Sports Medicine*, 29(1), 1-12.

- Dass, R. (2000). *Still here: Embracing aging, changing, and dying*. New York: Berkley Publishing Group.
- Davey, J. A. (2003). Human capital issues in an ageing workforce. *Social Policy Journal of New Zealand*, (20), 156-173.
- Davies, S., Ellis, L., & Laker, S. (2000). Promoting autonomy and independence for older people within nursing practice: An observational study. *Journal of Clinical Nursing*, 9(1), 127-137.
- Davis, A. J., Konishi, E., & Mitoh, T. (2002). The telling and knowing of dying: Philosophical bases for hospice care in Japan. *International Council of Nurses*, 49, 226-233.
- Davis, S. (2003, Spring). Ageism and its implications for the health care of older people. *Northern Health*, May 23. Retrieved October 16, 2003, from Centre for Applied Gerontology, www.nh.org.au/ResearchEdu/BECC/researchBECCageism.htm.
- de Beauvoir. (1996). *La veillesse - The coming of age* (P. O'Brian, Trans.). New York: W. W. Norton. (Original work published 1970)
- Dein, S., & Huline-Dickens, S. (1997). Cultural aspects of aging and psychopathology. *Aging & Mental Health*, 1(2), 112-121.
- deJong, N., Paw, M., deGroot, L., Rutten, R., Swinkels, D. W., Kok, F. J., et al. (2001). Nutrient-dense foods and exercise in frail elderly. *The American Journal of Clinical Nutrition*, 73(2), 338-346.
- Denby, T., & Godfrey, M. (2004). *Depression and older people: Towards securing well-being in later life*. Bristol, England: Policy Press.
- Denton W. (1999). *England in the fifteenth century*. London: B. Bell and Sons.

- Department for Work, & Pensions. (2003). *Age discrimination legislation* (Report of the Consultation on Age Discrimination in Employment). Sheffield, England: Department for Work & Pensions.
- Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *American Journal of Geriatric Psychiatry, 14*, 6-20.
- Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *American Journal of Geriatric Psychiatry, 14*(1), 6.
- Diener, D. D., & Mitchell J. M. (2005). Impact of a multifactorial fall prevention program upon falls of older frail adults attending an adult health day care center. *Topics in Geriatric Rehabilitation, 21*(3), 247-257.
- DiFabio, R. P., Zampieri, C., Henke, J., Olson, K., Rickheim, D., & Russell, M. (2005). Influence of elderly executive cognitive function on attention in the lower visual field during step initiation. *Gerontology, 51*, 94-107.
- Donahue, W. (1960). *Aging in today's society*. Englewood Cliffs, NJ: Prentice-Hall.
- Dragadze, T. (1990). The notion of adulthood in rural Soviet Georgian society. In P. Spencer (Ed.), *Anthropology & the riddle of the Sphinx* (pp. 89-101). London: Routledge.
- Droomers, M., Schrijvers, C. T. M., Casswell, S., & Mackenbach J. P. (2005). Father's occupational group and daily smoking during adolescence: Patterns and predictors. *American Journal of Public Health, 95*(4), 681-689.
- Dulin, P. L. (2005). Social support as a moderator of the relationship between religious participation and psychological distress in a sample of community dwelling older adults. *Mental Health, Religion & Culture, 8*(2), 81-86.

- Duncan, C., & Loretto, W. (2004). Never the Right Age? Gender and Age-Biased Discrimination in Employment. *Gender, Work and Organization*, 11(1), 95-115.
- Durie, M. (1994). *Whiaora: Maori health development*. Auckland, NZ: Oxford University Press.
- Durie, M. H. (1999). Kaumatautanga reciprocity: Maori elderly and whanau. *New Zealand Journal of Psychology*, 28(2), 102-110.
- Durie, M. (2003, July). *Te Pae Mahutonga - A model for Maori health promotion*. Keynote speech presented at the Public Health Association Conference 2003, Hamilton, New Zealand.
- Durie, M. S. (2003). The health of indigenous peoples: Depends on genetics, politics, and socioeconomic factors. *British Medical Journal*, 326(7388), 510-512.
- Dutch Care Ltd. (2003). *World changing - An Australian Dutch Perspective* (Handout). Sydney, Australia: International Association of Homes and Services for the Ageing. Retrieved July 20, 2004, from International Association of Homes and Services for the Ageing: Fifth International Conference Web site Web site: <http://www.aahsa.org/sydney/presentations>
- Dychtwald, K. (2002). Retirement is dead. *Journal of Financial Planning*, 15(112002), 16-20.
- Easterly, W. (2002). *What did structural adjustment adjust?* (Report for Center for Global Development). Washington, DC: Institute for International Economics.
- Ebrahim, S. (2002). The medicalisation of old age should be encouraged. *British Medical Journal*, 324, 861-863.
- Economic Policy Institute. (2000). In C. E. Weller (Ed.), *Raising the retirement age: The wrong direction for Social Security* (Briefing Paper). Washington, DC: Economic Policy Institute.

- Editorial. (2001). Doctor dearth: Doctors retiring earlier. *Hospitals & Health Networks*, 75(3), N/A.
- Editorial. (2006). How do seniors define successful aging? *Seniorjournal.com*, January 18. Retrieved May 2, 2006, from Seniorjournal.com Web site: <http://www.seniorjournal.com>.
- Edwards, H. (1998). Communication predicaments of older health care consumers: What can 'we' do about it? *Social Alternatives*, 24(2), 33-37.
- Elder, G. H., Jr. (1999). *Children of the Great Depression: Social change in life experience*. Boulder, CO: Westview Press. (Original work published 1974)
- Elder, G. H., Jr. (2000). Life course and aging: Some reflections. In D. K. Harris (Ed.), *Teaching Sociology of aging and the life course* (pp. ix-xxvv). Washington, DC: American Sociological Association.
- The elderly - burden or resource? (2002, Winter). *Europa World*, December(4). Retrieved May 12, 2006, from EuropaWorld Web site: <http://www.europaworld.org>.
- Elderly dental care decays. (2005, March 29). *New Zealand City News*, Health & Safety.
- Eldernet New Zealand. (2005a). *Aged still paying for rest homes* [Newspaper article]. Available from Eldernet.nz: <http://www.eldernet.co.nz/News>.
- Eldernet New Zealand. (2005b). *Parties offer more for aged, but bills huge* [Newspaper article]. Available from Eldernet.nz, <http://www.eldernet.co.nz/News>.
- Elias, N. (1985). *The loneliness of the dying*. Oxford, England: Basil Blackford Ltd.
- Else, A. (1997). Having it both ways? Social policy and the positioning of women in relation to men. *Social Policy Journal of New Zealand*, 9, 16-26.
- Else, A. (1999, August). *Through a glass darkly: Seeing old age and the old*. Winter Lecture presented at the University of Auckland, Auckland, New Zealand.

- Emberton, M. (1999). What urologists say they do for men with prostate cancer. *British Medical Journal*, 318(7179), 276.
- Emery, E. E., & Pargament, K. I. (2004). The many faces of religious coping in late life: Conceptualization, measurement, and links to well-being. *Ageing International*, 29(1), 3-27.
- Engardio, P., Matlack, C., Edmondson, G., Rowley, I., Barraclough, C., & Smith, G. (2005). Geezer Glut; A surge of graying baby boomers could wreak havoc on the world economy. But there are solutions. *Business Week*, January 31, 44-46.
- Enggvist, L. (2002). How to safeguard the right of common access in the health service. *Scandinavian Journal of Primary Health Care*, 20(2), 65-66.
- Erikson, E. H., Erikson, J. M., & Kivnick, H. G. (1986). *Vital involvement in old age*. New York: W. W. Norton.
- Etulain, R. W., & Malone, M. P. (1989). *The American West: A twentieth-century history*. Lincoln: University of Nebraska Press.
- Europa. (1999). *New Paradigm in Ageing Policy* (Conference "Towards a Europe for all ages"). Brussels, Belgium: European Commission. Retrieved May 8, 2006, from European Commission Web site: <http://ec.europa.eu>.
- European Employment Observatory. (2002). *Older workers on the labour market: An introduction* (Report on national labour market policies). Brussels, Belgium: European Employment Observatory.
- Evans, L. (1998). Statement of Ranking Democratic Member Lane Evans. In Full Committee Hearing (Ed.), *House Committee on Veteran's Affairs*. Retrieved July 19, 2006, from House Committee on Veteran's Affairs Web site: <http://www.veterans.house.gov/hearings>.

- Evashwick, C., & Ory, M. (2005). How to keep a public health and aging program going. *Generations*, 29(2), 76-81.
- Fadem, P., & Minkler, M. (2002). Successful aging: A disability perspective. *Journal of Disability Policy Studies*, 12, 229-244.
- Fehr, H., Sterkeby, W. I., & Thogersen, O. (2003). Social security reforms and early retirement. *Journal of Population Economics*, 16(2), 345-361.
- Fernandez-Stembridge, L. (2005). Shaping rural migrant women's employment: The role of housemaid agencies. *European Journal of East Asian Studies*, 4(1), 31-53.
- Finch, J. (1986). *Research and policy: The uses of qualitative methods in social and educational research*. London: The Falmer Press.
- Finlay, L. (2005). Reflexive embodied empathy: A phenomenology of participant-researcher intersubjectivity. *The Humanistic Psychologist*, 33(4), 271-292.
- Finn, S. C. (2000). Nutrition and healthy aging. *Journal of Women's Health & Gender-based Medicine*, 9(7), 711-716.
- Firth, R. (1959). *Economics of the New Zealand Maori*. Wellington, NZ: R. E. Owen.
- Firvida, J. L., Vinolas, N., Munoz, M. Grau., J. J., Daniels., M., & Estape, A. (1999). Age: A critical factor in cancer management. *Age and Ageing*, 28, 103-105.
- Fischer, D. H. (1978). *Growing old in America* (Expanded ed.). New York: Oxford University Press.
- Fisher, B. J., & Specht, D. K. (1999). Successful aging and creativity in later life. *Journal of Aging Studies*, 13(4), 457-472.
- Fitzgerald, T. (2004). Powerful voices and powerful stories: Reflections on the challenges and dynamics of intercultural research. *Journal of Intercultural Studies*, 25(3), 233-245.

- Fitzpatrick, A. L., Rowe, N. R., Cooper, L. S., Ives, D. G., & Robbins, J. A. (2004). Barriers to health care access among the elderly and who perceives them. *American Journal of Public Health, 94*(10), 1788-1794.
- Five Civilized Tribes. (2004). In *Encyclopedia of North American Indians* (Houghton Mifflin ed., Vol. College Division). Retrieved May 28, 2005, from Encyclopedia of North American Indians Web site: <http://www.college.hmco.com>.
- Flood, M. (2002). Successful aging: A concept analysis. *Journal of Theory Construction And Testing, 6*(2), 104-109.
- Flood, M. (2002). Successful aging: A concept analysis. *Journal of Theory Construction and Testing, 6*(2), 105-109.
- Flood, M. (2005/2006). A mid-range nursing theory of successful aging. *Journal of Theory Construction & Testing, 9*(2), 35-29.
- Florida Policy Exchange Center on Aging. (1997). In L. Povlika (Ed.), *Autonomy and dependency in an ethic of care for the frail elderly* (No. vi). Tampa: University of South Florida.
- Follette, G., & Sheiner, L. (2005). The sustainability of health spending growth. *National Health Journal, 58*(3), 391-409.
- Ford, A. B., Haug, M. R., Stange, K. C., & Gaines, A. D. (2000). Sustained personal autonomy: A measure of successful aging. *Journal of Aging and Health, 12*(4), 470-489.
- Forehand, R., Pelton, J., Chance, M., Armistead, L., Morse, E., & Morse, P. S. (1999). Orphans of the AIDS epidemic in the United States: Transition-related characteristics and psychosocial adjustment at 6 months after mother's death. *Aids Care, 11*(6), 715-723.
- Forster, A. (2005). Caregiver burden in stroke. *Stroke Review, 9*(1), 127-131.

- Fortes, M. (1984). Age, generation, and social structure. In D. I. Kertzer & J. Keith (Eds.), *Age & anthropological theory* (pp. 99-122). Ithaca, NY: Cornell University Press.
- Fowler, D. H., Fowler L. J., & Lamdin, L. (1982). Themes of old age in preindustrial Western literature. In P. N. Stearns (Ed.), *Old age in preindustrial society* (pp. 19-45). New York: Holmes & Meier.
- Freedman, M., & Moen, P. (2005). Academics pioneer 'the third age'. *The Chronicle of Higher Education*, 51(34), N/A.
- French L. A. (2000). *Addictions and Native Americans*. Westport, CT: Praeger Publishers.
- Fries, J. F. (1980). Aging, natural death, and the compression of morbidity. *New England Journal of Medicine*, 303, 130-135.
- Fries, J. F. (2004). *Living Well*. Cambridge, MA: DeCapo Press.
- Frizelle, F. A. (2002). Hospital waiting lists and advice from the Minister of Health. *The New Zealand Medical Journal*, 115(1160), 1-3.
- Frow, J. (1997). *Time and commodity culture: Essays in cultural theory and postmodernity*. Oxford, England: Clarendon Press.
- Fry, P. S. (2000). Religious involvement, spirituality and personal meaning for life: Existential predictors of psychological wellbeing in community-residing and institutional care elders. *Aging & Mental Health*, 4(4), 375-387.
- Fulmer, L. (2000). *Historical Notes on the Cherokee people*. Retrieved May 31, 2005, from International Reconciliation Coalition Research Web site: <http://www.gileadinternational.org/cherokeehistory.html>.
- Galambos, C., & Rosen, A. (1999). The aging are coming and they are us. *Health and Social Work*, 24(1), 73-77.

- Galasso, V., & Profeta, P. (2004). Lessons for an ageing society: The political sustainability of social security systems. *Economic Policy*, 19(38), 63-115.
- Gale, R. L. (1998). *An F. Scott Fitzgerald Encyclopedia*. Westport, CT: Greenwood Press.
- Garfein, A. J., & Herzog, A. R. (1995). Robust aging among the young-old, old-old, and oldest-old. *Journal of Gerontology*, 50(Bn2), S77.
- Garrett, M. T. (1996). Reflection by the riverside: The traditional education. *Journal of Humanistic Education & Development*, 35(1), 12027.
- Garrett, M. T., & Herring, R. D. (2001). Honoring the power of relation: Counseling native adults. *Journal of Humanistic Counseling, Education and Development*, 35(1), 12-27.
- Garrett, M. T., & Pichette, E. F. (2000). Red as an apple: Native American acculturation and counselling with or without reservation. *Journal of Counselling And Development*, 78(1), 3-14.
- Garrouette, E. M. (2001). The racial formation of American Indians. *American Indian Quarterly*, 25(2), 224-241.
- Gathercole, S. (2004). *Access to community services for the elderly in Gisborne* (Research project). Auckland, New Zealand: School of Geography & Environmental Science, University of Auckland.
- Gattuso, S., & Shadbolt, A. (2002). Attitudes toward aging among Pacific Islander health students in Fiji. *Educational Gerontology*, 28, 99-106.
- Gavin-Dreschnack, D., Nelson, A., Fitzgerald, S., Harrow, J., Sanchez-Anguiano, A., Ahmed, S., et al. (2005). Wheelchair-related falls. *Journal of Nursing Care Quality*, 20(2), 119-127.

- Gazso, A. (2005). The poverty of unattached senior women and the Canadian retirement income system: A matter of blame of contradiction? *Journal of Sociology And Social Welfare*, XXXII(2), 41-62.
- Gerber, J. B. (2001). Kuhn, Maggie. In *American National Biography Online* (January ed.). Retrieved March 26, 2003, from American National Biography Web site: <http://www/anb.org/articles>.
- Gergen, M., & Gergen, K. J. (2003). Positive aging. In J. F. Gubrium & J. A. Holstein (Eds.), *Ways of aging* (pp. 203-224). Oxford, England: Blackwell Publishers Ltd.
- Gibler, K. M. (2003). Aging subsidized housing residents: A growing problem in U.S. cities. *Journal of Real Estate Research*, 25(4), 395-420.
- Gilbert, A. A. (2003). *Beating the clock*. Mississauga, Ontario: Actively Aging.
- Gilbert, J. (1996). *The Trail of Tears across Missouri*. Columbia: University of Missouri Press.
- Giles, H., & Reid, S. A. (2005). Ageism across the lifespan: Towards a self-categorization model of ageing. *Journal of Social Issues*, 61(2), 389-404.
- Gilhooly, M. (2002). *Ageism in the NHS?* (Discussion paper prepared for the Chief Medical Officer's Expert Group for Health Care of Elderly People) [Electronic version]. Glasgow, Scotland: Scottish Executive.
- Gilleard, C., & Higgs, P. (1998). Ageing and the limiting conditions of the body. *Sociological Research Online*, 3(4), <http://www.socresonline.org.uk>.
- Gilmore, G. (1999). But she can't find her [v.o.] key. *Feminist Studies*, 25(1), 133-153.
- Glantz, S. A. (2006). Smoking. In *Grolier Multimedia Encyclopedia* (Grolier Online ed.). Retrieved July 19, 2006, from Grolier Online Web site: <http://www.gme.golier.com>.

