# International Journal of Ageing and Later Life

Volume 4, No. 1, 2009

# IJAL

# International Journal of Ageing and Later Life

Volume 4, No. 1, 2009

Published with the support of the Swedish Council
for Working Life and Social Research
(Forskningsrådet för Arbetsliv och Socialvetenskap, 2008-1788)

Linköping University Electronic Press

ISSN 1652-8670 (www)
URL: http://www.ep.liu.se/ej/ijal/

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ISBN 978 1 84742 291 0 (paperback)
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International Journal of Ageing and Later Life, 2009 4(1): 5–21. © The Author

# Dying old – and *preferably* alone? Agency, resistance and dissent at the end of life

*By* ALLAN KELLEHEAR*

## Abstract

Older people who die alone are commonly portrayed negatively in the academic and popular literature. Dying alone is viewed either as an outcome of anti-social behaviour or the result of family, neighbourhood or social services neglect. The idea that people may be exercising agency, resistance or dissent at the end of life and that they do not want attention from services or the wider community receives little or no consideration. By comparing the community and professional views with those of the elderly about end of life preferences, this paper argues that the academic and community image of the elderly as ''victims'' has eclipsed the usual ability to see this group in pluralist terms. This stereotype of older people who die alone has negative consequences for sociological and policy analysis.

Keywords: older people, dying, alone, end of life care, stereotypes.

## Introduction

This essay reviews the literature on dying old and alone and asks: have we overlooked experiences of agency, resistance and dissent in these examples

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of the end of life? Much of the modest body of research in this area seems to focus on the passivity, disability and even negative deviance of this small but growing group of dying people. This is rather ironic from the point of view of the gerontology literature since so much of this writing has concerned itself with ''healthy'' or ''active'' living (Leishman 2008). However, when gerontology writers turn their attention to the end of life of older persons who live and die alone, these ideas of agency quickly submerge under other ideas about loneliness, helplessness or vulnerability.

Reinforcing these ideas are palliative care writers (Gelo 2004; McKee et al. 2007; Roy 2003), who commonly concern themselves with what they see as the importance of ''companioning'' people at the end of life, with little or no awareness that their company may neither be required nor desired by some older dying people living alone. These palliative care writers, along with many journalists writing about those dying or found dead alone, believe that dying old and alone is self-evidently ''bad'' for everyone. As Seale (1995, 1996, 2004) regularly observed, dying old and alone is commonly viewed as a failure of care – from friends, family, neighbours, even by society at large. For many cases of people found dying alone or already dead and alone in their homes, the question and the research into failing social and professional care may indeed be legitimate and proper. However, the aim of this paper is to raise a critical but parallel sociological possibility. I will argue that, from the point of view of at least some of the elderly people dying alone, this form of dying may not represent failures of care but rather individual triumphs of agency, resistance and dissent. Establishing the legitimacy of this critical possibility can create a more discerning sociological and policy space for future end of life care analysis and assessment.

In support of this under-recognized argument I will compare and contrast two sets of literature. I will review the research literature on dying alone and then evaluate this body of work by contrasting this with a review of the research literature on elderly views of their end of life care preferences. I will first begin by explaining what is meant by the phrase ''dying alone'' and provide some social and demographic context to the people for whom this experience and circumstance apply. This will be followed by a review of the prominent societal and elderly explanations

believed to be so crucial to our understanding of this experience. Finally, I will show how the common societal and research understandings of dying alone seem not to accord with the views of the elderly themselves about the end of life more generally. Social explanations not generated from the elderly often take a negative view of living and dying alone obscuring and overwhelming the logical possibility of diversity among older people. This diversity might be expected to include a small, but growing minority of people for whom dying alone – without informal or professional care – may be an actively preferred and understandable end of life choice.

## What Does "Dying Alone" Mean?

For the purposes of this discussion, "dying alone" refers simply to an experience of approaching death in a lone residential context. In other words, the dying person does not usually reside with others. Klinenberg (2001: 505) emphasises the importance of distinguishing this "residing without others" with related but quite different experiences such as "being isolated" (limited social ties), "being reclusive" (confining one self to the house) and the most common conflation of "being lonely" (feeling alone). The most common rhetorical feature of the media, professional and some research literature is this latter conflation of "dying alone" with "lonely dying" (see, for examples, Adams & Johnson 2008; Field 1984; Gelo 2004).

There are serious problems with this common habit of conflating "alone" with "lonely" not the least because, as several researchers have observed in purely theoretical terms, the first experience does not necessarily lead to the second (see Weeks 1994 for an excellent conceptual review). Indeed, being alone may in fact lend itself to very many positive psychological and spiritual experiences (see Hamiltby 2000 for a review of these). Furthermore, the association between "dying alone", having a "lonely death" and this being an indication of a "lonely life" are three independent experiences whose linkages are not empirically established (Howse 1997: 2–3). "Dying alone" does not even mean the dying were isolated (or lonely), and those isolated (or lonely) don't always experience "dying alone" (Adams & Johnson 2008).

A further methodological observation important to recognise is that although living alone is a minority experience among the elderly, so too is loneliness (Howse 1997: 6; Victor et al. 2009; although see Elias 1985 for a dissenting view about this). Indeed, there is some evidence that advanced age might be a protective factor *against* loneliness (Victor et al. 2004). Moreover, an early study by Tunstall (1966: 55) reports that most older people living alone actively prefer to live this way. Finally, Klinenberg (2001: 506) warns us that most of our research about living alone is drawn from those older people willing to participate, who are reasonably active, or may use the participation as a way to alleviate loneliness. The number of isolated and reclusive older people who might tell us a different story about the relationship between being alone and loneliness may be underestimated. In that category, we may know least about those who prefer to be reclusive.

Aside from these broad sociological distinctions, Seale (1995: 383–385) offers several other interpersonal and perceptual distinctions. Dying alone may mean no conscious awareness of either carer or dying party of each other as when a spouse dies while the couple are asleep together; or when carers leave the room for a few minutes and return to find their loved one dead. Sometimes, ''dying alone'' has been employed to mean dying without kin or kith rather than dying without other human beings present, as when people die with staff present or even with other patients present. Some people occasionally include ''dying alone'' in hospitals when the dying person is known not to have had any visitors. In these ways, people often die ''alone'' even in hospitals, hospices or at home with others (Howse 1997: 4). Finally, some people suggest that ''everybody dies alone'' because only the dying person must face death, not the carers of any stripe, and in that task the dying person is ''alone'' (Owen 2005: 13). This latter observation refers to the existential nature of dying – further discussion of which is obviously beyond the scope of the present article.

These distinctions are very important to rehearse for they highlight the broad and diverse array of meaning available for rhetorical use by researchers and professionals when discussing the simpler social fact of individuals who live and die without others in their residence. The closely related, but very different meanings of being ''lone'' and lonely, being ''isolated'' as a social consequence or being deliberately and preferably

''reclusive'', and facing death with company (us) or none (them) are ambiguous and regularly subject to subtle and misleading use in this area. To set the stage for further discussion of how these terms and concepts have been used to create a research and popular impression of bad, lonely, regrettable and ''preventable'' deaths, I will now summarise the current social and demographic context of older people now living – and possibly dying – alone.

## Social and Demographic Background

The people who die alone in the UK represent less than 1% of all deaths in any one year. About two-thirds of these people were over the age of 70 (Bradshaw et al. 1977; Howse 1997) and had lived alone in their own homes (over 93%). The figures for this population are approximately the same for the USA (Gurley et al. 1996) or perhaps slightly higher (Klinenberg 2001). Over half of the people who die alone seem to die of circulatory diseases such as heart attacks or strokes, while about 5 or 6% have suicide as their cause of death. Other causes include accidents, such as falls and accidental poisoning for examples, or respiratory diseases (Bradshaw et al. 1977). These figures are mainly gleaned from studies employing coronial reports. They reflect broader figures about ageing and living alone more generally.

In the UK, although one-person households now comprise about 12% of the general population (National Statistics 2002a), this rises on average to about half of those in the over 65 age group. Some 32% of women and 61% of men over 75 years of age now live alone (Age Concern 2008). Although there are about 1.2 million people in the 85+ age group in Britain (Leishman 2008), they are also now the fastest growing age group (Dunnel 2008). The levels of solitary living are highest in North-West Europe and lowest in Southern Europe and the USA (Tomassini et al. 2004). The social reasons for the growth of these single-person households generally and single older person households in particular are many.

A decline in marriage and a rise in separation and divorce are said to be one reason (National Statistics 2002b). Other reasons offered include: fragmentation of extended families of migrants; better health and social services making living alone more feasible; and rising levels of home

ownership (Krivo & Mutchler 1989). Diversity in cultural attitudes to co-residential living may also play a role (Tomassini et al. 2004). Finally, a widespread desire, especially in societies that encourage and celebrate individual autonomy and independence, may make living alone an extension of the prevailing cultural values. Seale (1996: 80), for example, recorded the common observation made by family and friends of older people's ''deep concern'' for their own independence.

We have very little information about the kinds of people who were found dead or dying alone. What we know we have gleaned from coronial records, interviews with family and friends, or the reports of emergency services personnel. These all suggest, at least in their introductory remarks, that the social situation of all these people were diverse and included people who were normally active and outgoing, or moderately sociable, to people who were more or less regarded by others as reclusive and private. The actual proportion of those who die alone and were regarded as reclusive or private is unknown or subject to any number of speculations and interpretations. Bradshaw and colleagues' (1977) study of 203 people who were ''found dead'' suggested that over half of these might be considered reclusive (36%) or private (25%). Twenty years later a further study of people found dead in their UK homes (Howse 1997) suggested that as little as 16 out of 647 cases might be considered reclusive or very private. A major US study (Klinenberg 2001: 503) that examined the reports of emergency service workers who found people dead during and after a major heat wave in Chicago in 1995 simply observed that ''many'' police officers described victims as reclusive types. How, then, have these possibly different kinds of people who have died alone been viewed by the professional, academic and lay literature?

## Prominent Social Perspectives on ''Dying Alone''

Much of the literature on dying alone or being ''found dead'' alone is drawn from policy, sociology, anthropology or psychology researchers who quickly move to ''identify'' one or several social ''types''. This is a long-standing ethnographic-based habit of the human sciences and a review of these in studies or commentaries about dying alone reveal a common pattern of moral and political views towards people who die

alone. Noteworthy is the fact that almost all the ''types'' identified with lone dying are negative ascriptions. Positive conduct or anecdotes seem either not to attract labels or attract negative ones. For example, in Tunstall's (1966) study, despite documenting the fact that his sample of nearly 200 older people living alone preferred that lifestyle proceeded to spend the remainder of his work describing ''the isolated'', ''the lonely'' or ''the anomic''. There was no attempt to identify any positive ''type'' in his sample. I identify and discuss more of these typical categories below.

## *Loners and Lonelies*

I have already identified the palliative care literature as central to promoting the view that dying alone suggests lonely dying. Field (1984) was one of the earliest researchers to record that palliative care nurses viewed dying alone as undesirable and felt equally that it was important to ''be with a dying person'' at their moment of death so that dying people knew that ''someone cares''. This sentiment is echoed in recent writing by Gelo (2004) and McKee and colleagues (2007). Smith-Reese (2005), for example, although insisting that patients have a right to shape their own way of dying, nevertheless advocates this to be facilitated by technologies that perform ''in-home monitoring'', medallions that provide help call services and machines that assist with ''medication compliance''. If some older people feel uncomfortable with professionals in their own homes when dying (Gott et al. 2004), it is difficult to imagine what this same group would make of these newer forms of surveillance (Seale 1996). The UK study by the Centre for Policy on Ageing (Howse 1997: 19–22) identifies a sample of what neighbours describe as ''hermits'' and ''loners'' and what the report describes as ''service refusers''. These are negatively described as people who kept to themselves, ''refused'' to open doors or receive social or health care workers. Even individuals who displayed clarity of mind and purpose, such as a 93-year-old woman discharging herself to her home after a heart attack (''she *insisted* on discharge'' reads this report), is included under the category of ''service refusers'' (Howse 1997: 22). Klinenberg's (2001) emergency service workers in his US study make similar charges – these dying people were often ''reclusive'', ''kept to themselves'' and never ''opened their doors''. Those who die alone in these

storylines are pictured as anti-social, fearful, lonely, even pathetic figures who need help despite themselves or their lifestyles.

### *Tragics*

The media are most fond of this social image. Here, those who die alone are considered the ''forgotten'' (Adams & Johnson 2008). People who die alone are tragic figures – either they have lived a life as a social failure, without love, respect or social accomplishments, or they have been isolated through no fault of their own and it is ''society'' that has cruelly withdrawn its supportive social web or canopy from them (Seale 2004: 973). The media will frequently select the more sensational types of dying alone – suicide, drug overdose, murder or elderly persons found dead some years after they had died alone in their flat or house (Lishman 2009; Seale 2004: 969). There will be outrage, questions asked, calls for investigation, review or new actions, all very reminiscent as Seale (2004) argues, of anthropological accounts of witch-hunts following what the community declares as a ''bad death''. Family and friends of those who have died alone have also contributed their share of resentment and detail of their own ''tragic'' loved ones who had died alone remembering them as ''being difficult'', stubborn, awkward, ''not easy to get on with'' and more bitterly, as people who ''failed to be sufficiently grateful'' (Seale 1996: 86).