- Glass, T. A. (2003). Assessing the Success of Successful Aging. *Annals of Internal Medicine*, 139(5), 382-384.
- Glassner, B., & Hertz, R. (1999). Introduction. In B. Glassner & R. Hertz (Eds.), *Qualitative sociology as everyday life* (pp. v-xi). Thousand Oaks, CA: Sage Publications.
- Glendenning, F. (2001). Education for older adults. *Journal of Lifelong Learning*, 20(1/2), 63-70.
- Global Action of Aging. (2005). *Pension Watch Worldwide* [Ongoing Reports]. Available from Global Action on Aging, <http://www.globalaging.org/>.
- Global Action on Aging. (2003). *Retirement age chewed over* (May 27). New York: Global Action on Aging. Retrieved May 12, 2006, from Global Action on Aging Web site: <http://www.globalaging.org/pension>.
- Globerman, J. (1996). Motivations to care. *Family Relations*, 45, 37-45.
- Glover, I., & Branine, M. (1997). Ageism and the labour process: Towards a research agenda. *Personnel Review*, 26(4), 274-293.
- Glover, R. J. (1998). Perspectives on aging: Issues affecting the latter part of the life cycle. *Educational Gerontology*, 24(4), 325-332.
- Goldberg, E. (2002). A healthy retirement. *AORN Journal*, 76(5), 873-875.
- Gonzalez, H. M., Haan, M. N., & Hinton, L. (2001). Acculturation and the prevalence of depression in older Mexican Americans: Baseline results of the Sacramento area Latino Study on Aging. *Journal of the American Geriatrics Society*, 49(7), 948-954.
- Goodman, J. C., & Cordell, D. E. (1998). *The nightmare in our future: Elderly entitlements* (Study #212). Dallas, TX: National Center for Policy Analysis. Retrieved May 12, 2006, from <http://www.ncpa.org>.

- Gordon, A., & Mathers, A. (2004). State restructuring and trade union realignment. *Capital & Class*, 83, 9-18.
- Gorin, S. H., & Lewis, B. (2004). The compression of morbidity: Implications for social work. *Health and Social Work*, 29(3), 249-255.
- Gottfries, C. G. (2001). Late life depression. *European Archives of Psychiatry & Clinical Neuroscience*, 251(6), 1157-1162.
- Gould, O. N., & Shaleen, L. (1999). Collaboration with diverse partners: How older women adapt their speech. *Journal of Language & Social Psychology*, 18(4), 395-418.
- Green, B. S. (1993). *Gerontology and the construction of old age: A study in discourse analysis*. New York: Aldine De Gruyter.
- Green, T. J., Knight, R. G., McMahon, J., & Skeaff, C. M. (2004). Some normative and psychometric data for the Geriatric Depression Scale and the Cognitive Failures Questionnaire from a sample of healthy older persons. *New Zealand Journal Of Psychology*, 33(3), 163-174.
- Greller, M. M. (1999). In search of late career: A review of contemporary social science research applicable to the understanding of late career. *Human Resource Management Review*, 9(3), 309-348.
- Grewal, I., Nazroo, J., Bajekal, M., Blane, D., & Lewis, J. (2004). Influences on quality of life: A qualitative investigation of ethnic differences among older people in England. *Journal of Ethnic and Migration Studies*, 30(4), 737-761.
- Griffith, R. W. (2004, July 16). Gender differences in longevity. *Health and Age*. Retrieved March 16, 2005, from Health and Age for Healthcare Professionals Web site: <http://www.healthandage.com>.

- Grybaite, V. (2006). Analysis of theoretical approaches to gender pay gap. *Journal of Business Economics And Management*, VII(1), 85-91.
- Gubrium, J. F., & Holstein J. A. (1999). At the border of narrative and ethnography. *Journal of Contemporary Ethnography*, 28(5), 561-574.
- Gullette, M. M. (1997). *Declining to decline*. Charlottesville: University of Virginia Press.
- Gunderson, A., Tomkowiak, J., Menachemi, N., & Brooks, R. (2005). Rural physicians' attitudes toward the elderly: Evidence of ageism? *Health Care*, 14(3), 167-176.
- Gutmann, D. (1997). *The human elder in nature, culture and society*. Boulder, CO: Westview Press.
- Haber, C. (1978). Mandatory retirement in nineteenth-century America: The conceptual basis for a new work cycle. *Journal of Social History*, 12(1), 77-96.
- Haber, D. (2003). *Health promotion and aging*. New York: Springer Publishing.
- Hagberg, M., Hagberg, B., & Saveman, B-I. (2002). The significance of personality factors for various dimensions of life quality among older people. *Aging & Mental Health*, 6(2), 178-185.
- Hagestad, G. O., & Uhlenberg, P. (2005). The social separation of old and young: A root of ageism. *Journal of Social Issues*, 61(2), 343-361.
- Hall, R., Platt, D. E., & Hall, Ryan. (1999). Suicide risk assessment: A review of risk factors for suicide in 100 patients who made severe suicide attempts. *Psychosomatics*, 40(1), 18-28.
- Hall, S. (Ed.). (1996). *Modernity: An introduction to modern societie*. Malden, MA: Blackwell Publishing Ltd.

- Hallinger, P., & Kantamara, P. (2000). Educational change in Thailand: Opening a window onto leadership as a cultural process. *School Leadership & Management*, 20(2), 189-205.
- Hamer, J., Gulpers, M., & Strik, W. (2004). Use of physical restraints with cognitively impaired nursing home residents. *Journal of Advanced Nursing*, 45(3), 246-251.
- Hammersley, M. (1990). *Reading ethnographic research: A critical guide*. Essex, England: Longman Group UK Ltd.
- Hannah, L. (1986). *Inventing retirement: The development of occupational pensions in Britain*. Cambridge, England: Press Syndicate of the University of Cambridge.
- Hareven, T. K. (1978). *The Family* (T. K. Hareven, J. Kagan, & A. S. Rossi, Eds.). New York: W. W. Norton.
- Hareven, T. K. (1994). Aging and generational relations: A historical and life course perspective. *Annual Review of Sociology*, 20, 437-461.
- Hareven, T. K. (2000). *Families, history, and social change*. Boulder, CO: Westview Press.
- Harper, S. (2000). Ageing update: Ageing 2000. *Ageing and Society*, 20, 111-122.
- Harrell, S. (1981). Growing old in rural Taiwan. In *Other ways of growing old* (pp. 193-210). Stanford, CA: Stanford University Press.
- Hart-Hughes, S., Quigley, P., Bulat, T., Palacios, P., & Scott, S. (2004). An interdisciplinary approach to reducing fall risks and falls. *Journal of Rehabilitation*, 70(4), 46-52.
- Hartman-Stein, P. E., & Potkanowicz, E. S. (2003). Behavioral determinants of healthy aging: Good news for the Baby Boomer Generation. *Online Journal of Issues in Nursing*, 8(2), 127-146.

- Harvard Women's Health Watch. (2001). *Aging and eyesight - supplements slow the course of macular degeneration* (9(5)). Cambridge, MA: Harvard Health Publications, Harvard Medical School.
- Harwood, J., Giles, H., McCann, R. M., Cai, D., Somera, L. P., Ng, S. H. Gallois., et al. (2001). Older adults' trait ratings of three age-groups around the Pacific Rim. *Journal of Cross-cultural Gerontology*, 16, 157-171.
- Hatch, L. R. (2005). Gender and ageism. *Generations*, 29(3), 19-24.
- Havighurst, R. J. (1961). Successful aging. *The Gerontologist*, 1(1), 8-13.
- Havighurst, R. J., Neugarten, B. L., & Tobin, S. N. S. (1968). Disengagement and patterns of aging. In *Middle age and aging* (pp. 161-172). Chicago: The University of Chicago Press.
- Haviland, W. A. (1993). *Cultural anthropology*. Fort Worth, TX: Harcourt Brace Publishers.
- Hawke's Bay Regional Council. (1995). In Waitangi Tribunal (Ed.), *Te Whanganui-A-Orotu Report* (Hawke's Bay Regional Council's policy statement: Appendix V). Wellington, New Zealand: Department of Justice.
- Hazlehurst, K. M. (1993). *Political expression and ethnicity: Statecraft and mobilisation in the Maori world*. Westport, CT: Praeger Publishers.
- Healthy Aging*. (2004). Retrieved August 6, 2005, from The Healthy Aging Campaign Web site: <http://www.healthyaging.net>.
- Hechter, M., Opp, & Wippler, R. (Eds.). (1990). *Social institutions: Their emergence, maintenance and effects*. Berlin, Germany: Walter De Gruyter.
- Heckhausen, J., & Schulz, R. (1995). A life span theory of control. *Psychological Review*, 102, 284-304.

- Heid-Grudman, J. (2005). Management decisions and their impact on resident behaviors. *Alzheimer's Care Quarterly*, 6(2), 103-111.
- Heikkila, K. (2004). The role of ethnicity in the care of elderly Finnish immigrants. *Dissertation Abstracts*, 1-66. (UMI No. 91-7349-802-5)
- Helgason, A. R., Dickman, P. W., Adolfsson, J., & Steineck, G. (2002). Emotional Isolation: Prevalence and the effect on well-being among 50-80 year-old prostate cancer patients. *Scandinavian Journal of Urology & Nephrology*, 35(2), 97-102.
- Helmchen, H., Baltes, M. M., Geisselmann, B., Kanowski, S., Linden, M., & Reischies, F. M. (1999). Psychiatric illnesses in old age. In P. B. Baltes & K. U. Mayer (Eds.), *The Berlin aging study: Aging from 70 to 100* (pp. 167-196). New York: Cambridge University Press.
- Henderson, J. N. (1990). Anthropology, health and aging. In R. L. Rubenstein (Ed.), *Anthropology and aging: Comprehensive reviews* (pp. 39-68). Dordrecht, Holland: Kluwer Academic Publishers.
- Hendricks, J. (2005). Ageism: Looking across the margin in the new millennium. *Generations*, 29(3), 5-7.
- Hendricks, J., & Cutler, S. J. (2005). Volunteerism and the socioemotional selectivity in later life. *The Journals of Gerontology: Series B: Psychological and Social Sciences*, 59B(5), S251-S258.
- Henrard, J. C. (1996). Cultural problems of ageing especially regarding gender and intergenerational equity. *Social Science & Medicine*, 43(5), 667-681.
- Hifler, J. S. (1992). *A Cherokee feast of days*. Stillwater, OK: Council Oak Books.
- Higgs, P., Hyde, M., Wiggins, R., & Blane, D. (2003). Researching quality of life in early old age: The importance of the sociological dimension. *Social Policy & Administration*, 37(3), 239-253.

- High, K. P. (2001). Nutritional strategies to boost immunity and prevent infection in elderly individuals. *Clinical Infectious Diseases*, 33(11), 1892-1901.
- Higuchi, K. (2004). Women's Association for a Better Aging Society. *Geriatrics and Gerontology International*, 4, S229-S231.
- Hill, K., & Schwarz, J. (2004). Assessment and management of falls in older people. *Internal Medicine Journal*, 34, 557-564.
- Hill, R. D. (2006). *Positive aging*. New York: W. W. Norton.
- Hill, R. D. (2006). *Positive aging: a guide for mental health professionals and consumers*. New York: W. W. Norton & Company.
- Hirsch, M. A. (1999). Promoting productive aging. *Palaestra*, 15(2), 5-9.
- Hirshbein, L. D. (2001). Popular views of old age in America, 1900-1950. *Journal of the American Geriatrics Society*, 49(11), 1555-1561.
- Hively, J., Gates, M., & Britts, T. (2003). Creating a new vision for growth. In J. Hively (Ed.), *Proceedings from the workshop: Vital aging* (p. Published online). St. Paul, MN: Vital Aging.
- Holmes, E. R., & Holmes, L. D. (1995). *Other cultures, elder years: An introduction to cultural gerontology*. Thousand Oaks, CA: Sage Publications.
- Holstein, M. (1998). Attending to elder's voices: A moral obligation. *Park Ridge Center Bulletin*, 6. Retrieved March 30, 2006, from The Park Ridge Center for Health, Faith, and Ethics Web site: <http://www.parkridgecenter.org>.
- Holstein, M. B. (2000). The "New Aging": Imagining alternative futures. In J. Hendricks & K. W. Schaie (Eds.), *The evolution of the aging self: The societal impact on the aging process* (pp. 319-332). New York: Springer.
- Holstein, M. B., & Minkler, M. (2003). Self, society, and the "New Gerontology". *The Gerontologist*, 43(6), 787-796.

- Holy, L. (1990). Strategies for old age among the Berti of the Sudan. In P. Spencer (Ed.), *Anthropology & the riddle of the Sphinx* (pp. 167-182). London: Routledge.
- Hooyman, N. R., & Asuman, K. (1999). *Social gerontology: A multidisciplinary perspective* (5th ed.). Needham Heights, MA: Allyn & Bacon.
- Horowitz, B. P., & Pei-Fen, J. C. (2004). Promoting well-being and engagement in life through occupational therapy lifestyle redesign: A pilot study within adult day programs. *Topics in Geriatric Rehabilitation*, 20(1), 46-59.
- Hoyt, D. R., Whitbeck, L. B., & Yoder, K. A. (1998). Suicidal behavior among homeless and runaway adolescents. *Journal of Youth and Adolescence*, 27(6), 753-762.
- Hughes, F. A., & Gray, N. (2003). Cultural safety and the health of adolescents. *British Medical Journal*, 327(7412), 457-458.
- Hughes, K. H. (2005). Facing the global competitiveness challenge: A renewed and systematic focus on innovation is the key to U.S. economic growth and prosperity. *Issues in Science and Technology*, 21(4), 72-79.
- Huisman, M., Kunst, A. E., Andersen, O., Bopp, M., Borgan, J. K., borrell, C., et al. (2004). Socioeconomic inequalities in mortality among elderly people in 11 European populations. *Journal of Epidemiology And Community Health*, 58, 468-475.
- Hummert, M. L., & Nussbaum, J. E. (1992). Communication and the elderly. *Communication Research*, 19(4), 413-423.
- Hummert, M. L., Shaner, J. L., Garstka, T. A., & Henry, C. (1998). Communication with older adults: The influence of age stereotypes, context, and communicator age. *Human Communication Research*, 25(1), 124-152.

- Hyde, M., Wiggins, R. D., Higgs, P., & Blane, D. B. (2003). A measure of quality of life in early old age: The theory, development and properties of a needs satisfaction model. *Aging & Mental Health*, 7(3), 186-194.
- Hyman, C. (2002, July 30). Industrialized nations follow US lead on market-driven welfare reform. *Campus News, News Release*. Retrieved May 25, 2006, from Berkeley Campus News Center Web site: <http://berkeley.edu/news/media/releases>.
- Ilmarinen, J. E. (2001). Aging workers (aging of workforce in the European Union). *Occupational and Environmental Medicine*, 58(8), 546-551.
- Imrie, R. (2004). Disability, embodiment and the meaning of the home. *Housing Studies*, 19(5), 745-763.
- Information - Institute for life-span development and gerontology. (2006). Retrieved June 15, 2006, from Institute for Life-span Deveopment and Gerontology Web site: <http://www3.uakron.edu>.
- Inglehart, J. K. (2000). Family, marketplace & the state: Striking a balance. *Health Affairs*, 19(3), 6-7.
- Institute for Women's Policy Research. (2004). *Women's economic status in the States: Wide disparities by race, ethnicity, and region* (Released at a press conference sponsored by Representatives Nancy Pelosi and Carolyn Maloney and Senator Lisa Murkowski). Washington, DC: Institute for Women's Policy Research.
- International Association of Gerontology. (2006). *About the IAG* [Website]. Available from International Association of Gerontology, <http://www.iagg.com.br>.
- International Monetary Fund. (2005). *The IMF's enhanced structural adjustment facility (ESAF): Is it working?* [Data file]. Available from International Monetary Fund, <http://www.imf.org>.