### *Self-destructors*

The idea that those who die alone may be more responsible for their miserable fate than an uncaring society has some support from the academic literature. Gove and Hughes (1980), for example, wrote a major review article that linked living alone with similar morbidity and mortality data from suicides, alcoholics and those in psychiatric treatment. They asserted that, ''there is a substantial body of evidence which indicates that living alone is correlated with a wide variety of pathological phenomena'' (Gove and Hughes 1980: 1160). The review links living alone with drinking or depression and these, in their turn, may be an outcome or consequence of deeper personality and behaviour problems. They advocate more empirical research into several of their own hypotheses about people who live alone including the idea that ''social control of behaviour requires

social interaction and the isolated individual, lacking such control, will be free to act in deviant ways'' (Gove & Hughes 1980: 1173). Linked to other portrayals of those dying alone as tragics, these ideas compound and exaggerate the stigma of living and dying alone (Seale 2004); increase the pressure on surveillance of the elderly who live alone (Seale 1996), as well as helping reinforce views that single older people might be better off in institutions such as hospitals or care homes – in fact, places that are not guarantees for more peaceful or less lonely deaths anyway (Bradshaw et al. 1977: 23).

The idea that people who live and die alone are social misfits and deviants – loners, lonelies, tragics and self-destructors – obscures and distracts our gaze away from the greater sociological facts of this form of death and lifestyle. People who live alone are increasing, especially among the very old, and anyway represent a significant proportion of all people who live in affluent, urban communities. So many of the elderly fear crime (Age Concern 2008; Klinenberg 2001), or are so regularly preyed upon by unscrupulous salespeople, neighbourhood deviants or hustlers, or have heard so much about others who have fallen victim to these types, that many do barricade themselves or withdraw into their flats and houses. These people hole up in their residence seeing few people, confining themselves to TV, phone buddies or their mail. If they are affluent, this only increases their ability to go out less as they can order most things in or be provided services in their own homes (Krivo & Mutchler 1989).

Other observations about the end of life preferences of the elderly also do not square with the available negative social categories and explanations of people who die alone. Kelner (1995), for example, studied hospitalised elderly people's preferences about ''control at the end of life'' and found that he could divide the responses into ''activists'' and ''delegators''. Activists were people who desired control as opposed to delegators who were more than happy for other agents such as God, fate or doctors to take control. Activists were a 2:1 majority. How are people who are ''activists'', people who take control, accounted for among those who live – and die – alone? Are we to believe that those who die alone are unrepresentative? No empirical evidence to support that conclusion seems available. A review of elderly views about the end of life does suggest a further range of social decisions or circumstances that can logically and

understandably lead to dying alone as forms of self-control (agency), resistance and dissent.

## Prominent Elderly Perspectives on ''Dying Alone''

Studies of death and dying from older people's point of view are sparse (Hallberg 2004) but what we do have is insightful, although the vast majority of these studies have small samples. If for example, you ask older people about what a ''good death'' might look like for them (Gott et al. 2008; Howarth 1998; Lloyd-Williams et al. 2007; Steinhauser et al. 2000; Vig et al. 2002), some consistent themes do emerge. Howarth (1998) found among her 42 respondents a desire for quick death, preferably without much pain and a desire for autonomy and control. Steinhauser and colleagues (2000) found among their 72 respondents of professionals, families and older people the themes of good symptom management, preparation, sense of life completion and the affirmation of a person's life. All of these themes are not incompatible with a death or dying at home – with or without palliative care.

Lloyd-Williams and colleagues (2007) found similar themes among their 40 interviewees adding that fear of becoming a burden was also one of the issues that concerned their sample of over 80s. The studies by Vig and colleagues (2002) and by Gott and colleagues (2008), with samples of 16 and 40, respectively, did not find clear themes and also uncovered some paradoxes. But even they observed concerns about the desire to avoid any ''debasing'' processes involved in prolonged illness, institutionalisation or even families being present when they died. Again, these issues are also not inconsistent with a desire to be at home and to die at home – alone. Some of these issues can actually act *to promote the idea that death at home and alone would be an act of agency and control* because such a death or dying would avoid or postpone institutionalisation and constant surveillance while affirming their own identity and lifestyle.

Fear, for example, is a significant feature of older people's lives – fear of crime, fear for one's safety in public places, fear of loss of control and fear too of any threat to one's self-esteem (Fry 1990). Many of these fears, as we have seen explained in Klinenberg's (2001) US study and the data collected by Age Concern (2008) in the UK suggest that older people might cope by

withdrawal into their homes, seeking support remotely (by phone) or through prayer and pre-occupation with home activities and objects (Fry 1990). Fear of being a burden is also a re-occurring concern (Gott et al. 2008; Lloyd-Williams et al. 2007). Hallberg (2004) in reviewing 33 empirical studies of death and dying from older people's point of view argued that fear of being a burden is another way of manifesting a fear of dependency. This in turn encourages people to maintain their independence for as long as possible, perhaps appearing to others as people who are ''private'', ''reclusive'' or ''keeping to themselves''.

But there is little doubt that living alone does not necessarily mean socially isolated as many people who are able to visit and be visited do so. Winter and colleagues (2007), for example, found in their sample of 40 people in their 70s that most desired active treatment if they were dying. Social interaction was an important idea associated with a ''good death'' for them. These authors go on to suggest that perhaps the desire rather than simply the necessity of active medical treatments were suggestive of a desire to be with others. If that is true the reverse may be true also, so that the so-called ''service refusers'' in the 1997 Centre for Policy on Ageing represent a desire to simply be left alone. The ability to exercise that choice, and live with that preference, is an example of personal agency and autonomy *par excellence*. For some of the very old, for example, there is no ''quality of life'' to be had or to be recaptured when most of your friends and loved ones have predeceased you (Farquhar 1995). This is a particularly important point when successive researchers of quality of life have recognised the importance of social relationships over health, medical or other physical issues for most of the elderly (Carmel 2001; Farquhar 1995; Victor et al. 2004).

A significant (''significant'', that is, enough to appear as a few respondents in small studies) number of older voices believe they are just filling in time till they die (Farquhar 1995; Kim et al. 2008; Owen 2005). And although Cicirelli (1998) found that most of his 447 elderly respondents ''strive to live'' (52%), a sizeable minority find suicide an acceptable idea (31%). Such underlying values tell us something more than that the high suicide rate among the elderly is simply and only about depression (Cattell 2000; Kellehear 2007). Even older homeless people express a fear of dying alone and in the streets (O'Connell 2005), but many

do die alone in the streets anyway and not all of these can be rationalised as accidental. As even O'Connell observes alongside this earlier point, homeless people often give ''aliases'' – an old identity has already died, or is dying alone. And these are decisions made – rightly or wrongly, with some reservations or none – of people who choose to adopt this kind of end of life lifestyle.

Together, all these social influences suggest that the decision to live and die at home alone, has understandable and practical factors that underpin them – from fear of crime and dependency, to an idiosyncratic interpretation of a ''good death'' without others that satisfies some personal idea of affirmation of their own life both among the housed and even the homeless. Some desire professional contact but yet others find their generation gone and simply lose interest in a world that has little or nothing to offer them. Dying at home alone may represent a personal sense of agency and a resistance towards the threat of increasing surveillance, dependency or institutionalisation. For some, even a small some, dying alone in suffering, or by suicide in their own homes, may represent dissent or a refusal to take the meagre social care choices offered to them.

## Conclusion

When we review the diverse views of the elderly about the end of life, we are forced either to believe that those who die alone are unrepresentative of that diversity (by virtue of their flawed character as Gove & Hughes 1980 argue); or that we have not managed to interview them (as Klinenberg 2001 suggest might be happening); or that we have the actual data that includes them but, as I have already suggested, have obscured those facts with negative over-generalisations. Until there is genuine evidence that those who die alone truly do represent the lonely, tragic and self-destructive elements of an older society, we must look to the latter two possibilities.

There are methodological challenges in reaching groups who do not wish to be reached but the early work of Seale (1996) in interviewing family and friends, seeing past their rationalisations of guilt and regret to gain access to modest images of the people who died alone have further,

future promise. In this regard, promising also will be the identification and use of any records left by the dying such as last testimonies, suicide notes or diaries, to give us further clues to the values and decisions that these people make in charting their life and dying styles.

As for the possibility of already having the data but recognising neither the diversity nor the positive nature of some of this solitary conduct at the end of life, we can only take the caution offered us by most ethnographers and grounded theorists. We depart from the voices and experiences of those we wish to study at our own peril. And if those voices or experiences are difficult to access, they are by no means unreachable, however contested might be their subsequent interpretation. A set of conclusions about the conduct of other people that is consistently negative and disempowering suggests that either the reading or the data is compromised. The choice of what to do suggests itself – it is easier to re-visit the reading if the data available is unavoidably limited and preciously slim.

The experience of dying alone, even if this is not associated with loneliness or social isolation, is not incompatible with compassionate views and questioning about failure of care. Clearly, the sociological and policy dilemmas and complexities surrounding the care of the elderly, at a time when we are at the commencement of a major rise in this population, is of major and legitimate concern. But this social compassion and moral responsiveness neither should be uncritical of social differences, nor minimise the growing community perception that choices are few for most older people, and even less for the poor.

Occupational, ethnic, spiritual and even cohort differences between older people make institutional care of every sort a highly threatening prospect that appears dull at best, frightening at worst (Elias 1985; Millar 2003). It is important to attune our understandings to these social differences and preferences and this must start with a more nuanced dissection of the empirical findings about those who die alone, however limited those data may be. This is only a call for a more thoughtful and pluralist interpretation of older person's actions at the end of life when we attempt readings for this kind of data.

Critical observations of a poor fit between elderly views of end of life care and the common observations about dying alone also suggest an important and timely caution against theoretically positioning of all

elderly people as ''victims''. Although it is true that many older people wish to be taken care of by their health and social care establishments and authorities, and do feel abandoned and victimised if they are not (Gott et al. 2008), many others do not share these sentiments (Kelner 1995).

Increasingly, the more affluent and educated older person does not desire this paternalism. As Hallberg (2004) and some older persons speaking through Owen's (2005) work suggest, many dying people do not fear death, are prepared for death and are resigned to dying, but desire above all their autonomy and value any attempts, either formal or informal, to maintain that independence. Dying old, and alone, is a small demographic outpost of the mortality statistics in any country but its scrutiny may prove to be valuable sociological ground. For those of us interested in an inclusive vision of end of life care, the study of lone dying may provide a conveniently containable research front in which to witness – and witness with unrivalled clarity – conflicts of interests over the age-old problem of mortality.

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International Journal of Ageing and Later Life, 2009 4(1): 23–54. © The Authors

# Successful aging as an oxymoron: older people – with and without home-help care – talk about what aging well means to them

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## Abstract

Notions of what it means to age well or successfully are central to social gerontological research and practice. As such, one would expect that there would be consensus as to what the construct of successful aging means and/or how aging well is achieved. This is not, however, the case which is why this study explores the meanings that a group of older people (i.e. some with home-help care and some without) attach to this construct. The empirical material is constituted of 16 semi-structured interviews. The findings bring to fore the different resources (such as physical, mental, psycho-social, spiritual, and financial ones) that are associated with successful aging and the kind of outlook on life that is regarded as useful if one wants to age well. Differences between home-help care recipients and those that do not receive this type of care were found. Those that are managing without the help offered by home-help care services listed more resources and offered more nuanced descriptions of what successful aging

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means than those that receive home-help care. This suggests that receiving home-help care and/or not being able to manage primarily on one's own might shape the manner in which older people think about what constitutes a good old age. The in-depth analysis of the notions of successful aging that were brought to the fore suggests also the paradoxical fact that the title of this article attests to; namely that some associate aging well with not aging at all and deem, in fact, the term successful aging to be an oxymoron.

Keywords: successful aging, aging well, older people, aging, home-help care recipients.

## Introduction

Ideas regarding what it means to age well and/or successfully date back to Cicero's writing from 44 BC (Bowling 1993; Rodeheaver 1993). They permeate most social gerontological research and practice still, even though there is no consensus as to how the construct of successful aging should be defined, how it can be operationalized and how it is best measured. The fact that we are yet to reach an agreement in these respects is rather puzzling, especially if one takes into account that this construct has been a highly debated one since its inception into the vernacular of aging research some 50 or so years ago. Stock (1982) has suggested that it was the establishment of the Committee on Social Adjustment to Old Age by the American Social Science Research Council that gave this construct the place it undoubtedly has in social gerontology. Fisher (1995) has argued, however, that it was not until the Gerontological Society of America made successful aging the theme of their 1986 annual meeting that this construct became established – so to speak – as one of gerontology's guiding principles. He argues also that Rowe and Khan's now seminal article on successful aging (published originally in 1987) played also an important role in establishing this term since this was the first piece of work that explicitly challenged the idea that aging and disease came hand in hand.[1]

There has been some debate as to when the idea of successful aging was first documented, when the term was originally launched within social

gerontology and when it was in fact established as one of our discipline's guiding principles. Successful aging is, therefore, still regarded as a highly controversial and much debated concept (e.g. Thomas & Chambers 1989). It has, for example, been argued that the successful aging paradigm that Rowe and Khan launched is parochial since it fails to take into account the fact that age-related losses and dependency can be defined differently and that there are numerous ways to age well (Scheidt et al. 1999). Some have also contended that this paradigm is a blatant example of the fact that it is the Western template that dominates the gerontological imagination (Thomas & Chambers 1989); a fact that is problematic in a highly globalized world since non-Western understandings of this construct are seldom taken into consideration (Torres 2001, 2003, 2004). Dannefer (1987) has also argued that the focus on normative outcomes that is often characteristic of gerontological work on successful aging fails to acknowledge the fact that old age is a social construction. Strawbridge et al. (2002) have, in turn, pointed out that the word "successful" suggests a competition, which some gerontologists find problematic; an angle that has been debated by disability researchers as well who have argued that the paradigm does not take into account the realities of those who age with disabilities (Minkler & Fadem 2002).