- Introduction to Sociology (Sociology 101Y)*. (2003). Retrieved October 3, 2003, from University of Toronto Department of Sociology Web site: <http://www.utoronto.ca/soc101>.
- Jackson, D. D., & Chapleski, E. (2000). Elderly American Indians and the notion of 'cohort'. *Journal of Cross-cultural Gerontology*, 15, 229-259.
- Jang, Y., Poor, L. W., & Martin, P. (2004). Individual differences in the effects of disease and disability on depressive symptoms: The role of age and subjective health. *International Journal of Aging And Human Development*, 59(2), 125-137.
- Jansson, B. (2005). Coding errors and underestimation of fall injury mortality. *American Journal of Public Health*, 95(8), 1305.
- Jette, A. M., Lachman, M., Giorgetti, M. M., Assmann, S. F. Harris., B. A., & Levenson, C. (1999). Exercise - it's never too late: The strong-for-life program. *American Journal of Public Health*, 89(1), 66-72.
- John, R. A. (1995). *Social integration of an elderly Native American population*. New York: Garland Publishing Inc.
- Johnson, A. P. (1988). The Protestant ethic and the legitimization of bureaucratic elites: A review of Peter Dobkins Hall's *The organization of American culture, 1700 - 1900: Private institutions, elites, and the origins of American nationality*. *Politics, Culture, and Society*, 1(4), 585-597.
- Johnson, M. L. (Ed.). (2005). *The Cambridge handbook of age and ageing*. Cambridge, England: Cambridge University Press.
- Johnson, P. (1998). Historical readings of old age and ageing. In P. Johnson & P. Thane (Eds.), *Old age from antiquity to post-modernity* (pp. 1-18). London: Routledge.
- Johnson, P. L. (1992). *Balancing acts: Women and the process of social change*. Boulder, CO: Westview Press.

- Johnson, T. F. (1995). Aging well in contemporary society. *American Behavioral Scientist*, 39(2), 120-130.
- Johri, M., Beland, F., & Bergman, H. (2003). International experiments in integrated care for the elderly: A synthesis of the evidence. *International Journal of Geriatric Psychiatry*, 18, 222-235.
- Jones, T. W. (2000, January). *Who are the Western Cherokee?* Paper presented at the Tribal meeting of the Western Cherokee Nation of Arkansas and Missouri at Southeast Missouri State University, Cape Girardeau, MO.
- Joseph, P. (2000). Maori and the Market: The Waitangi Tribunal. *Race and Class*, 41(4), 59.
- Joslin, D., & Harrison, R. (2002). Self-reported physical health among older surrogate parents to children orphaned and affected by HIV disease. *Aids Care*, 14(4), 619-624.
- Jurich, K. (2000). Getting the story straight: Grounded theory, hermeneutics, and the practice of fieldwork on the plains of South Dakota. *Sociological Perspectives*, 43(4), S149-S163.
- Kalache, A., Aboderin, I., & Hoskins, I. (2002, March). Compression of morbidity and active ageing. *Bulletin of the World Health Organization*, 80(3), 243-245.
- Kannus, P. (2005). Kannus responds. *American Journal of Public Health*, 95(8), 1306.
- Kannus, P., Parkkari, K. P., Niemi, S., & Palvanen, N. S. (2005). Fall-induced deaths among elderly people. *American Journal of Public Health*, 95, 422-424.
- Karp, D. A. (1999). Social science, progress, and the ethnographer's craft. *Contemporary Ethnography*, 28(6), 597-609.
- Katz, S. (1999, February). *Old age as lifestyle in an active society*. Occasional paper 19 presented at the Doreen B. Townsend Center for the Humanities, Berkeley, CA.

- Katz, S. (2000). Critical gerontology discourse: Nomadic thinking or postmodern sociology. *Discourse of Sociological Practice*, 3(1). Retrieved March 30, 2006, from University of Massachusetts Boston Web site: <http://www.sociology.umb.edu>.
- Kaufman, S. (1986). *The ageless self*. Madison: University of Wisconsin Press.
- Kawewe, S. M., & Dibie, R. (2000). The impact of economic structural adjustment programs [ESAPs] on women and children: Implications for social welfare in Zimbabwe. *Journal of Sociology And Social Welfare*, XXVII(4), 79-107.
- Kaye, L. W., & Crittenden, J. A. (2005). Principles of clinical practice with older men. *Journal of Sociology & Social Welfare*, 32(1), 99-124.
- Kaye, L. W., & Kosberg, J. I. (Eds.). (1997). *Elderly men: Special problems and professional challenges*. New York: Springer.
- Kaye, L. W., Butler, S. S., & Webster, N. M. (2003). Toward a productive ageing paradigm for geriatric practice. *Ageing International*, 28(2), 200-213.
- Keen, E. (2002). *Depression: Self-consciousness, pretending, and guilt*. Westport, CT: Praeger.
- Keese, M., Hirsch, D., & Bednarzik, R. (2006). *Live longer, work longer* (ISBN 92-64-035877). Paris: OECD Publishing.
- Kell, R. T., Bell, G., & Quinney, A. (2001). Musculoskeletal fitness, health outcomes and quality of life. *Sports Medicine*, 31(12), 863-873.
- Kelsey, J. (2002). *At the crossroads*. Wellington, New Zealand: Bridget Williams Books Limited.
- Kemp, C. L. (2004). "Grand" expectations: The experiences of grandparents and adult grandchildren. *Canadian Journal of Sociology*, 29(4), 499-525.

- Kendig, H. (2004). The social sciences and successful aging: Issues for Asia-Oceania. *Geriatrics & Gerontology International*, 4(1), S6-S11.
- Kenyon, G. (1998). Doctors refuse to operate on 80-year-old man. *British Medical Journal*, 317(7172), 1548.
- Kerr, A. L. (2002). *Senior citizens: Old age and citizenship in provincial New Zealand communities*. Dissertation, Massey University, Palmerston North, NZ.
- Kerse, N., Butler, M., Robinson, E., & Todd, M. (2002, Fall). *Fall prevention in residential care: A cluster, randomized, controlled trial*. Paper presented at the New Zealand Gerontological Association, Auckland, New Zealand.
- Khawaja, M. (2000, July). *Population ageing in New Zealand*. Paper composed of slide presentation presented at the Presented at the Demographics of Population Ageing, Wellington, New Zealand.
- Kijakaz, K., & Primus, W. (2000, January). *Options for reducing poverty among elderly women by improving supplemental security income*. Paper from the Center on Budget and Policy Priorities presented at the National Academy of Social Insurance 12th Annual Conference, Washington, DC.
- Kim, S., & Feldman, D. C. (2000). Working in retirement: The antecedents of bridge employment and its consequences for quality of life in retirement. *Academy of Management Journal*, 43(5), 1195-1210.
- Kim-Goodwin, Y. S., Alexander, J. W., Felton, G., Mackey, M. C., & Kasakoff, A. (2006). Prerequisites to providing culturally competent care to Mexican migrant farmworkers: A Delphi study. *Journal of Cultural Diversity*, 13(1), 27-33.
- King, M. (2000). 'Cooper, Whina 1895 - 1994'. In *Dictionary of New Zealand Biography* (1941-1960 ed., Vol. 5). Wellington, New Zealand: Ministry for Culture and Heritage.

- Kingfisher, C. P. (2002). *Western welfare in decline: Globalization and women's poverty*. Philadelphia: University of Pennsylvania Press.
- Kinsella, K., & Phillips, D. R. (2005). Global aging: The challenge of success. In *Population Bulletin* (Volume 60, No. 1, pp. 23-24). Washington, DC: Population Reference Bureau.
- Kirkwood, T. (Speaker). (2001). *New Directions: The end of age* [Radio] (Lecture 5). London: BBC Radio 4.
- Kiro, C. (2003, July). *Waiora: The effect of environmental factors on the health of New Zealanders*. Public Health Association Conference 2003 Papers presented at the Public Health Association of New Zealand, Hamilton, New Zealand.
- Kivinen, P., Halonen, P., Eronen, M., & Nissinen A. (1998). Self-rated health, physician-rated health and associated factors among elderly men: The Finnish cohorts of the Seven Countries Study. *Age and Ageing*, 27(1), 41-58.
- Kleyman, P. (2001, Spring). LTC official calls for diversity in defining 'successful aging'. *Aging Today*, May/June. Retrieved March 22, 2006, from Aging Today Web site: <http://www.asaging.org>.
- Koch, T. (2000). *Age speaks for itself: Silent voices of the elderly*. Westport, CT: Praeger.
- Koenig, H. G., George, L. K., & Titus, P. (2004). Religion, spirituality, and health in medically ill hospitalized older patients. *Journal Of The American Geriatrics Society*, 52, 554-562.
- Konadu-Agyemang, K. (2000). The best of times and the worst of times: Structural adjustment programs and uneven development in Africa: The case of Ghana. *Professional Geographer*, 52(3), 469-483.

- Korpi, W. (2003). Welfare-state regress in Western Europe: Politics, institutions, globalization and Europeanization. *Annual Review of Sociology*, 29, 589-610.
- Kosberg, J. I. (2005). Meeting the needs of older men: Challenges for those in helping professions. *Journal of Sociology & Social Welfare*, 32(1), 9-32.
- Koyano, W. (1989). Japanese attitudes toward the elderly: A review of research findings. *Journal of Cross Cultural Gerontology*, 4, 335-345.
- Kristof, N. D. (2005, January 12). Health Care? Ask Cuba. *The New York Times*. Retrieved March 10, 2006, from The New York Times Web site: <http://www.nytimes.com>.
- Kropf, N. P., & Burnette, D. (2003). Grandparents as family caregivers: Lessons for intergenerational education. *Educational Gerontology*, 29, 361-372.
- Kubler-Ross. (1978). *To live until we say goodbye*. New York: Simon & Schuster.
- Kunda, Z. (1999). *Social cognition: Making sense of people*. Cambridge, MA: The MIT Press.
- Kuster, D. (2006). A tale of two artists: Creativity in old age. *Delta Kappa Gamma Bulletin*, 72(2), 42-46.
- Lang, S. (2002, October 17). Caring for ill spouses prompts older women to retire earlier than men. *Cornell Chronicle*, 34(10). Retrieved May 12, 2006, from Cornell Chronicle Web site: <http://www.news.Cornell.edu>.
- Langer, N. (2004). Resiliency and spirituality: Foundations of strengths perspective counseling with the elderly. *Educational Gerontology*, 30, 611-617.
- Laslett, P. (1989). *A fresh map of life*. London: Weidenfeld & Nicholson.
- Laszio, D. (2002). AREDS supports the use of nutritional supplements for AMD. *Ophthalmology Times*, 27(13), 22-24.

- Laurrell, A. C. (2000). Structural adjustment and the globalization of social policy in Latin America. *International Sociology*, 15(2), 306-325.
- Lawrence, B. (2003). Gender, race and the regulation of native identity in Canada and the United States: An overview. *Hypatia*, 18(2), 3-32.
- Laxminarayan, R., Mills, A. J., Breman, J. G., Meesham, A. R., Alleyne, G., Claeson, M., et al. (2006). Advancement of global health: Key messages from the Disease Control Priorities Project. *The Lancet*, 367, 1193-1208.
- Lebo, D. (1953). Some factors said to make for happiness in old age. *Journal of Clinical Psychology*, 9, 384-390.
- Leder, D. (1999/2000). Aging into the spirit: From traditional wisdom to innovative programs and communities. *Generations*, 23(4), 36-41.
- Lee, C. (2005). Labor market status of older males in the United States 1880-1940. *Social Science History*, 29(1), 77-105.
- Lee, M. (2005). Stochastic infinitehorizon forecasts for us social security finances. *National Institute Economic Review*, October (194), 82-93.
- Lee, M. Y., & Melde-Mossey, L. (2004). Cultural dissonance among generations: A solution-focused approach with East Asian elders and their families. *Journal of Marital and Family Therapy*, 30(4), 497-514.
- Lee, T., & Mihailidis, A. (2005). An intelligent emergency response system: Preliminary development and testing of automated fall detection. *Journal of Telemedicine And Telecare*, 11, 194-198.
- Leonard, R., & Onyx, J. (Eds.). (1999). *Revisioning aging: Empowerment of older women*. New York: Peter Lang.
- Levine, H. B. (1999). Reconstructing ethnicity. *Journal of the Royal Anthropological Institute*, 5(2), 165-185.

- Levine, M. L. (2005). Focus on the economy; Budget deficit, trade deficit, savings deficit and monetary policy deficit: "are we ok?" *Real Estate Issues*, 30(1), 31-36.
- Levinson, R. W. (2003). Aging and time-binding in the-first century. *Etc: Review of General Semantics*, 60(1), 46-52.
- Levy, B. R. (2001). Eradication of ageism requires addressing the enemy within. *The Gerontologist*, 41(5), 578-579.
- Levy, B. R., & Banaji, M. R. (2002). Implicit ageism. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 49-75). Cambridge, MA: The MIT Press.
- The Library of Congress. (2006). *Today in History: June 2* [Data file]. Available from American Memory, <http://www.locweb2.loc.gov>
- Liebig, P. S. (2002). Gerontology. In *Grolier Multimedia Encyclopedia*. Retrieved September 13, 2002, from Grolier Online Web site: <http://www.gogrolier.com>.
- Lindio-McGovern, L. (2004). Alienation and labor export in the context of globalization. *Critical Asian Studies*, 36(2), 217-238.
- Lindquist, G. E. E. (1923). *The Red Man in the United States: An intimate study of the social economic, and religious life of the American Indian*. New York: George H. Doran.
- Lipscomb, V. B. (2006). "We need a theoretical base"; Cynthia Rich, women's studies, and ageism. *NWSA Journal*, 18(1), 3-12.
- Lisiankova, K., & Wright, R. E. (2005). Demographic change and the European Union labour market. *National Institute Economic Review*, October (194), 74-81.
- Litwin, H., & Zoabi, S. (2004). A multivariate examination of explanations for the occurrence of elder abuse. *Social Work Research*, 28(3), 133-142.

- Lloyd-Sherlock, P. (2000). Population ageing in developed and developing regions: Implications for health policy. *Social Science & Medicine*, 51, 887-895.
- Loefler, I. (2003). Eternal youth. *British Medical Journal*, 327(7425), 1235.
- Lookinland, S., & Anson, K. (1995). Perpetuation of ageist attitudes among present and future health care personnel. *Journal of Advanced Nursing*, 21, 47-56.
- Lopez-Claros, A., & Zahidi, S. (2005). *Women's empowerment: Measuring the global gender gap* (World Economic Forum). Davos, Switzerland: World Economic Forum.
- Loretto, W., Duncan, C., & White, P. J. (2000). Ageism and employment: Controversies, ambiguities and younger people's perceptions. *Ageing and Society*, 29, 279-302.
- Low status job health for immigrant women. (2005, Winter). *Working Life*, 1. Retrieved May 10, 2006, from National Institute for Working Life Web site: [http://www/arbetslivsinstitutet.se](http://www.arbetslivsinstitutet.se).
- Lu, L., & Kao, S. (2002). Traditional and modern characteristics across the generations: Similarities and discrepancies. *The Journal of Social Psychology*, 142(1), 45-49.
- Luborsky, M. R., & Sandar, A. (1993). Expanding the critical gerontology perspective. *The Gerontologist*, 33, 440-443.
- Lucas, S. (2004). The images used to "sell" and represent retirement communities. *Professional Geographer*, 56(4), 449-459.
- Lucchetti, M., Spazzafumo, L., & Cerasa, F. (2001). Italian people aged 50-75 years enrolled in a health promotion program: Health and lifestyle. *Educational Gerontology*, 27(6), 439-453.
- Lundberg, O., Diderichsen, F., & Yngwe, M. A. (2001). Changing health inequalities in a changing society? *Scandinavian Journal of Public Health*, 29(supplement 55), 31-39.

- Lundberg, U. (1999). Stress responses in low-status jobs and their relationship to health risks. *Annals of The New York Academy of Sciences*, 896, 162-172.
- Luo, L. (2006). "Cultural Fit": Individual and societal discrepancies in values, beliefs, and subjective well-being. *Journal of Social Psychology*, 146(2), 203-221.
- Lye, D. N. (1996). Adult child-parent relationships. *Annual Review of Sociology*, 22, 79-100.
- Lynch, G. S. (2004). Tackling Australia's future health problems: Developing strategies to combat sarcopenia - age-related muscle wasting and weakness. *Internal Medicine Journal*, 34, 294-296.
- Lyon, D. (2006). The organization of care work in Italy: Gender and migrant labor in the New Economy. *Indiana Journal of Global Legal Studies*, 13(1), 207-224.
- Lysack, C. L., & Seipke, H. L. (2002). Communicating the occupational self: A qualitative study of oldest-old American women. *Scandinavian Journal of Occupational Therapy*, 9, 130-139.
- Lyyra, T., & Heikkinen, R. (2006). Perceived social support and mortality in older people. *The Journals Of Gerontology*, 61B(3), S147-153.
- MacArthur Foundation. (2003). *MacArthur Foundation's 25th anniversary (Case in point: A new perspective on growing old)* [Data file]. Available from MacArthur Foundation, <http://www.macfound.org>.
- MacArthur Foundation. (2004). *MacArthur Foundation's 25th Anniversary* [25th Anniversary Report]. Available from MacArthur Foundation, <http://www.macfound.org>.
- MacArthur Network on SES, & Health. (2003, July). *Occupational status* (Summary prepared by S. Burgard & J. Stewart). San Francisco: MacArthur Research Network on Socioeconomic Status and Health. Retrieved May 10, 2006, from

MacArthur SES & Health Network Web site: <http://www.macses.ucsf.edu/Research>.