The suitability and applicability of this construct has been debated on numerous occasions. The popularity of successful aging has not, however, been dissipated by the controversy. Giving older people – in different circumstances – a voice in the matter seems therefore like a fruitful way to go about contributing to the never-ending debate about this construct. They are, after all, "the most appropriate people to define successful aging/ . . . / and although some researchers have made a start in this area, far more work needs to be carried out" (Bowling 1993: 452); an assessment that still stands even though more than a decade has passed since it was demonstrated that older people themselves are seldom given a chance to say what successful aging means to them. Thus, in this article we explore the understandings of successful aging that are upheld by a group of older people in two different predicaments; half of them receive help and support in their everyday lives from home-help care services, while the other half does not. The reason why we will focus on these groups is not only that the literature on older people people's own understandings of

successful aging is relatively scarce, but also that very little research on the importance of present life situation for these understandings has in fact been conducted.

## Literature Review

Successful aging studies have progressed over the years by moving their focus from the state or "what" of successful aging to the strategies through which we age well, i.e. the "how" of successful aging (e.g. Baltes & Carstensen 1996; Torres 2001, 2004). A look at the body of evidence collected through social gerontological endeavors that have looked into successful aging specifically[2] suggests also that there are at least three types of approaches to research in this area. The first one can be traced to Rowe and Khan's (1987, 1997, 1998) attempt to define successful aging by proposing what the state of successful aging entails. They define successful aging as low probability of disease and disability, high cognitive and physical-functional capacity and active engagement with life; a definition which has been criticized for several reasons, including its lack of cultural sensitivity (Scheidt et al. 1999; Torres 1999, 2001); its poor acknowledgement of the fact that aging implies not only losses but gains (Baltes & Carstensen 1996); its inability to encompass the realities of disabled older people (Minkler & Fadem 2002), and the inherent class bias that characterizes this approach (Cole 1984). Nevertheless, successful aging research, which aims to identify the conditions necessary to age well and which focuses on the objective measurement of successful aging, has grown over the past few years and further measures of this state, such as sustained personal autonomy (Ford et al. 2000) and well-being (Westerhof et al. 2001), have been proposed. Thus, although this is a highly debated construct, it has been acknowledged that Rowe and Khan's definition (as problematic as it might be) did in fact have a positive effect on the study of aging and old age, since it argued that aging and disease were two different things and it encouraged a shift in focus from people doing poorly to people doing well (Strawbridge et al. 2002). This is probably why studies of successful aging have continued to be designed and why other ways of approaching the study of this construct continue to be delineated.

There are also studies that have worked on how successful aging is achieved by focusing on the strategies people use to age well (e.g. Baltes &

Baltes 1990) as opposed to trying to define what the state of successful aging entails. As such, these studies represent attempts to overcome some of the problems associated with the normative focus on outcomes described earlier. Proponents of this approach believe that it is problematic to define successful aging as objective outcomes which only a few older people can achieve, which is why they argue that a shift in focus is necessary if we are to allow the heterogeneity of older people and of socio-cultural and historical constructions of success to be addressed (Baltes & Carstensen 1996). Thus, their focus is not on what constitutes successful aging per se but on how older people go about achieving a successful old age despite the various increasing limitations in resources that growing old can entail. This type of research focuses on the process of successful aging as opposed to the state of aging successfully and has often concentrated on the testing of the theoretical model that Paul and the late Margaret Baltes first formulated – the SOC model. Researchers working from this perspective tend to focus on how the strategies of selective optimization with compensation, which have been launched as the key to aging well, actually work, and on identifying the various outcomes that are associated with them (such as well-being, positive emotions, and absence of feelings of loneliness; e.g. Freund & Baltes 1998).

The third and last research type that can be identified with regard to successful aging is the one that is of particular relevance to the task at hand. This last type aims to shed light on the understandings of successful aging that older people uphold. Proponents of this approach argue for the theoretical fruitfulness embedded in older people's perspectives, since these are believed to be necessary for gerontological practice, patient-centered care and clinical programs (Phelan et al. 2004). Some of the studies belonging to this category have been designed in such a way that the older people interviewed have been asked to rate statements according to how important they believe them to be to aging well, while others have asked participants to define what the construct means to them without offering any preconceptions of how it can be defined. Regardless of which study design is employed, these types of studies aim to give the older population a voice in order to see if and how their perspectives differ from what we already know in terms of successful aging as a state and as a process.

In their study of college students' and independent living adults' opinions of successful aging, Charbonneau-Lyons et al. (2002) used a rating method and found that social and familial relationships, intrinsic values, financial concerns, accomplishments, cognitive functioning, physical appearance, and independence are believed to be factors that contribute to successful aging. Torres (2001, 2003, 2009) used vignette methodology to clarify the relationship between cultural values and understandings of successful aging, and found that there are a variety of ways in which this construct can be understood. Her findings show that not everybody associates aging well with the mastering of nature and with the future and productivity orientation that is so common in established definitions of successful aging within mainstream gerontology. The study of von Faber et al. (2001) compared results regarding objective measurements of successful aging with what older people believed to be necessary in order to age well and found that older people's views on the subject were more process-oriented than state-oriented. They tended also to value well-being and social functioning higher than physical and psychocognitive functioning. Thus, because character and attitude were found to be so central to the manner in which the older people interviewed viewed successful aging, these researchers concluded that ''the absence of limitations and losses does not constitute one's success at old age; rather, success is measured by the way these limitations and losses are integrated into one's attitude to old age'' (von Faber et al. 2001: 2699).

The idea that attitude is central to older people's understandings of successful aging has been confirmed by the various studies that have been launched to explore, with a more traditional qualitative approach, the meaning attached to this construct. Fisher (1992, 1995), who was among the first to explore the meaning older people themselves attach to this construct, set out to clarify this and another construct that is often used by aging researchers; i.e. life satisfaction. He found that people's understandings of successful aging involve attitudinal or coping strategies nearly twice as often as their understandings of life satisfaction, and that successful aging ideas were often described in present and future-oriented terms, whereas understandings of life satisfaction tended to be more oriented toward the past (Fisher 1995). The features associated with successful aging were, in short, interactions with others, a sense of

purpose, self-acceptance, personal growth, and autonomy, which is why he concluded that the understandings in question suggest an orientation to life that is future-oriented and adaptive in nature. Dorfman and Walsh (1996), who collected their data through focus groups, found that mental aptitude, attitude, social support, and self-care were central to their interviewees' understandings of successful aging, while other aspects such as physical activity, interpersonal behavioral skills, financial status, autonomy, coping strategies, and a sense of meaning and purpose seem also to be important even though they were mentioned less frequently. Fisher and Specht (1999) asked contributors to a senior art exhibition to define what successful aging meant to them and found, in turn, that aging well was associated with having a sense of purpose, interactions with others, personal growth, self-acceptance, autonomy, and health. Collings (2001) interviewed members of a Canadian Inuit community and found that they valued an individual's ability to handle declining health and their overall attitude toward life (and their willingness to transmit their wisdom to younger generations) as much more important than good health per se. Duay and Bryan (2006), who are amongst the latest researchers to explore the meaning that older people themselves attach to this construct, have found that senior adults' understandings of successful aging involve engaging with others, coping with changes and maintaining physical, mental, and financial health.

Studies such as these ones have started to yield results that point out the spheres of life that older people themselves deem to be important in order to age well. These include coping-related strategies and/or interaction with others whereas other areas – such as financial status – do not seem to have been brought up as often. Research in this area is, however, relatively limited especially if one takes into account that we have yet to shed light on how different circumstances – such as diminished everyday competence and/or having home-help care – affect the manner in which the construct of successful aging is understood. It is, in other words, too early to say whether or not studies of older people's understandings of this construct challenge the disciplinary understandings of it that have guided gerontological research over the past few decades. However, one thing that is already clear is that the few studies conducted have yielded a series of answers to the question of what successful aging means to those that are

undergoing the various types of transitions (such as those implied by declining health, diminishing everyday competence, and increasing dependency) that are associated with the process of growing into old age. This is why we will hereby focus not only on studying the content of older people's understandings of successful aging, but also on showing what characterizes the way in which they formulate their vision of what it means to age well.

## Methodology

### *The Overall Project to Which this Particular Study Belongs*

The research that will be presented departs from data collected for a project that investigated how "cognitively healthy" older people with minor physical health problems handle the transition that being in need of help and support in order to manage everyday life entails.[3] The data that was collected for this project was collected in a two-stage manner.[4] The first wave of data collection was conducted after the second author had completed a survey on home-help care commissioned by the municipality of Uppsala, Sweden,[5] and realized that qualitative data was needed in order to shed further light on the situation of older people who are in need of help and support because of diminished everyday competence. The second data collection wave was launched after preliminary analysis of the data collected in the first wave had been conducted, since it was then that the authors realized that more interviews were needed in order to tap into the understandings of older people who are managing primarily on their own despite having health problems and/or having had their everyday competence diminished by them.

### *Sampling Strategies and Sample*

As is customary in projects that have been designed in a two-stage manner, a variety of sampling strategies were used to recruit the informants. Some of them were, as implied already, recruited via a questionnaire used in a project that the second author of this article conducted about home-help care while those that did not have home-help care were recruited through a contact that worked at the local Red Cross as well as through the

snowball technique. The sampling strategies utilized in this project can therefore be described as a combination of criteria (since age, living on their own, and being home-help care recipients were among the criteria used in the first wave of data collection), disconfirming cases (since we did not want to be limited to home-help care recipients exclusively), and snowball (e.g. Creswell 1998).

The data that will be utilized in this article consists of 16 interviews with people between the ages of 77 and 86 who live either alone or with a spouse (seven men and nine women). All of them are people interviewed during the second wave of data collection described earlier which is when questions regarding successful aging were posed. Half of them receive some home-help care whereas the other half do not.

## *The Interviews*

The interviews lasted between an hour and a half and two hours, and were all tape-recorded and transcribed verbatim for the purpose of data storage and analysis. They tapped into a variety of themes, but were semi-structured since we were interested in exploring people's understandings and needed to follow their own trains of thought and pace. All of the interviews conducted during the second wave of data collection began with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) questions since we wanted to make sure that our informants were, among others, people that could be claimed to have diminished everyday competence. Table 1 shows a summary of the responses given by the informants with regards to the questions having to do with mobility in the shortened ADL and IADL questionnaire that we used.[6] A closer look at the two groups in which we have grouped our informants and at the number of answers that indicate that they could not execute and/or needed help with (see the second column of this table) clearly shows that those that received home-help care listed a fewer number of activities they could execute on their own (23 compared to the 64 that the non-home help care recipients listed). Hence we tentatively and cautiously draw the conclusion that the home-help care recipients interviewed in this study gave answers to the ADL and IADL questions we posed which indicate that they had more diminished everyday competence than those who did not receive help from home-help care

**Table 1.** Summary of answers to ADL and IADL questions having to do with mobility per informant

| Informant's pseudonyms, age and group | Number of answers indicating that they can execute the activities in question | Number of answers indicating that they cannot execute and/or that they receive help with the activities in question | Number of questions that were either not answered or which were not applicable |
|---|---|---|---|
| *Home-help care recipients* | | | |
| Bo (86) | 7 | 4 | 1 |
| Sören (85) | 4 | 8 | – |
| Niklas (85) | 4 | 5 | 3 |
| Britta (77) | 5 | 4 | 3 |
| Hedvig (82) | 3 | 6 | 3 |
| Annika (84) | – | 10 | 2 |
| Hermine (79) | – | 11 | 1 |
| Eyvind (83) | – | 11 | 1 |
| *Non-home-help care recipients* | | | |
| Hans (79) | 6 | – | 6 |
| Alexandra (83) | 5 | 6 | 1 |
| Fredrika (86) | 6 | 1 | 5 |
| Fanny (79) | 9 | 2 | 1 |
| Frans (80) | 9 | 2 | 1 |
| Fredrik (82) | 11 | – | 1 |
| Olivia (80) | 10 | 1 | 1 |
| Wilma (86) | 8 | 2 | 2 |

services. Of interest is, perhaps, that although Swedish home-help care services are a general right, they are in fact only awarded on the basis of an individual assessment of needs which is based, in part, on ADL and IADL questions. We would also like to draw attention to the fact that the differences we will be pointing toward cannot be attributed to age since there were not any major differences in the age distribution of those belonging to the group hereby referred to as home-help care recipients and the group that was managing without the help of home-help care services. This comes across if one pays attention to the ages of the

informants which are disclosed in parentheses next to their pseudonyms in both tables.

The particular section of the interview guide that is at stake in this article is the one that tapped into successful aging. In that section we asked people to share their thoughts on what aging well means and what they think is needed in order to age successfully. To this respect it must be mentioned that the construct of successful aging does not translate well into Swedish, which is why Swedish gerontologists talk about the ''*goda åldrandet*'' – which translates into good aging or aging well – when they are talking about this construct (e.g. Tornstam 2005). This is interesting in and by itself since it speaks to the kind of translation problems that highly culture-specific concepts such as success pose (cf. Pahl 1995). The construct's culture-specificity notwithstanding, it must be mentioned that we do not believe that the usage of the Swedish term for this construct poses a problem since the interviews tapped into the understandings that our informants had about what aging well meant and what was necessary in order to have a good old age. Something else worth mentioning when it comes to the interviews is that what we asked was for people to share their understandings of successful aging with us and not to assess whether or not they were aging successfully themselves. Our interest did not, after all, entail the ''actual'' state of affairs as perceived by our informants but how they define different aging-related constructs and whether or not their understandings in these respects had changed as a result of their present situation – i.e. because they are experiencing diminished everyday competence, live with various limitations and (in some cases) receive help and support from home-help care services.