Macdonald, A. (1997). Ageist - who, me? *Student BMJ*, 5, 431-433.

Macdonald, B., & Rich, C. (1991). *Look me in the eye: Old women, aging, and ageism*. Midway, FL: Spinsters Ink Books.

Maciel, A. G., & Staudinger, U. M. (1993). What became of the prophecy of senescence? A view from life-span psychology. In K. W. Schaie (Ed.), *Societal impact on aging: Historical perspectives* (pp. 182-187). New York: Springer.

Mails, T. E. (1996). *The Cherokee People*. New York: Marlowe & Company.

Maki, N., Moore, S., & Grunberg L. (2005). The responses of male and female managers to workplace stress and downsizing. *North American Journal Of Psychology*, 7(2), 295-312.

Malavolta, M., Mocchegiani, E., & Bertoni-Freddari, C. (2004). New trends in biomedical aging research. *Gerontology*, 50, 420-424.

Maples, M. F., & Abney P. C. (2006). Baby boomers mature and gerontological counseling comes of age. *Journal of Counseling And Development*, 84(1), 3-10.

Maps of Indian Territory, the Dawes Act, and Will Rogers' enrolment case file (Record Group 75). (2005). Retrieved March 23, 2005, from U.S. National Archives & Records Administration Web site: <http://www.archives.gov>.

Marks, N. F., & Lambert J. D. (1999). *Transitions to caregiving, gender, and psychological well-being* (NSFS Working Paper No. 83). Madison: University of Wisconsin Center for Demography and Ecology.

Marshall, V. W., & Altpeter, M. (2005). Cultivating social work leadership in health promotion and aging"Strategies for active aging interventions. *Health & Social Work*, 30(2), 135-144.

- Marshall, V. W., & Altpeter, M. (2005). Cultivating social work leadership in health promotion and aging: Strategies for active aging interventions. *Health & Social Work, 30*(2), 135-145.
- Martens, A., Goldenberg, J. L., & Greenberg, J. (2005). A terror management perspective on ageism. *Journal of Social Issues, 61*(2), 223-239.
- Martin, C. (1980). Subarctic Indians and wildlife. In C. Vecsey & R. W. Venable (Eds.), *American Indian environments: Ecological issues in Native American History* (pp. 38-45). Syracuse, NY: Syracuse University Press.
- Martin, E. (Ed.). (1994). *The American Indian and the problem of history*. New York: Oxford University Press.
- Martin, P., Long, M. V., & Poon, L. W. (2002). Age changes and differences in personality traits and states of the old and very old. *The Journals of Gerontology, 57B*(2), P144-P152.
- Martinez, I. L. (2002). The elder in the Cuban American family: Making sense of the real and ideal. *Journal of Comparative Family Studies, 33*(3), 359-376.
- Mather, A. C. (2003). Old promises: The judiciary and the future of Native American federal acknowledgement litigation. *University of Pennsylvania Law Review, 151*(5), 1827-1861.
- McConatha, J. T., Hayta, V., Rieser-Danner, L., & McConatha, D. (2004). Turkish and U.S. attitudes toward aging. *Educational Gerontology, 30*, 169-183.
- McCool, A. C., Huls, A., Peppones, M., & Schlenker, E. (2001). Nutrition for older persons: A key to healthy aging. *Topics in Clinical Nutrition, 17*(1), 52-72.
- McGregor, J., & Gray, L. (2002). Stereotypes and older workers: The New Zealand experience. *Social Policy Journal of New Zealand, June*, 163-178.
- McHugh, K. E. (2000). The ageless self. *Journal of Aging Studies, 4*(1), 103-115.

- McIntosh, W. A., Sykes, D., & Kubena, K. S. (2002). Religion and community among the elderly. *Review Of Religious Research*, 44(2), 109-125.
- McLoughlin, W. G. (1993). *After the Trail of Tears: The Cherokees' struggle for sovereignty*. Chapel Hill: University of North Carolina Press.
- McMahan, S., & Phillips, K. (1999). America's aging workforce: Ergonomic solutions for reducing the risk of CTDs. *American Journal of Health Studies*, 15(4), 199-203.
- McNeal, G. J., & Walker, D. (2006). Enhancing success in advanced practice nursing: A grant-funded project. *Journal of Cultural Diversity*, 13(1), 10-19.
- McTighe, M. J. (1986). 'True Philanthropy' and the limits of the female sphere. *Labor History*, 2, 227-256.
- Measure Communication. (2003). *Communicating population and health research to policymakers* [Makerere University workshop objectives]. Available from Population Reference Bureau, <http://www.measurecommunication.org>
- Melzer, D. (1999). Profile of disability in older people: Estimates from a longitudinal population study. *British Medical Journal*, 318(191), 1108-1112.
- Mendes, P. (2005). The NGO wars: Why neo-liberals are trashing non-government advocacy groups. *Social Alternatives*, 24(3), 40-45.
- Meraviglia, M. G. (2004). The effects of spirituality on well-being of people with lung cancer. *Oncology Nursing Forum*, 31(1), 89-94.
- Messkoub, M. (2005). Migrants in the European Union: Welfare in old age. *Public Finance And Management*, 5(2), 269-289.
- Metge, J. (1964). A new Maori migration: Rural and urban relations in northern New Zealand. *Monographs on Social Anthropology*, 27.

- Metules, T., & Bauer, J. (2004). Depression: A man's failure to recognize that he's depressed and reluctance to seek help can lead to dangerous delays in treatment. *RN*, 67(12), 36-42.
- Meyers, D. T. (1989). *Self, society, and personal choice*. New York: Columbia University Press.
- Middleton, A. (2003). Maori and European landscapes at Te Puna, Bay of Islands, New Zealand, 1805-1850. *Archaeology in Oceania*, 38(2), 110-125.
- Minichiello, V., Browne, J., & Kendig, H. (2000). Perceptions and consequences of ageism: Views of older people. *Ageing and Society*, 20, 253-278.
- Ministry of Health. (2003). *Health of older people strategy* (The Vision of the Health of Older People Strategy). Dunedin, New Zealand: New Zealand Ministry of Health Publications.
- Ministry of Maori Development. (2000). *Tikanga Oranga Hauora* (ISBN 0 478 091190 7). Wellington, NZ: New Zealand Ministry of Maori Development.
- Minkler, M., & Fadem, P. (2002). Successful aging: A disability perspective. *Journal of Disability Studies*, 12(4), 229-235.
- Minkler. (1991). Generational equity or interdependence? *Generations*, 15(4), 36-42.
- Minois, G. (1987). *Histoire de la vieillesse: De l'antiquite a la Renaissance* [History of old age: from antiquity to the Renaissance]. Cambridge, England: Polity Press. (Original work published 1989)
- Mirowski, P. (2005). A revisionist's view of the history of economic thought. *Challenge*, 48(5), 79-94.
- Mitchell, J. H. (1998). *Trespassing: An inquiry into the private ownership of land*. Reading, MA: Perseus Publishing.

- Moberg, D. J. (2001). The aging workforce: Implications for ethical practice. *Business & Society Review*, 106(4), 315-330.
- Mohanram, R. (1999). *Black body: Women, colonialism, and space*. Minneapolis: University of Minnesota Press.
- Mokeke-Pickering, T. (1996). *Maori identity with whanau: A review of literature*. Conference paper presented at the University of Waikato, Hamilton, New Zealand.
- Montepare, J. M., & Zebrowitz, L. A. (2002). A social-developmental view of ageism. In T. D. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 77-109). Cambridge, MA: The MIT Press.
- Montross, L. P. (2006). Correlates of self-rated successful aging among community-dwelling older adults. *American Journal of Geriatric Psychiatry*, 14(1), 43.
- Moody, H. R. (1993). Overview: What is critical gerontology and why is it important? In W. A. Achenbaum, P. L. Jakobi, & R. Kastenbaum (Eds.), *Toward a critical gerontology* (pp. xiv-xx). New York: Springer Publishing Company.
- Moody, H. R. (2002). *Aging: Concepts and controversies* (4th ed.). Thousand Oaks, CA: Sage Publications.
- Moody, H. R. (2002). *Conscious aging: A new level of growth in later life*. Retrieved March 30, 2006, from Articles by Harry R. Moody Web site: <http://www.hrmooddy.com>.
- Mooij, R. A., & Stevens, L. G. M. (2005). Exploring the future of ability to pay in Europe. *Intertax*, 33(4), S9-S16.
- Morgan, V. (2005, July 4). Rise in retirement age is inevitable, says pension chief. *The Scotsman*. Retrieved May 12, 2006, from The Scotsman Web site: <http://www.the.scotsman.scotsman.com>.

- Morrow-Howell, N. (2001). *Productive aging*. Baltimore: Johns Hopkins University Press.
- Motta, M., Bennati, E., Ferlito, L., Malaguamera, M., & Motta, L. (2005). Successful aging in centenarians: Myths and reality. *Archives of Gerontology & Geriatrics*, 40(3), 241-252.
- Mt. Holyoke College. (2005). *Are IMF policies in the best interest of the average Kenyan?* [Data file]. Available from Mt. Holyoke College, <http://www.mtholyoke.edu/~wwainain/>.
- Muller, K. (2005). Post-socialist pension reform: Contributory and non-contributory approaches. *Public Finance & Management*, 5(2), 290-309.
- Murphy, D. P. (2005). Aging matters: Strategies for optimal care of the elderly. *Consultant*, 45(4), 469-473.
- Murray, S. (2006). Doubling the burden: Chronic disease. *Canadian Medical Association Journal*, 174(6), 769.
- Nadkarni, J. B., Iyengar, K. P., Dussa, C., Watve, S., & Vishwanath, K. (2005). Orthopaedic injuries following falls by hospital in-patients. *Gerontology*, 51, 329-333.
- National Academy for Teaching and Learning about Aging. (2002). *Problems of ageism in literature* [Online paper]. Available from University of North Texas, <http://www.cps.unt.edu/natla>.
- National Alliance for Caregiving, & AARP. (2004). *Caregiving in the U.S* (Research funded by MetLife Foundation). Bethesda, MD: National Alliance for Caregiving.
- National Center for Chronic Disease Prevention. (2001). *Surgeon General's Report: Women and Smoking* (Fact Sheet - Marketing Cigarettes to Women).

- Washington, DC: National Center for Chronic Disease Prevention and Health Promotion.
- National Center for Policy Analysis. (2001). *Government spending on the elderly: Social Security and Medicare* (NCPA Policy Report 247). Dallas, TX: National Center for Policy Analysis.
- National Health Service. (2004). Healthy & active life promotion. In *Older People* (National Electronic Library for Health). London: National Health Service. Retrieved August 11, 2004, from National Electronic Library for Health Web site: <http://www.nelh.nhs.uk>.
- National Partnership for Women & Families. (2006). *Medicare* [Report]. Available from National Partnership for Women & Families, <http://www.nationalpartnership.org>.
- National Party: Welfare, Family and Pacific Island Affairs. (2005). *1500 cataract patients* [Report by Judith Collins, Clevedon MP]. Available from National New Zealand, <http://www.judithcollins.co.nz>.
- National Women's Law Center. (2000). *Women and Social Security: What's at stake* (Report from the Information Center). Washington, DC: National Women's Law Center.
- A Native of Maine Traveling in the Western Country. (1839, January 26). The suffering exiles: A traveler's view of one of the last emigrant parties. *The New York Observer*.
- Nelson, T. D. (2005). Ageism: Prejudice against our feared future selves. *Journal of Social Issues*, 61(2), 207-221.
- Nelson, T. D. (Ed.). (2002). *Ageism: Stereotyping and prejudice against older people*. Cambridge, MA: MIT Press.

- Neugarten, B. L. (1974). Age groups in American society and the rise of the young-old. *Annals of the American Academy of Political And Social Science*, 329, 187.
- New American Bible*. (1987). Nashville, TN: Nelson Bibles.
- The New England Centenarian Study. (2005, March 16). *A look at centenarians*. (Boston University School of Medicine Report). Boston: NECS.
- New Zealand Conservation Authority. (1997). *Maori customary use of native birds, plants & other traditional materials* (Interim Report and Discussion Paper). Wellington, New Zealand: Whitcombe and Tombs.
- New Zealand Department of Internal Affairs. (Ed.). (1945). *Introduction to New Zealand*. Wellington, New Zealand: Whitcombe and Tombs.
- New Zealand Management. (2001). *Discriminating Kiwis* [Data file retrieved from Massey University Library Online]. Available from New Zealand Management, <http://80-tiki.knowledge-basket.co.nz>.
- New Zealand Ministry for the Environment. (2001). Restoring the mauri. In *Water publications (Reports and guides)* (Case study 3: Waipunahau). Wellington, New Zealand: Ministry for the Environment.
- New Zealand Ministry of Education. (1996). *Te Whariki* (Early childhood curriculum). Wellington, New Zealand: Learning Media Ltd.
- New Zealand Ministry of Health. (1997). *The health and wellbeing of older people and kaumatua* (Public Health Issues: Department Report). Wellington, NZ: Ministry of Health.
- New Zealand Ministry of Health. (2002). *Health of older people strategy*. Wellington, New Zealand: Ministry of Health Publications. Retrieved August 11, 2004, from New Zealand Ministry of Health Web site: <http://www.moh.govt.nz>.

- New Zealand Ministry of Justice. (2001). *He Hinatore ki te Ao Maori - A glimpse into the Maori world: Maori perspectives on justice*. In *Reports 2001* (Part I - Traditional Maori concepts). Wellington, New Zealand: New Zealand Ministry of Justice.
- New Zealand Ministry of Social Policy. (2001). *Towards a Society for All Ages*. In *New Zealand Positive Ageing Strategy* (ISBN 9-478-25104-1). Wellington, NZ: New Zealand Ministry of Social Policy.
- The New Zealand Positive Ageing Strategy Action Plan*. (2005). Retrieved September 11, 2005, from Office for Senior Citizens, Ministry of Social Development Web site: www.osc.govt.nz.
- Newman, J., Davidhizaar, R. E., & Fordham, P. (2006). Multi-cultural and multi-ethnic considerations and advanced directives. *Journal of Cultural Diversity*, 13(1), 3-9.
- Ng, S. H. (1994, September). *'You are too old to drive dear!'* Elderspeak and ageism in an ageing society. New Series XII presented at the Victoria University of Wellington Inaugural Addresses, Wellington, NZ.
- Ng, S. H. (1999). Patterns in discourse about elderly people in New Zealand. *Journal of Aging Studies*, 13(4), 473-490.
- Ng, S. H. (2002). Will families support their elders? Answers from across cultures. In T. Nelson (Ed.), *Ageism: Stereotyping and prejudice against older persons* (pp. 295-309). Cambridge, MA: MIT Press.
- Nicholas, A. S., Andrieu, S., Nourhashemi, F., & Rolland, Y. (2001). Successful aging and nutrition: Part 2. *Nutrition Reviews*, 59(8), S88-S92.
- Nicholas, A. S., Nourhashemi, L. F., Lanzmann-Petithory, D., & Vellas, B. (2001). Nutrition and Cognitive Function. *Nutrition in Clinical Care*, 4(3), 146-158.

- Noor Al-Deen, H. S. (1997). *Cross-cultural communication and aging in the United States*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Nunez, D. E., Armbruster, C., Phillips, W. T., & Gale, B. J. (2003). Community-based senior health program using a collaborative practice model: The Escalante Health Partnerships. *Public Health Nursing*, 20(1), 25-32.
- Nursing Standard Reading Panel. (2005). Raising the stakes: Will the government have a fight on its hands if it goes ahead with its plans to raise the retirement age for NHS staff? *Nursing Standard*, 19(22), 24.
- Nussbaum, J. F. (1991). Communication, language, and the institutional elderly. *Aging and Society*, 11, 149-165.
- Nussbaum, J. F., & Hummert, M. L. (Eds.). (2000). *Aging, communication and health: Linking research and practice for successful aging*. Mahwah, NJ: Lawrence Erlbaum & Associates.
- Nussbaum, J. F., Pitts, M. J., Huber, F. N., Krieger, J. L., & Ohs, J. E. (2005). Ageism and ageist language across the life span: intimate relationships and non-intimate interactions. *Journal of Social Issues*, 61(2), 287-306.
- Nussbaum, J., Pecchioni, L., Robinson, J., & Thompson, T. (2000). *Communication and Aging*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Nyangweso, M. A. (1998). Transformations of care among Africans - A study of the Kenyan situation. *Aging & Mental Health*, 2(3), 181-185.
- O'Dwyer, G. (2005). New system will last for decades (NHS pension review). *Nursing Standard*, 19(42), 33.
- OECD. (2004). *Social Expenditure Database* (OECD report). Paris: OECD. Retrieved May 25, 2006, from OECD Web site: <http://www.oecd.org/dataoecd>.