## *The Analysis*

The first phase of analysis for this particular study entailed the identification of themes brought up when our informants shared their understandings of successful aging with us. This means that each of the answers we obtained regarding successful aging was dissected into the smallest unit of meaning possible. A total of 36 units of meaning were uncovered in this stage of the analysis. These units were sorted into categories by virtue of what they shared in common. Once this sorting out had been completed, we identified the three types of themes into which the units

of meaning identified could be categorized. As Table 2 shows, these were: resource-related statements (five different kinds were identified), attitude-related statements and continuity-related statements. Once these themes had been uncovered, we proceeded to read and re-read each of the statements in order to reduce the data so that the meaningfulness of each of these was emphasized. During this phase of the analysis we realized that we were in fact dealing with two types of categories: one concerning *what* successful aging means [i.e. the different kinds of resources that seemed to be associated with successful aging – be they of a physical, psycho-social, mental, spiritual or financial nature – or the kind of outlook in life believed to be conducive to aging well] and another concerning *how* the understandings of successful aging that were disclosed were in fact constructed. We have therefore chosen to present our findings in three separate sections; one concerning the state and/or resources that our informants associated with successful aging, another concerning the outlook they described as conducive to a good old age, and a third one concerning how the understandings in question were formulated.

## *The Findings' Credibility: Ensuring the Quality of Qualitative Research*

In order to guarantee the credibility of the findings we shared the responsibility for data analysis between ourselves. The first author was responsible for the identification of units of meaning and for sorting these out into themes and categories, whereas the second author assumed the role of inter-rater of the analysis in a peer-debriefing session (Cresswell 1998). This entailed the double checking of the units of meaning that had been identified by the first author and the themes and categories into which these had been sorted. This involved also suggesting alternative coding (cf. Silverman 2001). As inter-rater, the second author corroborated most of the identified units of meaning and the classification of these into themes, but it was her inter-rater coding that suggested that another resource type be added (the mental one). Thus, although a relatively high degree of inter-reliability agreement was reached rather easily, the credibility of the findings was guaranteed by the alternative coding that the second author conducted. The peer-debriefing session in question

worked, therefore, for the inter-subjective verification purpose for which it was conducted (cf. Seale 1999).

## Findings

Three different kinds of themes were disclosed with regard to the way in which the construct of successful aging was understood. These had to do with resources, attitude, and continuity. The first two themes concerned the aspects our informants believed to be needed for a person to age successfully, while the latter was more about the manner in which the units of meaning were formulated; i.e. the fact that continuity seemed to have played such a central role when some of our informants described what successful aging meant for them. It is these findings that suggest that the term successful aging is perceived to be, as the title of this article indicates, an oxymoron, since it is not uncommon for people to equate successful aging with not aging at all. The following section will tap into this angle after the first two aspects of understanding successful aging (i.e. resources and attitude needed to age well) are presented.

### *Resource-related Statements Regarding What Successful Aging Means*

The most common statements made about what successful aging means entailed the listing of the kind of states and/or resources one needs in order to age well. Whereas these were of the physical, psycho-social, mental, spiritual, and/or financial type, our informants often began their descriptions of what successful aging meant to them by mentioning what they felt were necessary pre-requisites for aging well. Table 2 shows, however, that interesting differences were found between the types of resources that were listed by those with home-help care and those that manage without. Thus, although informants belonging to both groups made allusions to physical resources, it was mostly those that did not receive home-help care that brought up mental, psycho-social, and financial resources as necessary for a successful old age. This means that home-help care recipients were in fact less nuanced in their understanding of successful aging since their answers focused mostly on one aspect; physical resources being the ones most often brought to the fore in their

case. This is, in and by itself, an interesting observation and one that deserves further exploration since it suggests that present situation might play a role when understanding of successful aging are being described; which in this case is related to receiving home-help care and to what seems to be – at least comparatively speaking – a higher degree of diminished everyday competence as suggested by the answers to ADL and IADL questions shown in Table 1.

With regards to physical resources – or health which was the term that most of them used – it must be mentioned that these were listed by the vast majority of our informants. Aging well seems to be associated with healthy aging which makes us wonder whether our least healthy informants would define themselves as successful agers had we asked them to assess if they were aging well or not. The following informant, who had rather a hard time formulating what successful aging meant to him, said for example:

> Interviewer: If I were to say to you – aging well – what would you associate with that term? What do you consider a successful old age?
>
> Niklas: Hmm ... whoever came up with that term should explain it to me, I think ... I don't know what it means, I guess, it means different things to different people, doesn't it?
>
> Interviewer: I am sure it does ... but what do you think? How would you define a good old age?
>
> Niklas: I would ... if anything ... I would want to be healthy so that I can move about. I am disabled. (Niklas, 85 years old, home-help care recipient)

This quote, which is interesting in and by itself because of the hesitation the informant expressed when first asked to define what successful aging means to him (a matter which we will discuss in the section on continuity), shows how being healthy (which in this case seems to be synonymous with being mobile) often became the first spontaneous thing our informants brought up when talking about what aging well means. Having said this, it must be pointed out that although the later part of this quote suggests that this particular informant did not think that the term successful aging was useful to describe his situation, we cannot in fact draw that conclusion since

**Table 2.** Understandings of successful aging: distribution of themes by informants

| Informants' pseudonyms and age | Physical resources | Mental resources | Psycho-social resources | Spiritual resources | Financial resources | Attitude/ Outlook | Continuity in life |
|---|---|---|---|---|---|---|---|
| *Home-help care recipients* | | | | | | | |
| Bo (86) | X | X | X | X | | | X |
| Sören (85) | | | | | | | |
| Niklas (85) | X | | | | | | |
| Britta (77) | X | X | X | | | | X |
| Hedvig (82) | X | | | | | | X |
| Annika (84) | | | | | | | X |
| Hermine (79) | X | | | | | | X |
| Eyvind (83) | | | | | | | |
| *Non-home-help care recipients* | | | | | | | |
| Hans (79) | | X | X | | | X | |
| Alexandra (83) | X | X | X | | | | X |
| Fredrika (86) | | X | | | | | X |
| Fanny (79) | X | X | X | | | X | X |
| Frans (80) | X | X | X | | | X | X |
| Fredrik (82) | X | X | X | | | | X |
| Olivia (80) | X | | X | | X | X | |
| Wilma (86) | X | X | X | | X | | X |

we did not explicitly asked people to assess whether or not they were aging successfully. The only thing we can say and which we would like to use this one statement to point out is that being healthy (and in this case, ''being able to move about'') was one of the first resources our informants listed when asked to define what this term means to them. Statements to this end were made in various ways. Some said, for example:

> /. . ./ to be able to still have the opportunity to move about. (Bo, 86 years old, home-help care recipient)

> yeah . . . well . . . it is about being able to remain healthy, not having any aches and pains. (Hedvig, 82 years old, home-help care recipient)

> /. . ./ remaining healthy, I think . . . that is it. (Hermine, 79 years old, home-help care recipient)

Remaining healthy, having one's health, being free from aches and pains, and having physical strength or health were all among the resources that were spontaneously listed when our informants were asked to define what successful aging meant to them.