- Offer, D., & Sabshin, M. (Eds.). (1984). *Normality and the life cycle: A critical integration*. New York: Basic Books.
- Office for Senior Citizens. (2005). *New Zealand Positive Ageing Strategy* [Data file]. Available from Office for Senior Citizens, <http://www.gov.osc.nz>.
- Oginska-Bulik, N. (2005). The role of personal and social resources in preventing adverse health outcomes in employees of uniformed professions. *International Journal Of Occupational Medicine And Environmental Health*, 18(3), 233-240.
- O'Hanlon, A., & Coleman, P. (2004). Attitudes towards aging: Adaptation, development and growth into later years. In J. Coupland & J. F. Nussbaum (Eds.), *Handbook of communication and aging research*, (pp.31-63). Mahwah, NJ: Lawrence Erlbaum Associates.
- Ohno, H., Kizaki, T., Hitomi, Y., Watanabe, S., Ishibashi, Y., Izawa, T. Saitoh., et al. (2004). We have two strategies to attain healthy aging. *Geriatrics and Gerontology International*, 4, S311-S312.
- Ohno, Y., Aoki, R., Tamakoshi, A. Kawamura., T., Wakai., K., Hashimoto., S., Kawakami., et al. (2000). Successful aging and social activity in older Japanese adults. *Journal of Aging & Physical Activity*, 8(2), 129-140.
- Okamoto, K., & Tanaka, Y. (2004). Subjective usefulness and 6-year mortality risks among elderly persons in Japan. *Journal of Gerontology: Psychological Sciences*, 59B(5), 246-249.
- Okoye, U. O. (2006). *The erosion of traditional forms of care for the elderly and its implication for the elderly in Nigeria*. Retrieved June 15, 2006, from Department of Social Work, University of Nigeria Web site: <http://www.uaps.org/confageing/>.

- Okuna, S., Tagaya, M., & Davis, A. (1999). Elderly Japanese people living in small towns reflect on end-of-life issues. *Nursing Ethics*, 6(4), 308-315.
- The Old Woman's Project. (2006). *Why is ageism an old woman's issue?* [Data file]. Available from OWP, <http://www.oldwomansproject.org>.
- Old, J. L. (2000). *Vintage people - the secrets of successful aging*. Cleveland, TN: Pathway.
- Ongley, P. (2001). *Gender and unpaid work: Findings from the Time Use Survey* (Issued by the Social Policy Division of Statistics New Zealand). Wellington, New Zealand: Statistics New Zealand.
- Ontario Human Rights Commission. (2002). In Ontario Human Rights Commission (Ed.), *Promotion and awareness of human rights* (Commission report) [Electronic version]. Ontario, Canada: Ontario Human Rights Commission.
- Organisation for Economic Co-operation, & Development. (2005). *Economic survey of Belgium 2005: Keeping older workers in employment longer* (OECD Economic Surveys). Paris: OECD Publishing.
- Orimo, H. (2004). Clinical medicine and successful aging. *Geriatrics and Gerontology International*, 4, S3-S5.
- Osgood, N. J. (1995). Assisted suicide and older people - a deadly combination: Ethical problems in permitting assisted suicide. *Issues in Law & Medicine*, 10(4), 415-436.
- Oslin, E. W., Zubritsky, C., Brown, G., & Mullahy, M. (2004). Managing suicide risk in late life: Access to firearms as a public health risk. *The American Journal of Geriatric Psychiatry*, 12(1), 30-37.

- Palermo, G. B. (2001). The affective alienation of the elderly. In D. N. Weisstub, D. C. Thomasma, S. Gauthier, & G. F. Tomossy (Eds.), *Aging: Culture, health, and social change* (pp. 217-229). Dordrecht, Holland: Kluwer Academic Publishers.
- Palmer, S. (2004). Homai te Waiora ki Ahau: A tool for the measurement of wellbeing among Maori - the evidence of construct validity. *New Zealand Journal of Psychology*, 33(2), 50-58.
- Palmore, E. (1975). *The honorable elders: A cross-cultural analysis of aging in Japan*. Durham, NC: Duke University Press.
- Palmore, E. (1979). Predictors of successful aging. *Gerontologist*, 19, 427-431.
- Palmore, E. B. (1992). Positive Ageism? *The Gerontologist*, 53(5), 582.
- Palmore, E. (1999). *Ageism: Negative and positive*. New York: Springer.
- Palmore, E. B. (2004). Research Note: Ageism in Canada and the United States. *Journal of Cross-cultural Gerontology*, 19(1), 41-46.
- Palmore, E. (2005). Three decades of research on ageism. *Generations*, 29(3), 87-90.
- Pampel, F. C., & Williamson, J. B. (1989). *Age, class, politics, and the welfare state*. Cambridge, England: Press Syndicate of the University of Cambridge.
- Panayiotopoulos, P. (2005). The globalisation of care: Filipina domestic workers and care for the elderly in Cyprus. *Capital And Class*, (86), 99-134.
- Panel study of income dynamics*. (2005). Retrieved July 25, 2005, from Panel Study of Income Dynamics Web site: <http://psidonline.isr.edu>.
- Park, A. (2005). Between a rocker and a high chair. *Business Week*, 2/21(3921), 86-88.
- Parkin T. G. (1998). Ageing in antiquity: Status and participation. In P. Johnson & P. Thane (Eds.), *Old age from antiquity to post-modernity* (pp. 19-42). London: Routledge.

- Parkin, T. G. (2004). *Old age in the Roman world: A cultural and social history*. Baltimore: The Johns Hopkins University Press.
- Parsonson, A. (2003). 'Herangi, Te Kirihaehae Te Puea 1883 - 1952'. In *Dictionary of New Zealand Biography* (Vol. 3). Retrieved May 15, 2005, from Dictionary of New Zealand Biography Web site: <http://www.dnzb.govt.nz..>
- Patterson, J. (1999). Respecting nature: The Maori way. *The Ecologist*, 29(1), 33-39.
- Patterson, J. (2000). Mana: Yin and Yang. *Philosophy East & West*, 50(2), 229-242.
- Paun, O. (2004). Female Alzheimer's patient caregivers share their strength. *Holistic Nursing Practice*, 18(1), 11-17.
- Payne, S. (2002). Dilemmas in the use of volunteers to provide hospice bereavement support: evidence from New Zealand. *Mortality*, 7(2), 139-154.
- Paytiammo, J. (1932). *Flaming Arrow's people*. New York: Duffield and Green.
- Pearce, W. B., & Cronen, V. E. (1980). *Communication, action, and meaning: The creation of social realities*. New York: Praeger Publishers.
- Pecchioni, L. L., Ota, H., & Sparks, L. (2004). Cultural issues in communication and aging. In J. Coupland & J. F. Nussbaum (Eds.), *Handbook of communication and aging research* (pp. 167-207). Mahwah, NJ: Lawrence Erlbaum Associates.
- Penetito, W. (2002). Research and context for a theory of Maori schooling. *Mcgill Journal of Education*, 37(1), 89-110.
- Penick, J. M. (2004). Purposeful aging: Teleological perspectives on the development of social interest in late adulthood. *Journal of Individual Psychology*, 60(3), 219-233.
- Penick, J. M., & Fallshore, M. (2005). Purpose and meaning in highly active seniors. *Adultspan Journal*, 4(1), 19-36.
- Pension promises (Editorial). (2005). *OECD Observer*, May (249), 61.

- Perls, T. T. (1995). The oldest-old. *Scientific American*, 272(1). Retrieved April 7, 2003, from Boston University Medical Center Website Web site: <http://www.bumc.bu.edu>.
- Perls, T. T. (2000, March 17). *The New England Centenarian Study* (Overview). Boston: Boston University School of Medicine
- Perls, T. T. (2002, Spring). Centenarians - the ultimate survivors. *Alliance for Aging Research*, 12. Retrieved August 11, 2004, from Alliance for Aging Research Web site: <http://www.agingresearch.org>.
- Perls, T. T., Silver, M. H., & Lauerman, J. F. (1999). *Living to 100: Lessons in living to your maximum potential at any age*. New York: Basic Books.
- Perls, T., & Terry, D. (2003). Understanding the determinants of exceptional longevity. *Annals of Internal Medicine*, 139(5[2]), 445-449.
- Perricone, N. (2002). *The Perricone Prescription*. New York: HarperCollins.
- Peterson, W. C. (1991). *Transfer spending, taxes, and the American welfare state*. Norwell, MA: Kluwer Academic Publishers.
- Philibert, M. (1979). Philosophical approach to gerontology. In J. Hendricks & C. C. Hendricks (Eds.), *Dimensions of aging* (pp. 379-394). Cambridge, MA: Winthrop.
- Phillips, D. R. (2000). *Ageing in the Asia-Pacific Region: Issues policies, and future trends*. London: Routledge.
- Phillipson, C. (1997). Social relationships in later life: A review of the research literature. *International Journal of Geriatric Psychiatry*, 12, 505-512.
- Phillipson, C. (2002, April). *Globalization and the future of ageing: Economic, social, and policy implications*. Valencia Forum Keynote Paper presented at The Valencia Forum: An International Scientific Congress, Valencia, Spain.

- Pilcher, J. (1995). *Age and generation in modern Britain*. New York: Oxford University Press.
- Pinquart, M., & Sorensen, S. (2000). Influences of socioeconomic status, social network, and competence on subjective well-being in later life. *Psychology & Aging*, 15(2), 187-225.
- Policy oriented gerontology curriculum*. (2002). Retrieved October 16, 2004, from Syracuse University Center for Policy Research Web site: <http://www-cpr.maxwell.syr.edu/gero.ed>.
- Population Reference Bureau. (2003). *About PRB* [Data file]. Available from Population Reference Bureau, <http://www.prb.org>.
- Population Reference Bureau. (2004). *Grandparent responsibilities on the rise* [Report]. Available from Population Reference Bureau, <http://www.prb.org>.
- Population Reference Bureau. (2005). *2005 World Population Data Sheet*. Available from Population Reference Bureau, <http://www.prb.org>.
- Port, Cynthia. (2006). "Ages are the stuff!": The traffic in ages in interwar Britain. *NWSA Journal*, 18(1), 138-161.
- Poupart, L. M. (2002). Crime and justice in American Indian communities. *Social Justice, Spring-Summer*, 144-160.
- Powell, J. L. (2005). Aging and family policy: A sociological excursion. *Journal of Sociology & Social Welfare*, 32(2), 63-75.
- Powell, J. P. L. (2001). Theorising Social Gerontology: The case of social philosophies of age. *The Internet Journal of Internal Medicine*, 2(1), Online document.
- Powell, J., Bray, J., Roberts, H., Goddard, A., & Smith, E. (2000). Goal negotiation with older people in three day care settings. *Health and Social Care in The Community*, 8(6), 380-389.

- Presbyterian Older Adult Ministry. (2003). *The six myths of aging* [Data file]. Available from Presbyterian Older Adult Ministry Network, <http://www.pssusa.org/>.
- Primm, D. (2005). What workplace stress research is telling technical communicators. *Technical Communication*, 52(4), 449-455.
- The Project on Global Working Families. (1992). In Harvard School of Public Health (Ed.), *Work, family, and gender* (Research leader: J. Heymann). Boston: Harvard School of Public Health.
- Prucha F. P. (1975). *Documents of United States Indian policy*. Lincoln: University of Nebraska Press.
- Pullen, C., & Walker, S. N. (2001). Determinants of health-promoting lifestyle behaviors in rural older women. *Community Health*, 24(2), 49-72.
- Putnam, M. (2002). Linking aging theory and disability models: Increasing the potential to explore aging with physical impairment. *The Gerontologist*, 42(6), 799-806.
- Questions, & Answers. (2004). Do older women develop eating disorders too? *Eating Disorders Review*, 15(6), 8.
- Radcliffe, D. (1984). The international perspective of U3As. In *Age is opportunity* (pp. 60-82). London: Centre for Policy on Aging.
- Raise the retirement age [Electronic version]. (2004, October 4). *USA Today*.
- Raj, A. (2004). Depression in the elderly: Tailoring medical therapy to their special needs. *Postgraduate Medicine*, 115(6), 26-42.
- Ranzijn, R. (2002). The potential of older adults to enhance community quality of life: Links between positive psychology and productive aging. *Ageing International*, 27(2), 30-55.
- Rao, S. S. (2005). Prevention of falls in older patients. *American Family Physician*, 72(1), 81.

- Raschick, M., & Ingersoll-Dayton, B. (2004). The costs and rewards of caregiving among aging spouses and adult children. *Family Relations*, 53(3), 317-325.
- Rashmi, G., & Pillai, V. K. (2002). Elder care giving in South Asian families: Implications for Social Services. *Journal of Comparative Family Studies*, 33(4), 565-576.
- Rayer, C. (1999). Will the NHS still want me when I'm 65? *New Statesman*, 128(4432), 30.
- RealtyTimes Agent Marketing. (2005). *The appeal of 55-plus communities* [Data File]. Available from New Zealand Home Advisor Website: <http://homeadvisor.realtytimes.com>
- The RECORD Trial Group. (2005). Oral vitamin D3 and calcium for secondary prevention of low-trauma fractures in elderly people. *Lancet*, 365, 1621-1628.
- Redfern, S. (1989). Key issues in nursing elderly people. In A. Warnes (Ed.), *Human ageing and later life* (pp. 146-160). London: Edward Arnold.
- Redwood, H. (2003, January 13). Patients' health and education: How strong is the link? *Health and Age*. Retrieved March 16, 2005, from Health and Age for Healthcare Professionals Web site: <http://www.healthandage.com>.
- Reedy, T. (2000). Te reo Maori: The past 20 years and looking forward. *Oceanic Linguistics*, 39(1), 157-170.
- Reibold, M. (2002). *The politics of aging*. Homily presented at the Sunday morning worship service, Minneapolis, MN.
- Reichmann, W. J. (1962). *Use and abuse of statistics*. New York: Oxford University Press.
- Remennick, L. (2003). Retired and making a fresh start: Older Russian immigrants discuss their adjustment in Israel. *International Migration*, 41(5), 153-175.

- Rice, D. P., & Fineman, N. (2004). Economic implications of increased longevity in the United States. *Annual Review of Public Health*, 25, 457-473.
- Richmond, D. et al. (1995). *Care for older people in New Zealand* (A report to the National Advisory Committee on Core Health and Disability). Wellington, New Zealand: National Advisory Committee.
- Richmond, T. S., Kauder, D., Strumpf, N., & Meredith T. (2002). Characteristics and outcomes of serious traumatic injury in older adults. *Clinical Investigations*, 50, 215-222.
- Robbins, R., Stoltenberg, C., Robbins, S., & Ross, J. M. (2002). Marital satisfaction and Cherokee language fluence. *Measurement & Evaluation in Counselling & Development*, 35(1), 27-35.
- Robertson, A. (1997). Beyond apocalyptic demography: Towards a moral economy of interdependence. *Ageing and Society*, 17(4), 425-446.
- Robins, R. W., & Trzesniewski, K. H. (2005). Self-esteem development across the lifespan. *Current Directions In Psychological Science*, 14(3), 158-162.
- Robinson, D., & Williams, T. (2001). Social capital and voluntary activity: giving and sharing in Maori and non-Maori society. *Social Policy Journal of New Zealand*, December, 52-71.
- Robinson, J. D., & Nussbaum, J. F. (2004). Grounding research and medical education about religion in actual physician-patient interaction: Church attendance, social support, and older adults. *Health Communication*, 16(1), 68-85.
- Rodts, M. F. (2006). Encouraging increased physical activity in the elderly. *Orthopaedic Nursing*, 25(2), 91-92.

- Rogers, M. E. (2005). Standing strong: Help older adults reduce their risk of falls with a strategically designed balance and strength training program. *IDEA Fitness Journal*, 2(6), 64-73.
- Rook, K. S., & Ituarte, P. H. G. (1999). Social control, social support, and companionship in older adult's family relationships and friendships. *Personal Relationships*, 6, 199-211.
- Roos, N. P., & Havens, B. (1991). Predictors of successful aging: A twelve-year study of Manitoba elderly. *American Journal of Public Health*, 81, 63-68.
- Rosenwaike, I. (1988). *The extreme aged in America: A portrait of an expanding population*. Westport, CT: Greenwood Publishing Group.
- Rosow, I. (1974). *Socialization to old age*. Berkeley: University of California Press.
- Rowe, J. W. (1991). Reducing the risk of usual aging. *Generations*, 15(1), 25-29.
- Rowe, J. W. (1997). The new gerontology. *Science*, 278, 367-369.
- Rowe, J. W., & Kahn, R. L. (1987). Human aging: Usual and successful (physiological changes associated with aging). *Science*, 237, 143-150.
- Rowe, J. W., & Kahn, R. L. (1998). *Successful aging*. New York: Dell Publishing.
- Rupp, D. E., Vodanovich, S. J., & Crede, M. (2005). The multidimensional nature of ageism. *The Journal of Social Psychology*, 145, 336-353.
- Russell, R. (2004). Social networks among elderly men caregivers. *The Journal of Men's Studies*, 13(1), 121-142.
- Ryan, E. B., & Butler, R. N. (1996). Communication, aging, and health: Toward understanding health provider relationships with older clients. *Health Communication*, 8(3), 191-197.

- Ryan, E. B., & Hummert, M. L. (1995). Communication predicaments of aging: Patronizing behavior toward older adults. *Journal of Language & Social Psychology, 14*(2), 144-167.
- Rybczynski, W. (1996). Myths of family past. In J. R. Gillis (Ed.), *A world of their own making: Myth, ritual and the quest for family values* (pp. 3-19). New York: Basic books.
- Sabin, K. L. (2005). Older adults and motivation for therapy and exercise: Issues, influences, and interventions. *Topics In Geriatric Rehabilitation, 21*(3), 215-221.
- Sachweh, S. (1998). Granny Darling's nappies: Secondary babytalk in German nursing homes for the aged. *Journal of Applied Communication Research, 26*(1), 52-65.
- Sadler, W. A. (2000). *The Third Age: Six principles of growth and renewal after forty*. Cambridge, MA: Perseus Publishing.
- Sagner, A. (2000). Ageing and social policy in South Africa: Historical perspectives with particular reference to the Eastern Cape. *Journal of South African Studies, 26*(3), 532-554.
- Salmon, H. E. (1981). Theories of aging, disability, and loss. *Journal of Rehabilitation, 47*(4), 44-50.
- Salter, G. (2002). Locating 'Maori movement' in mainstream physical education: Curriculum, pedagogy and cultural context. *Journal of Physical Education New Zealand, 35*(1), 34-44.
- Salthouse, T. A. (1991). Cognitive facets of aging well. *Generations, 15*(1), 35-38.
- Sangree, W. H. (1989). Age and power: Life-course trajectories and age structuring of power relations in East and West Africa. In D. Kertzer, I., & K. W. Schaie (Eds.), *Age structuring in comparative perspective* (pp. 23-46). Hillsdale, NJ: Lawrence Erlbaum Associates.

- Sarros, J. C., & Santora, J. C. (2001). Leaders and values: A cross-cultural study. *Leadership & Organization Development Journal*, 22(5/6), 243-249.
- Saucier, M. G. (2004). Midlife and beyond: Issues for aging women. *Journal of Counselling and Development*, 72(4), 420-426.
- Savishinsky, J. (2001). The passions of maturity: Morality and creativity in later life. *Journal of Cross-cultural Gerontology*, 16, 41-55.
- Sawatzky, J. E., & Fowler-Kerry, S. (2003). Impact of caregiving: Listening to the voice of informal caregivers. *Journal of Psychiatric And Mental Health Nursing*, 10, 277-286.
- Saxton, M. (2005). Caring for Aunt Alice. *Journal of Disability Policy Studies*, 16(1), 61-67.
- Sayers, G. M., & Nesbitt, T. (2002). Ageism in the NHS and the Human Rights Act 1998: An ethical and legal inquiry. *European Journal of Health Law*, 9, 5-18.
- Schactman, D., & Altman, S. H. (2000). The United States confronts the policy dilemmas of an aging society. *Health Affairs*, 19(3), 252-258.
- Schaie, K. W. (1993). Ageist language in psychological research. *A Psychologist*, 48, 49-51.
- Schank, M. J., & Lough, M. A. (1990). Profile: frail elderly women, maintaining independence. *Journal of Advanced Nursing*, 15, 674-682.
- Scheidt, R. J., Humpherys, D. R., & Yorgason, J. B. (1999). Successful aging: What's not to like. *Journal of Applied Gerontology*, 18(3), 277-282.
- Scheidt, R. J., Humpherys, D. R., & Yorgason, J. B. (1999). Successful aging: What's not to like? *Journal of Applied Gerontology*, 18(3), 277-282.

- School of Health, Physical Education & Recreation. (2005). *Leisure and aging* [Course overview: Foundations for recreation services for older adults]. Available from Indiana University, <http://www.indiana.edu>.
- Schroots, J. F. (2003). Ageism in Science: Fair-play between generations. *Science & Engineering Ethics*, 9(4), 445-451.
- Schroots, J. F., & Birren, J. E. (1990). Concepts of time and aging in science. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (pp. 44-54). San Diego, CA: Academic Press Inc.
- Schulz, R. (1996). A life-span model of successful aging. *American Psychologist*, 51, 702-714.
- Schulz, R., & Heckhausen, J. (1996). A life span model of successful aging. *American Psychologist*, 51(7), 702-714.
- Schulz, R., & Heckhausen, J. (1999). Aging, culture and control: Setting a new research agenda. *Journal of Gerontology: Psychological Sciences*, 54B, P139-P145.
- Schuster, E. O., Francis-Connelly, E., Alford-Trewn, P., & Brooks, J. (2003). Conceptualization and development of a course on aging to infancy: A life course retrospective. *Educational Gerontology*, 29, 841-850.
- Seabrook, J. (2000, April 13). Nasty, brutish and long: Rapid population ageing in developing countries means workers face decades of hard labour. *Financial Times*, p. News and Analysis/World.
- Selby, R. (1999). *Still being punished*. Wellington, New Zealand: Huia Publishers.
- Senate Special Aging Committee. (2002). *Image of aging in media and marketing* [FDCH Congressional Testimony]. Available from Senate Special Aging Committee, <http://30-web12.epnet.com>.

- Settersten, R. (2005). Linking the two ends of life: What gerontology can learn from childhood studies. *Journals of Gerontology*, 60B(4), S173-S180.
- Settersten, R. A., Jr. (1997). Adulthood and aging: Research on continuities and discontinuities/The human elder in nature, culture, and society/The meanings of age: Selected papers of Bernice L. Neugarten. *The Gerontologist*, 37(5), 693-698.
- Settersten, R. A., Jr., & Mayer, K. U. (1997). The measurement of age, age structuring and the life course. *Annual Review of Sociology*, 23(29), 31-38.
- Shahar, S. (1998). Old age in the high and late Middle-Ages: Image, expectation and status. In P. Johnson & P. Thane (Eds.), *Old age from antiquity to post-modernity* (pp. 43-63). London: Routledge.
- Shaikh, A. (2003). Who pays for the "welfare" in the welfare state? A multicountry study. *Social Research*, 70(2), 531-552.
- Sharps, M. J., Price-Sharps, J. L., & Hanson, J. (1998). Attitudes of young adults toward older adults: Evidence from the United States and Thailand. *Educational Gerontology*, 24, 655-660.
- Sherman, F. T. (2003). Baby boomer Senators must face their own dismal future! *Geriatrics*, 58(9), 10-12.
- Sheung-Tak, C., & Chan, A. C. M. (2006). Relationships with others and life satisfaction in later life. *Journals Of Gerontology*, 61B(1), 46-54.
- Shrier, I. (2003). Tai Chi retards bone loss and improves muscle strength. *Sportsmedicine*, 31(3), 16-17.
- Shrier, I., & Pipe, A. (2004). Comment. *Physician and Sports Medicine*, 32(7), 7.
- Sieri, T., & Beretta, G. (2004). Fall risk assessment in very old males and females living in nursing homes. *Disability and Rehabilitation*, 26(12), 718-723.

- Sihvonen, S., Sipila, S., Taskinen, S., & Pertti, E. (2004). Fall incidence in frail older women after individualized visual feedback-based balance training. *Gerontology*, 50, 411-416.
- Silveira, E. R. T., & Ebrahim, S. (1998). Social determinants of psychiatric morbidity and well-being in immigrant elders and whites in East London. *International Journal of Geriatric Psychiatry*, 13, 801-812.
- Silverman, P., & Maxwell, R. J. (1982). Cross-cultural variation in the status of old people. In P. N. Stearns (Ed.), *Old age in preindustrial society* (pp. 46-69). New York: Holmes & Meier.
- Silverstein, M., Burholt, V., Wenger, G. C., & Bengtson, V. L. (1998). Parent-child relations among very old parents in Wales and the United States: A test of modernization theory. *Journal of Aging Studies*, 12(4), 384-410.
- Simmons, L. W. (1960). *The role of the aged in primitive society*. New Haven, CT: Yale University Press. (Original work published 1945)
- Simon, J. A. (1998). Anthropology, 'native schooling' and Maori: The politics of 'cultural adaptation' policies. *Oceania*, 69(1), 61-79.
- Simonton, D. K. (1994). *Greatness: Who makes history and why*. New York: Guilford.
- Smith, J., & O'Sullivan, A. (2004). Longitudinal research and the evaluation of homelessness. In *Interventions in the UK* (Centre for Housing and Community Research). London: Cities Institute: London Metropolitan University.
- Smith, P. M. (2005). *A concise history of New Zealand*. Port Melbourne, Australia: Cambridge University Press.
- Smith, R. J. (1991). *Fortune-tellers and philosophers: Divination in traditional Chinese society*. Boulder, CO: Westview Press.

- Smootha, S. (2002). Types of democracy and modes of conflict management in ethnically divided societies. *Nations and Nationalism*, 8(4), 423-431.
- Snape, E., & Redman, T. (2003). Too old or too young? The impact of perceived age discrimination. *Human Resource Management Journal*, 13(1), 78-89.
- Sneed, J. R., & Whitbourne, S. K. (2005). Models of the aging self. *Journal of Social Issues*, 6(2), 375-390.
- Snipp, C. M. (2003). Racial measurement in the American census: Past practices and implications. *Annual Review of Sociology*, 29, 563-588.
- Snyder, C. R. (Ed.). (2001). *Coping with stress: Effective people and processes*. New York: Oxford University Press.
- Social Security Administration. (2005). *The full retirement age is increasing* (Tuesday, December 13). Washington, DC: US Social Security Administration. Retrieved May 12, 2006, from Social Security Online Web site: <http://www.ssa.gov>.
- Sorensen, A. B., Sherrod, L. R., & Weinert F. E. (Eds.). (1986). *Human development and the life course: Multidisciplinary perspectives*. Hillsdale, NJ: Lawrence Erlbaum Associates.
- Sorkin, D., Rook, K. S., & Lu, J. L. (2002). Loneliness, lack of emotional support, lack of companionship, and the likelihood of having a heart condition in an elderly sample. *Annals of Behavioral Medicine*, 24(4), 290-299.
- Spradley, J. P. (1979). *The ethnographic interview*. Orlando, Florida: Harcourt Brace Jovanovich College Publishers.
- Spring, J. (1996). *The cultural transformation of a Native American family and its tribe, 1763-1995: A basket of apples*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Stallard, J. M., Decker, I. M., & Sellers, J. B. (2002). Health care for the elderly: A social obligation. *Nursing Forum*, 37(2), 5-16.

- Stanley, M., Blair, K. A., & Beare, P. G. (2004). *Gerontological nursing: Promoting successful aging with older adults*. Philadelphia: F. A. Davis Company.
- Statistics New Zealand. (2002). 2001 Census Snapshot. In B. Pink (Ed.), *Census 2001* (Data collected from the 2001 Census of Population and Dwellings) [Electronic version]. Wellington, New Zealand: Statistics New Zealand.
- Statistics New Zealand. (2002). *Population summary for age group by sex* [Report]. Available from Statistics New Zealand, <http://www.stats.govt.NA/census/2001>.
- Steadman, J., Donaldson, N., & Kalra, L. (2003). A randomized controlled trial of an enhanced balance training program to improve mobility and reduce falls in elderly patients. *American Geriatrics Society*, 51, 847-852.
- Stearns, P. N. (1982). *Old age in preindustrial society*. New York: Holmes & Meier.
- Stearns, P. N., & Van Tassel, D. (Eds.). (1986). *Old age in a bureaucratic society: The elderly, the experts, and the State in American history*. Westport, CT: Greenwood Press.
- Stelle, C. D., & Uchida, M. (2004). The stability and change in the social support networks of widowers following spousal bereavement. *The Journal of Men's Studies*, 13(1), 85-106.
- Stephenson, P. H. Wolfe., N. K., Coughlan., R., & Koehn, S. D. (1999). A methodological discourse on gender, independence and frailty: Applied dimensions of identity construction in old age. *Journal of Aging Studies*, 13(4), 391-402.
- Sternberg, R. J. (2005). Older but not wiser? The relationship between age and wisdom. *Ageing International*, 30(1), 5-26.

- Stevenson, O. (1989). *Age and vulnerability: A guide to better care*. London: Edward Arnold.
- Steyn, H. P. (1994). Role and position of elderly !Xu in the Schmidtsdrift Bushman community. *South African Journal of Ethnology*, 17(2), 31-38.
- Stickle, F., & Onedera, J. D. (2006). Depression in older adults. *Adultspan Journal*, 5.1, 36-46.
- Stone, M. E. (2005). Shelter Poverty. *New England Journal of Public Policy*, 20(1), 107-119.
- Strawbridge, W. J., & Wallhagen M. I. (2003). Self-rated successful aging. In L. Q. Poon, S. H. Gueldner, & B. M. Sprouse (Eds.), *Successful aging and adaptation to chronic diseases* (pp. 1-24). New York: Springer Publishing.
- Strawbridge, W. J., Wallhagen, M. I., & Cohen, R. D. (2002). Successful aging and well-being: Self-rated compared with Rowe and Kahn. *The Gerontologist*, 42, 727-733.
- Successful Aging Ottawa. (2005). *Charting our Course* (Summary Report) [Electronic version]. Ottawa, Canada: Successful Aging Ottawa.
- Suffolk County Council. (2006). *Positive Ageing* [Data File]. Available from Suffolk County Council, <http://www.suffolk.gov.uk>.
- Syme, S. L. (2003). Psychosocial interventions to improve successful aging. *Annals of Internal Medicine*, 139(5, Part 2), 400-405.
- Szanto, K., Gildengers, A., Mulsant, B. H., Brown, G., Alexopoulos, G. S., & Reynolds, C. F., III. (2002). Identification of suicidal ideation and prevention of suicidal behaviour in the elderly. *Drugs & Aging*, 19(1), 11-24.

- Tai, R. M. (2002). WAI - spirit, water, song, memory. *The Aroha Way Eletter*, 25 November(5). Retrieved May 29, 2004, from The Aroha Way Web site: <http://www.thearohaway.com>.
- Tanaka, H., Dinunno, F. A., Monahan, K. D., Clevenger, C. M., DeSouza, C. A., & Seals, D. R. (2002). Arterial compliance: Aging and exercise effects. *Journal of Aging & Physical Activity*, 10(3), 360-362.
- Tate, C. (1996). *Psychoanalysis and Black novels: Desire and the protocols of race*. New York: Oxford University Press.
- Tawney, R. H., & Firth, R. (1929). *Primitive economics of the New Zealand Maori*. New York: E. P. Dutton & Company.
- Te Ara: The Encyclopedia of New Zealand. (2006). *20th-century migration* [Data file]. Available from Te Ara: The Encyclopedia of New Zealand, <http://www.teara.govt.nz>.
- Te Ara: The Encyclopedia of New Zealand. (2006). *History of immigration - assisted immigration revives 1946-1975* [Data file]. Available from Te Ara: The Encyclopedia of New Zealand, <http://www.teara.govt.nz>.
- Tee, S. R., & Lathlean, J. A. (2004). The ethics of conducting a co-operative inquiry with vulnerable people. *Journal of Advanced Nursing*, 47(5), 536-543.
- Thane, P. (2003). Social histories of old age and aging. *Journal of Social History*, 37(1), 93-113.
- Thane, P. M. (2001). Changing paradigms of aging and being older. In D. N. Wiestub, D. C. Thomasma, G. Gauthier, & G. F. Tomossy (Eds.), *Aging: Culture, health, and social change* (pp. 1-14). Dordrecht, Holland: Kluwer Academic Publishers.

- Thapar-Bjorkert, S., & Henry, M. (2004). Reassessing the research relationship: Location, position and power in fieldwork accounts. *Social Research Methodology*, 7(5), 363-381.
- Thomas, D. L., & Zhang, J. (1994). Modernization theory revisited: A cross-cultural study of adolescent conformity to significant others in Mainland China, Taiwan, and the USA. *Adolescence*, 29(116), 885-895.
- Thomas, M. C., Martin, V., Alexander, J. J., Cooley, F. R., & Loague, A. M. (2003). Using new attitudes and technology to change the developmental counselling focus for older populations. *Counselling and Human Development*, 35(8), 1-9.
- Thomas, S. B., Fine, M. J., & Said A. I. (2004). Health disparities: The importance of culture and health. *American Journal of Public Health*, 94(12), 2050.
- Thomas, W. H., & Johansson, C. (2003). Elderhood in Eden. *Topics in Geriatric Rehabilitation*, 19(4), 282-290.
- Thompson, E., & Wilson, L. (2001). The potential of older volunteers in long-term care. *Generations*, 25(1), 58-64.
- Thompson, S. (1990). Metaphors the Chinese age by. In P. Spencer (Ed.), *Anthropology & the riddle of the Sphinx* (pp. 89-101). London: Routledge.
- Thornton, J. E. (2002). Myths of aging or ageist stereotypes. *Educational Gerontology*, 28, 301-312.
- Thurow, L. (1996). *The future of capitalism*. New York: William Morrow.
- Tien-Hyatt, J. L. (1986-1987). Self-perceptions of aging across cultures: Myth or reality. *International Journal of Aging and Human Development*, 24, 129-148.
- To avoid a nursing home, avoid falling. (1998, February). *Tufts University Health & Nutrition Letter*, 15(12), 1-3.

- Tobert, N., & Pitt, F. (1994). The Southwest. In *Native American myths and legends* (pp. 26-39). New York: Smithmark Publishers, Inc.
- Tornstam, L. (1994). Gero-transcendence: A theoretical and empirical exploration. In L. E. Thomas, S. A. Eisenhandler, & H. R. Moody (Eds.), *Aging and the religious dimension* (pp. 203-225). Westport, CT: Auburn House.
- Torres, S. (2002). Relational values and ideas regarding "successful aging". *Journal of Comparative Family Studies*, 33(3), 417-436.
- Torres, S. (2003). A preliminary empirical test of a culturally-relevant framework for the study of successful aging. *Journal of Cross-cultural Gerontology*, 18(1), 79-100.
- Trade Union Advisory Committee. (2003). *Approaches to improve the prospects of older workers in the labour market* (Report to the OECD). Paris: Trade Union Advisory Committee to the Organisation for Economic Co-operation and Development.
- Train, G. H., Nurock, S. A., Manela, M., Kitchen, G., & Livingston, G. A. (2005). A qualitative study of the experiences of long-term care for residents with dementia, their relatives and staff. *Aging & Mental Health*, 9(2), 119-128.
- Trapeznik, A. (1996-7). Heritage and Public History in New Zealand. *Public History Review*, 5(6), 62-77.
- Traphagan, J. W. (2004). Interpretations of elder suicide, stress and dependency among rural Japanese. *Ethnology*, 43(4), 315-330.
- Trela, J. E., & Sokolovsky, J. H. (1979). Culture, ethnicity, and policy for the aged. In D. E. Gelfand & A. J. Kutzik (Eds.), *Ethnicity and aging: Theory, research, and policy* (pp. 117-136). New York: Springer Publishing Co.
- Tropper, M. S. (1997, Summer). Migration and aging. *International Psychogeriatric Association Bulletin, Bulletin Archive*, 1-3.

- Tulle-Winton, E. (1999). Growing old and resistance: Towards a new cultural economy of old age? *Ageing and Society*, 19, 281-289.
- Tyner, J. A. (1999). The web-based recruitment of female foreign domestic workers in Asia. *Singapore Journal of Tropical Geography*, 20(2).
- U. S. Census Bureau. (2002). *Demographic trends in the 20th century* [Report]. Available from U.S. Census Bureau, <http://www.census.gov/population/www/cen2000>.
- U. S. Preventive Services Task Force. (2004). Screening for suicide risk: Recommendation and rationale. *American Family Physician*, 70(11), 2187-2191.
- The U.S. Equal Employment Opportunity Commission. (2004). *Glass ceilings: The status of women as officials and managers in the private sector* (Executive Summary). Washington, DC: EEOC. Retrieved May 10, 2006, from Equal Employment Opportunity Commission Web site: <http://www.eeoc.gov/stats/reports/glassceiling>.
- Unger, J. B., Cruz, T., Shakib, S., Mock., J., Shields., A., Baezconde-Garbanati., L. Palmer, P., et al. (2003). Exploring the cultural context of tobacco use: A transdisciplinary framework. *Nicotine & Tobacco Research*, 5(Supplement 1), S101-S117.
- United Nations Department for Social Policy, & Development. (1997). *Caregiving and older persons - Gender dimensions* (Expert group meeting). New York: United Nations.
- United Nations Division for Social Policy and Development. (2003). *Vienna International Plan on Ageing* [Date file]. Available from Gateway to social policy and development: ageing, <http://www.un.org/esa/socdev/ageing/ageipaa.htm>.

- United Nations. (1996). *The ageing of the world's population* (DPI/1858/AGE) [Electronic version]. New York: United Nations Department of Public Information.
- United Nations. (2002). *International strategy for action on ageing* (E/CN.5/2001/PC/L.9). New York: United Nations. Retrieved April 29, 2006, from The Second World Assembly on Ageing 2002 Web site: <http://www.un.org/esa/socdev/ageing>.
- United Nations. (2002). *Madrid Political Declaration* (A/Conf.197/9). Geneva, Switzerland: United Nations Division for Social Policy and Development. Retrieved May 8, 2006, from United Nations Web site: <http://www.un.org/esa/socdev/ageing>.
- United Nations. (2003). *New Zealand policy on ageing* [Report]. Available from United Nations, <http://www.un.org/esa/socdev/ageing/workshops>.
- United Nations. (2003). *Vienna international plan of action on ageing* (United Nations International Report on Ageing) [Electronic version]. New York: United Nations Division for Social Policy and Development.
- United Nations. (2005). *Demographic profile of the older population* (Population Division, DESA). New York: United Nations Population Division.
- United Nations. (2005, February 24). *World population prospects* (The 2004 Revision, p. 24). New York: United Nations.
- United States Department of Justice. (2004). *Civil rights: Law and history* [Data file]. Available from US DOJ, <http://www.usdoj.gov>
- United States Social Security Administration. (2005). *Full retirement age is increasing* (Find your retirement age website). Washington, DC: U.S. SSA. Retrieved June

- 10, 1996, from United States Social Security Administration Online Web site:
<http://www.ssa.gov/retiredchartred.htm>.
- University College London. (2003). *Theories of ageing* [Lecture 1]. Available from
 University College London Web site, <http://www.ucl.ac.uk>.
- University of Georgia Gerontology Center. (1995). *Hale and hearty at 100* (Report from
 the Georgia Centenarian Study). Atlanta: The University of Georgia. Retrieved
 April 7, 2003, from The University of Georgia Web site: [http://
 www.geron.uga.edu](http://www.geron.uga.edu).
- University of Texas. (2002). *Rhetoric of American Indians* [Course description].
 Available from University of Texas, www.cwrl.utexas.edu
- University of Toronto. (2003). *Introduction to Sociology (Sociology 101T)* [Course
 material]. Available from University of Toronto Department of Sociology, [http://
 www.utoronto.ca/soc101](http://www.utoronto.ca/soc101).
- Uotinen, V., Suutama, T., & Ruoppila, I. (2003). Age identification in the framework of
 successful aging, a study of older Finnish people. *International Journal of Aging
 & Human Development*, 56(3), 173-196.
- Vaillant, G. E. (2002). *Aging Well*. New York: Little, Brown & Company.
- Valle, R. (1998). *Caregiving across cultures: Working with dementing illness and
 ethnically diverse populations*. Washington, DC: Taylor & Francis.
- van Grootheest, D. S., Beekman, A. T. F., Broese van Groenou, M. I., & Deeg, D. J. H.
 (1999). Sex differences in depression after widowhood: Do men suffer more?
Social Psychiatry & Psychiatric Epidemiology, 34(7), 391-399.
- Vaupel, J. (2000). Setting the stage: A generation of centenarians? *Washington
 Quarterly*, 23(3), 197-201.

- Vaux, A. (1988). *Social support: Theory, research, and intervention*. New York: Praeger Publishers.
- The very old: How different from you and me? (2005, Winter). *Harvard Health Letter*, February, NA.
- Vincent, J. (2003). *Old age*. New York: Routledge.
- von Faber, M., van der Wiel, A. B., van Exel, E., Gussekloo, J., Lagaay, A. M., & van Dongen, E. (2000). Successful aging in the oldest old: Who can be characterized as successfully aged? *Archives of Internal Medicine*, 16(22), 2694-2700.
- Waern, M., Rubenowitz, E., & Wilhelmson, K. (2003). Predictors of suicide in the old elderly. *Gerontology*, 49(5), 328-338.
- Wagner, C. G. (2005). Robin Hood and the no-free lunch bunch. *Futurist*, 39(2), 7-8.
- Waitangi Fisheries Commission. (1999, April). Maori fisheries conference has an international flavour. *The Newsletter of the Treaty of Waitangi Fisheries Commission*, 48, 2.
- Waitangi Tribunal. (1987). Report of the Waitangi Tribunal on the Orakei claim. In Brooker & Friend Ltd (Eds.), *The Tribunal, I v* (0113-4124:1(WAI-9)). Wellington, New Zealand: Waitangi Tribunal.
- Waldon, J. (2004). Oranga kaumatua: perceptions of health in older Maori people. *Social Policy Journal of New Zealand*, 23, 167-181.
- Walker, A. (1993). Intergenerational relations and welfare restructuring. In *The changing contract across generations* (pp. 141-165). New York: de Gruyter.
- Walker, A. (1999). Public policy and theories of aging. In V. L. Bengston & K. W. Schaie (Eds.), *Handbook of theories of aging* (pp. 361-377). New York: Springer Publishing Co.

- Wallace, K. A., & Lahti, E. (2005). Motivation in later life: A psychosocial perspective. *Topics in Geriatric Rehabilitation, 21*(2), 95-107.
- Wareham, P., McCallin, A., & Diesfeld, K. (2006). Advanced directives: The New Zealand context. *Nursing Ethics, 12*(4), 350-359.
- Warnes, A. M. (1989). *Human ageing and later life*. London: Edward Arnold.
- Warnke, A., Meyer, G., Bender, R., & Muhlhauser, I. (2004). Predictors of adherence to the use of hip protectors in nursing home residents. *American Geriatrics Society, 52*, 340-345.
- Waterson, N. (2006, April). Pensions in the UK: An elusive search for consensus? *AARP Policy & Research*. Retrieved April 26, 2006, from AARP Policy & Research Web site: <http://www.aarp.org/research>.
- Waxman, B. F. (1990). *From the hearth to the open road: A feminist study of aging in contemporary literature*. New York: Greenwood Press.
- Weil, A. (2005). *Healthy Aging*. New York: Knopf.
- Weil, A. (2005, October 17). Aging naturally. *Time, 166*(16), 60-74.
- Weir, E. C. (2004). Identifying and preventing ageism among health-care professionals. *International Journal of Therapy & Rehabilitation, 11*(2), 56-63.
- Well-being. (1989). In *Oxford English Dictionary* (2nd ed., Vol. Online, p. OED Online). Oxford, England: Oxford University Press.
- Well-being. (1989). In *Oxford English Dictionary* (Second ed., OED Online). Oxford, England: Oxford University Press.
- Wellbery, C. (2005). Muscle weakness as a risk factor for falls in the elderly. *American Family Physician, 71*(9), 1791.
- Weller, C. E. (2000). *Raising the retirement age* (Economic Policy Institute). Washington, DC: Economic Policy Institute.

- Westerhof, G. J., Katzko, M. W., Dittmann-Kohli, F., & Hayslip, B. (2001). Life contexts and health-related selves in old age. *Journal of Aging Studies, 15*(2), 105-127.
- Westman, J. C. (1994). *Licensing parents: Can we prevent child abuse and neglect?* New York: Perseus Publishing.
- Whitbeck, L. B., McMorris, B. J., Stubben, J. D., & LaFromboise, T. (2002). Perceived discrimination, traditional practices, and depressive symptoms among American Indians in the upper Midwest. *Journal of Health And Social Behavior, 43*(4), 400-419.
- Whitton, L. W. (2001). Finding the elder voice in social legislation. In D. N. Weisstub, D. C. Thomasma, S. Gauthier, & G. F. Tomossy (Eds.), *Aging: Culture, health and social change* (pp. 101-117). Dordrecht, Holland: Kluwer Academic Publishers.
- Wikler, D. (2002). Personal and social responsibility for health. *Ethics and International Affairs, 16*(2), 47-56.
- Willcox, B. J., Willcox, C. D., & Suzuki, M. (2002). *The Okinawa program*. New York: Three Rivers Press.
- Williams, G. N., Higgins, M. J., & Lewek, M. D. (2002). Aging skeletal muscle: Physiologic changes and the effects of training. *Physical Therapy, 82*(1), 62-68.
- Williams, K., & Umberson, D. (2004). Marital status, marital transitions, and health: A gendered life course perspective. *Journal of Health and Social Behavior, 45*(1), 81-99.
- Wiltshire, K. T. (2005). Reject retirement age of sixty-five. *Nursing Older People, 17*(3), 35.

- Winakur, J. (2005). What are we going to do with Dad? *Health Affairs*, 24(4), 1064-1072.
- Wise, D. A. (2005). Facing the age wave and economic policy: Fixing public pension systems with healthcare in the wings. *Fiscal Studies*, 26(1), 5-35.
- Witkin, S. L. (1999). How 'Ripened' are you? *Social Work*, 44(6), 509-512.
- Wittenburg, D., Stapleton, D., & Scrivner, S. (2000). How raising the age of eligibility for Social Security and Medicare might affect disability insurance and Medicare programs. *Social Security Bulletin*, 63(4), 17-26.
- Women face extra hurdles to retirement. (2004, Winter). *National Center for Policy Analysis - Daily Policy Digest, Tuesday*(January 13). Retrieved May 12, 2006, from NCPA - Daily Policy Digest Web site: <http://www.ncpa.org/iss/eco/2004>.
- Women, & the Economy. (2006). In UN Platform for Action Committee (Ed.), *Women and unpaid work* (UNPAC Women's Economic Contributions). Winnipeg, Manitoba: UNPAC Manitoba.
- Wong, P. T. P. (2000). Meaning in life and meaning in death in successful aging. In A. Tomer (Ed.), *Death attitudes and the older adult* (pp. 23-36). Philadelphia: Brunner-Routledge.
- Woo, J., Ho, S. C., & Yu, A. L. M. (2002). Lifestyle factors and health outcomes in elderly Hong Kong Chinese aged 70 years and older. *Gerontology*, 48, 234-240.
- Wood, F. L. W. (1944). *Understanding New Zealand*. New York: Coward-McCann.
- Wood, M. J., & Atkins, M. (2006). Immersion in another culture: One strategy for increasing cultural competency. *Journal of Cultural Diversity*, 13(1), 50-54.
- Woods, B. T. (2003). What's so different about older people? *Clinical Psychology & Psychotherapy*, 10(3), 129-132.
- Woodward, G. S. (1963). *The Cherokees*. Norman: University of Oklahoma Press.

- Woodward, K. (Ed.). (1999). *Figuring age: Women, bodies, generations*. Bloomington, IN: Indiana University Press.
- Woolf, L. M. (1998). *Ageism* [Data file]. Available from Webster University, <http://www.webster.edu>.
- Woolf, L. M. (1998). *Theroetical perspectives relevant to developmental psychology*. Retrieved June 15, 2006, from Webster University Web site: <http://www.webster.edu/~woolfm/perspectives.html>.
- The World Bank. (1996). *Averting the old age crisis: Policies to protect the old and promote growth* (1996 Report). Oxford, England: Oxford University Press.
- World Europe. (2000, November 2). Age-old problem. *The Economist*. Retrieved July 15, 2005, from The Economist Web site: <http://www.economist.com>.
- World Health Agency. (2001). *Integrated response to population aging* (Ageing and Life Course Programme). Geneva, Switzerland: World Health Organization. Retrieved May 17, 2002, from World Health Organization Web site: activeageing@who.ch.
- World Health Organization. (1998). *Aging and health: A shift in the paradigm* (50th session of the regional committee). Washington, DC: Pan American Health Organization.
- World Health Organization. (1999). *Active ageing makes the difference* [Speech by G. H. Brundtland, Director General]. Available from World Health Organization, <http://www.who.int/directorgeneral/speeches/1999>.
- World Health Organization. (1999). *The Global Movement for Active Ageing* (Initiated through Global Embrace). Geneva, Switzerland: Ageing and Health, World Health Organization. Retrieved May 8, 2006, from Ageing and Health, World Health Organization Web site: <http://www.unsystem.org>.

- World Health Organization. (2006). *The world is ageing fast - have we noticed?* (Ageing and the life course). Geneva, Switzerland: World Health Organization. Retrieved April 29, 2006, from World Health Organization Web site: <http://www.who.int/ageing/en>.
- Wrosch, C., Schulz, R., & Heckhausen, J. (2004). Health stresses and depressive symptomatology in the elderly: A control-process approach. *Current Directions in Psychological Science*, 13(1), 17-20.
- Wykle, M. L., Whitehouse, P. J., & Morris, D. L. (2005). *Successful aging through the life span*. New York: Springer.
- Xu, X., & Ji, J. (1999). Supports for the aged in China: A rural-urban comparison. *Journal of Asian and African Studies*, 34(3), 247-262.
- Yanagisako, S. Y. (1985). *Transforming the past: Tradition and kinship among Japanese Americans*. Stanford, CT: Stanford University Press.
- Yassour-Borochowitz, D. (2004). Reflections on the researcher-participant relationship and the ethics of dialogue. *Ethics & Behavior*, 14(2), 175-186.
- Yau, K-S., Kwai-Sang, M., & Packer, T. L. (2002). Health and well-being through T'ai Chi: Perceptions of older adults in Hong Kong. *Leisure Studies*, 21(2), 163-178.
- Yi, Z., & Vaupel, J. W. (2002). Functional capacity and self-evaluation of health and life of oldest-old in China. *Journal of Social Issues*, 58(4), 733-749.
- Yi, Z., Vaupel, J. W., Zhenyu, X., Chunyuan, Z., & Yushi, L. (2002). Sociodemographic and health profiles of the oldest-old in China. *Population and Development Review*, 28(2), 251-273.
- Yorburg, B. (1983). *Families and societies: Survival or extinction*. New York: Columbia University Press.

- Young, K. (2004). Globalisation and the changing management of migrating service workers in the Asia Pacific. *Journal of Contemporary Asia*, 34(3), 287-303.
- Zeev, B-S. (1991). *Regression, stress, and readjustment in aging: A structured biopsychosocial perspective on coping and professional support*. New York: Praeger Publishers.
- Zweigenhaft, R. L., Armstrong, J., Quintis, F., & Riddick, A. (1996). The motivation and effectiveness of hospital volunteers. *Journal of Social Psychology*, 136, 25-34.

APPENDIX A

MAORI GLOSSARY

Ahi ka – the right of a tribe to access and use ancestral lands.

Ariki – paramount chief.

Aroha – love.

Hapū – sub-tribe.

Hauora – health, healthy, robust, hardy, pert, jaunty.

Hawaiiki – the mythical homeland of the Maori people.

Himine - hymn

Iwi – tribe.

Kai – food.

Kaikaranga – the person who releases a karanga.

Kākahi – freshwater mussel.

Karaitiana – Christian.

Karakia – prayer, chant, incantation, church.

Karanga – women’s speech making, call, shout.

Kaumātua – old man, elder (term of respect).

Kia ora – hello, thank you, may you have health.

Koretake – a nobody, useless.

Koroheke – grandfather, old man.

Kuia – old lady (a term of respect).

Kūmara – sweet potato.

Mana – power, prestige, influence.

Manawhenua – people with tribal affiliation to the land.

Manuwhiri – guest, visitor.

Maoritanga – Maori culture, Maori perspective.

Marae – open space in front of meeting house.

Mauri – a life force common to all creation.

Mokopuna – grandchild.

Nehunga - burial

Nikau – palm tree.

Oriori – sleep-time chant, lullaby.

Pa – village.

Pākehā – a European, a Caucasian.

Pukohukohu – moss, lichen

Rangatira – aristocrat.

Taha hinengaro – mental health.

Taha tinana – physical health.

Taha wairua – spiritual health.

Taha whanau – family health.

Tangi – wail, mourn.

Taonga – treasure.

Tangata whenua – hosts, home people, people of the place.

Tauparapara – chant, verse to start a speech.

Te reo maori – the Maori language.

TeWhariki – the bicultural national curriculum statement of the New Zealand

Ministry of Education.

Toheroa – shellfish

Toi te Huatahi – one of the first Maori to arrive in Aotearoa

Tupuna – ancestor.

Tūrangawaewae – home, home turf.

Urupā – cemetery.

Waiata – song, chant, song poem.

Whāea– mother, aunt, nanny.

Whai mana – whai: to possess, to have; mana: authority, power, prestige

Whakapapa – genealogy.

Whānau – extended family.

Whare paku – toilet, latrine.

Whare tapa whā – a four-sided house, a Maori perspective of health.

Whenua – land, placenta.

APPENDIX B

STEREOTYPING OLD AGE: A CASE EXAMPLE

Stereotypes of older people are mixtures of misconceptions and truths (Thornton, 2002). They are also generalisations, seldom fitting the dimensions of the individual. It is the combination of fact and falsehood that makes the stereotype difficult to disprove, arduous to apply to personal attitudes, and most especially onerous to change. This was clearly demonstrated by the nurses I had handpicked to deliver care to the elderly patients admitted to the newly formed Hip, Stroke, and Rehabilitation Unit (HSRU) of the acute care facility where I was employed as a nurse manager. These were extraordinarily professional nurses. They were dedicated to the care of older people and the high standard of care they delivered to patients had become the gold standard for the hospital. However, in the second year of its operation, rumours and accusations of ageist behaviour on the HSRU became the number one topic on the hospital grapevine. The source of these rumours was the lodging of a series of complaints by American, English, German, and Canadian patients⁵³ against nurses of the Hip, Stroke, and Rehabilitation Unit. Soon after this information was leaked, hospital administrators began an investigation, ostensibly of the entire facility, but in actuality centred on the HSRU. The result was a formal condemnation of ageism and a banning of secondary baby talk (SBT) on the part

⁵³ The hospital of which the HSRU was a part is located in a Pacific Island city with a large population of affluent older people, both tourist and resident. It is also home to a large population of elderly migrant workers from the Philippines, Hong Kong, Viet Nam, Korea, and other Pacific Island countries. Consequently, at any given time, the patients on the HSRU were a mixture of rich and poor, Asian and Western elders. Knowing that this would be the case, I had chosen as my staff a similar ethnic mixture.

of all hospital staff. Following this action, discontent in the Hip, Stroke, and Rehabilitation Unit grew and dissension over the use of SBT diminished the focus of quality care delivery to patients. Nurses against whom the complaints had been lodged, were infuriated that SBT had been banned. Taking the position that SBT was an aid to the delivery of care, they vowed to continue the practice; other nurses, upset that the practice of SBT had damaged the reputation of the HSRU, promised to support administration by reporting incidents of SBT whenever they occurred in the Unit. A cohesive team was in danger of falling apart and prompt action was required.

To resolve the conflict, I scheduled a staff meeting with a single agenda – the use of secondary baby talk – and encouraged nurses to state their beliefs and feelings. In fact, accord between nurses did not occur in one meeting. It took several meetings over a period of months and much debate on the subject of ageism and SBT to reach compromise and to repair the damage done to relationships between nurses between nurses, administrators, and management. Over time, however, debates among staff members revealed that nurses who viewed their older patients as cognitively and physically dysfunctional, and consequently more childlike than adult, were those who most often practiced secondary baby talk. With discussion, and looking beyond the temporary impairment brought about by hospitalisation, some nurses began to link their perceptions of generalised elderly dysfunction and childishness to stereotypical constructions of old age as a stage of illness, impotency, mental decline, dependence, and depression, and on that basis were willing to consider other ways of communicating with their patients. However, change was not easily accomplished; nurses interact with their patients not only based on stereotypical images of old age, but based on stereotypes of illness, and on issues relating to nursing control, power, and authority. Some nurses

never moved beyond the point of defending their positions, saying, "But everybody knows old people are like that." At the time, I was frustrated by the fact that a proportion of these outstandingly professional nurses were unable to abandon their beliefs about older people, even though their own colleagues had presented them with cogent arguments for doing so. Research offers an explanation:

...once an implicit stereotype is formed, the stereotype is usually not diminished when a person encounters contradictory evidence (Hill et al. 1990). If anything, the contradiction, such as the successfully aging 78-year-old astronaut John Glenn, may be classified as an exception. The process of aging has been hidden from us all our lives (Levy and Banaji 2002: 65).

In my experience, the opportunity to challenge and alter ageist practices in the workplace, with the support of management, is rare. In the situation I have described, the criticism and banning of SBT had an adverse impact on staff morale. Administration was anxious to undo the damage to staff, but not at the expense of revoking the ban on SBT. Consequently, I had strong administrative support for in-services and staff meetings designed to address SBT and ageism. However, due to staff turnover, the changing mix of patient and staff ethnicity, gender and age, and the admission of patients whose age-related stereotypes were particularly negative (such as felons, homeless, psychotic, and homosexual older persons), the fight against ageism in this health care delivery site was ongoing. There was a continual need for staff education on the subject.

APPENDIX C
CHRONIC DISEASES AND DISABILITIES OF PARTICIPANTS

Name	Age	Disability
Armstrong, Mabelle	99	Deafness; Parkinson's Disease; poor vision; History of falls with hip fracture
Burgess, Simon	75	Heart condition; shortness of breath
Carey, Harriet	88	Diabetes; obesity; Arthritis; coronary artery disease
Dickerson, Sally	83	Obesity; heart condition; history of stroke; can only walk with assistance
Doherty, Estelle	71	Diabetes; osterarthritis; heart condition; history of falls with multiple fractures
Eyres, Susan	84	Post-polio; poor function in left arm; walks with difficulty; history of falls
Gage, Fanny	93	Profound deafness; history of falls with fractures of hip, right leg and arm; poor vision; cancer
Gordon, Robert	94	Deafness; history of falls with broken pelvis and hip; poor vision
Gregson, Annabelle	100	History of falls with fractured right leg, left arm, and hip; poor vision
Holt, Edna	77	Short-term memory

		deficit; easily fatigued; can walk short distances only
Howard, Mildred	93	Blind; history of falls with broken hip; needs knee replacements.
Hunter, Sarah	77	No apparent chronic diseases or disabilities
Landman, Theresa	89	Alzheimer's Disease; deafness; poor vision
Meyers, Hannah	94	Arthritis; failed right hip replacement; chronic pain; needs knee replacement
Parker, Emma	60	Heavy smoker; diabetes
Richards, Eileen	89	Macular degeneration
Robinson, Nancy	75	Heart condition; needs dentures; fall-related left arm weakness.
Schultz, Agnes	102	Deafness; poor vision; history of falls; can walk short distances only.
Schuster, Neville	85	Short-term memory Deficit; history of falls; deafness
Struthers, Anika	75	Poor vision; history of falls
Traub, Jacob	87	Smoker; obesity
Turner, Allison	86	Congestive heart failure; end-stage emphysema; deafness; glaucoma; needs knee replacement
Winters, Rose	78	Diabetic; poor vision; needs knee replacements

APPENDIX D INFORMATION SHEET

- Researcher:

Jeanne Holmes
Voice: 64 4 298-8226, Fax: 04 298-8227
Email: jholmes@xtra.co.nz

- Supervisors:

Dr. Celia Briar
Telephone: (6) 356 9099, ext. 2815
Email: C.J.Briar@massey.ac.nz

Dr. Mary Murray
Telephone: (6) 356 9099, ext. 261
Email: M.Murray@massey.ac.nz

Dr. Leland Ruwhiu
Telephone: (6) 356 9099, ext. 2830
Email: L.A.Ruwhiu@massey.ac.nz

This project has been reviewed and approved by the Massey University Human Ethics Committee, PN Protocol 01/117.

Purpose of the study:

The goal of this research is to examine the role of meaningful communication in the lives of elderly people.

Method by which your name was obtained:

A minister of the church of which you are a member or a case manager of the Parkinsonism Society in the community in which you live made initial contact with you regarding this study. Your name was given to me after you indicated an interest in participating in this study.

Nature and duration of participant's involvement – what will you be asked to do?

Participation is voluntary and will consist of 4 – 6 meetings with Jeanne Holmes (researcher) at times you select. Total time involved for participation is approximately 4 hours.

Participants' rights:

If you take part in this study, you have the following rights:

- The right to withdraw from the study at any time.
- The right to halt the interview at any time.
- The right to refuse to answer a question.
- The right to agree or disagree to the interview being taped.
- The right to turn off the tape recorder at any time.
- The right to ask questions at any time.
- The right to amend the content of the transcripts of the interviews. The right to eliminate from the transcript any portion which you do not want to be used.
- The right to determine the disposal of tapes, drafts, and notes taken during meetings.
- The right to confidentiality: your name will not be disclosed; you will not be identified in any drafts, notes, or the final report; all information you provide will be confidential to the researcher. Results of this study will be confidential to the research and any publications resulting from it.
- The right to a summary of the research findings when the study is completed.
- The right to have a support person of your choosing present during the interviews.

Use of collected data:

Audio tapes

- Although it will be incorporated in my thesis, data collected during my meetings with you will not be made available to others. I will retain possession of the tapes at all times. I will transcribe all interview data privately without outside help.
- I will retain custody of all raw data. All information and material generated by the research including audio tapes, interview transcripts and computer data files will be stored in a locked filing cabinet in a secure location, with access only by this researcher.
- Audiotapes will be labelled using code names only.
- After completion of the study, it will be your decision to have the tapes returned to you, destroyed, or stored in a research archive.

Confidentiality and anonymity

- Interviews will be conducted in private.
- Any potentially identifying information, e.g., names, personal details, and geographic locations will be altered or removed at the time of transcribing and will not be included in either the thesis document, summary report or ensuing publications.
- Tapes and transcripts will not be labelled with your name, but will be coded with a unique identifier known only to the researcher.
- No information, which could personally identify you, will be used in any written material arising from the research. Only this researcher will know your identity.
- I will retain custody of all raw data. All information and material generated by the research including audio tapes, interview transcripts and computer data

files will be stored in a locked filing cabinet in a secure location, with access only by this researcher.

- I will transcribe all the interview data without outside help. I will not make the data available or share the information obtained with others without your consent.
- As added protection of confidentiality, you have the right to remove from the interview transcript any information you do not wish to be included in the research.
- The data I collect will be gathered from interviews. Thus, I can promise confidentiality, but not anonymity.
- Because interview information will be recorded, you should be aware that it is not possible for me to guarantee absolute confidentiality. However, I give my assurance that all precautions, as outlined above, will be taken to provide the maximum confidentiality possible.
- Once it is no longer required for this study, and according to your wishes, your interview information will be archived, destroyed or returned to you.

Please note: If I were to discover elder abuse, I would inform the relevant social service agency – protection of the elder would mandate abandoning confidentiality in the process of removing the abuse.

APPENDIX E

CONSENT FORM

The Role of Meaningful Communication in the ‘Successful Ageing’ of Elderly People

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand I have the right to withdraw from the study at any time and to decline to answer any particular questions.

I agree to provide information to the researcher on the understanding that my name will not be used without my permission.
(The information will be used only for this research and publications arising from this research project).

I agree/do not agree to the interview(s) being taped.

I also understand that I have the right to ask for the audio tape to be turned off at any time during the interview(s).

I agree to participate in this study under the conditions set out in the Information Sheet.

Signed _____

Name _____

Date _____

APPENDIX F

INTERVIEW GUIDE

Interviews will be conducted using an interview guide approach, that is, major issues will be discussed in each interview but the order and wording of the questions will vary following the lead of each individual participant.

Major issues to be addressed in each interview

The major issues to be addressed in each interview are (1) the status of the current communication network; (2) frequency with which communication with others occurs; (3) individuals with whom communication is important; (4) topics of importance; (5) barriers to communication; (6) factors of social support which influence communication; (7) age-related factors detracting from or contributing to communication; and (8) participants' comments on improving communication between themselves and others.

Major issues with prompting questions

1. Current communication network:

- Through what means do you maintain contact with the external environment: Television, telephone, radio, Internet, newspapers, photographs, magazines, books, letter writing, visitors, home health providers, caregivers.
- Which of the above do you most frequently use to maintain contact with the outside world?

2. How frequently does communication with others occur?

- How many contacts with other people – in one-on-one interactions – do you have in a normal day?
- Are you satisfied with the number of visitors you usually have?
- Do the people you care about the most visit you often enough?
- Are you able to visit other people?

3. With whom is communication most important?

Family members

- Do you have family members living nearby?
- How often do you see members of your family?

Health care providers, (doctors, nurses, therapists, home health workers, caregivers).

- Does the health care delivery system offer opportunities for you to communicate one-on-one with your health care providers?

- Do you feel that it is important for your well-being to establish one-on-one communications with health care providers?
- How do you attempt to do this?

Friends

- Do you have friends of long-standing acquaintance?
- How do you make new friends?

4. Topics of conversation:

- What do you most enjoy talking about? (For example, the past, current world events, events that compose your daily life, events planned for the future, your family, your state of health, the quality of your physical care, your faith).
- Do you reminisce with others?
- Do you feel that people are usually interested in what you have to say?

5. What factors make communication difficult?

- Do you have trouble hearing what people say to you?
- Is fatigue a factor in your efforts to communicate with others?
- Are you dependent upon others to get from one place to another?
- Do you see well? Are you able to read and watch television without problems?

6. Social support

- If you ask your family or friends to visit you, do they usually come?
- In what ways do you feel supported by family and friends?

7. Age-related factors

- Do you feel respected by those with whom you communicate?
- Do you feel that your age is a barrier when communicating with others?
- Do you feel that people communicate differently with you now that you are older – do they speak more loudly, slower, with shorter sentences, do they repeat themselves?

8. How could your communications with others be improved?