Some of our informants made statements that were more about mental resources as well. These were people that felt that remaining alert and/or being able to remember things were needed in order to age well. One of our informants began to formulate what he felt was needed to age well by saying:

> That demands a bit of thought . . . well, good aging? . . . that is, in my case, about having some clear headedness left so that one doesn't need to think about it. (Bo, 86 years old, home-help care recipient)

Clear-headedness, being able to remember things and being alert were all among the things that were described as pre-requisites, so to speak, to aging well. When talking about the opposite of a good old age, one of our informants said, for example, that ''becoming demented'' (Alexandra, 83 years old, without home-help care) would be the worst. The thought of losing one's memory and/or of being afflicted by dementia were often brought up when our informants tried to describe what the opposite of a

successful old age would look like. Some of those who talked in detail about their fear of losing their memory talked about this as a threat to one's quality of life; a threat some of them thought was more devastating than the capacity to function physically. It is therefore as if mental resources were the most coveted even though physical resources (such as good health and the ability to move around) were also listed spontaneously when our informants first started to formulate what aging well meant for them.

Psycho-social pre-requisites were also mentioned when trying to formulate what successful aging meant. Having good relationships with other people (which some described as being the kind of relationships which one considers close, and others as relationships which are free from conflict and animosity), remaining active in one's social network of affiliation and maintaining one's engagement in social events were among the psycho-social-like resources listed when our informants tried to formulate their understandings of this construct. Some brought up the fact that having something meaningful to do was important if one is to age well, as is being able to enjoy the company of one's partner in life (which was an issue brought up by the two informants that still lived with their partners), one's children and grandchildren and/or of one's friends. Thus, when asked to describe the opposite of successful aging some of them talked about loneliness and social isolation as ''threats'' to aging well since ''good friends can cheer one up,'' as one of our informants said.

Although not as common, some of our informants made resource-related statements that tapped into the spiritual sphere. The following response came, for example, from one of our male informants, who had always been involved in his local church:

> Something else that means a lot, since it is a natural part of who I am is the congregational community, which I think is also a part of what a successful old age is all about. To have the wisdom necessary to know upon which leg one stands in one's spiritual life, that means a lot as well. (Bo, 86 years old, home-help care recipient)

The financial sphere was also brought up in the interviews. One of our female informants said the following when asked what she thought successful aging meant:

> /. . . / I think I am aging successfully but that is also because I have . . . I can't say that my financial situation is fantastic but I manage and I have a nice home and I . . . so in that sense I think I have a very good old age even though these are material things but they mean a lot to be able to have a comfortable life and have it nice and good and as one wants/. . . / I can afford to do the things I am interested in . . . music, for example, I can go to concerts and I can afford to travel to visit my children and grandchildren. (Olivia, 80 years old, without home-help care)

There were a variety of pre-requisites (hereby referred to as resources) with which the construct of successful aging seemed to have been associated. As Table 2 clearly shows, some interesting differences were observed with regards to what the informants listed as needed resources in order to age well since those without home-help care were in fact more nuanced in the manner in which they talked about successful aging. They were also – as shown in Table 1 – those that listed a higher number of ADL and IADL-mobility oriented activities that they could manage on their own.

### *Attitude-related Statements Regarding What Successful Aging Means*

Some of our informants described an attitude to life that they defined as conducive to aging well. Interestingly enough, however, only those that were not home-help care recipients made attitude-related statements when describing what the construct of successful aging meant to them (see the next last column of Table 2). Among the things that were mentioned with respect to attitude are: having a positive approach to things, being curious enough to learn new things and/or keep up with the latest developments in, for example, technical advances or music, avoiding nagging and/or dwelling on difficulties and being able to forget other people's wrong-doings. Descriptions of successful aging that touched upon the topic of attitudes were about having the kind of positive and optimistic outlook in life that one assumes joyful people have.

Some explained why they felt this kind of approach was necessary by saying, for example, that when one has such an outlook one remains stimulated and positive, which is good if one is to avoid dwelling on the various infirmities with which the process of growing into old age is associated, or as the one couple we interviewed said when asked what is needed in order to age well:

Frans: It is necessary that one doesn't have big worries. One could say that we each have our share of those but we try to disregard them ... and that one can do a few things now and then that one has the strength to do.

Interviewer: Hmm ... is health important?

Frans: Yes.

Fanny: Yes, health is important.

Frans: That is what is important.

Interviewer: But at the same time you say that the tumor is something you disregard.

Frans: Well as long as it doesn't spread.

Interviewer: Hmm ... ok.

Fanny: Yes but one just has to accept that. One has some ailments when one is running around and one thinks that everybody else has it OK but then one starts ... and then one sees that everybody is feeble in some way or another.

Frans: Yeah.

Fanny: But it is very important, I think ... And I think that is something I learned while being sick that year that one has to have a positive outlook and be curious and continue to live ...

Frans: Yeah, and avoid nagging ...

Fanny: Well one has to be able to nag sometimes ... [we all laugh] ... but one can't dwell on it.

Frans: Yes, that is probably more important.

Fanny: That one continues to be curious and like that ... (Frans, 80 years old, without home-help care & Fanny, 79 years old, without home-help care)

Outlook-related statements were, in other words, made in order to allude to the kind of attitude one needs in order to be able to manage the various vicissitudes that are associated with the process of growing into old age. One of our informants said the following when asked to describe what the opposite of successful aging would be like:

> Successful aging, ha … if I were to remember earlier wrongdoings that would be bad aging … if I were to get hung up on those and try to exploit them in some way … that would be bad aging … let me see if I can think of more examples for what bad aging means/…/ Bad aging is also when all possible sorts of physical handicaps crop up … well what I just mentioned about remembering wrongdoings … that is not physical but on top of that if one were to have physical handicaps … well that would naturally be bad aging but that can be compensated for by a kind of more forgiving and understanding attitude to things (Hans, 79 years old, without home-help care).

In this quote we see how different types of themes were intertwined in this idea that successful aging entails a positive and tolerant outlook on life. This particular informant pointed also out that even though physical handicaps could be perceived as a threat to a successful aging, one's approach to them is just as important.

Related to the idea that it is up to us to decide how to handle the various challenges that life and aging pose is also the idea that remaining engaged and/or remembering that one needs to continue to do what one can to make sure that one gives of one's best is also conducive to aging well. One of the women we interviewed talked, for example, about this when the topic of social relationships came up, and she spontaneously began by saying that being surrounded by one's children and grandchildren was important, as was having a good social network. But as she reflected more she said the following:

> Yes, a good social network, that is … but then it depends also a lot on how one is … There are many that … one hears sometimes … well it maybe doesn't matter if I tell but … there is this old lady that sulks and says oh, I am so lonely … And yes but one must also … one must give of one's best so to speak. One can't just sit in a chair and wait for others to come … and like, one has to do that and if one can't, for there are some people that can't … they don't have the strength to do that and what not, but one has to do something also … and this woman that I am talking about … the only thing she does is nag about everything, everything is wrong. It is never clean in the laundry room and it is always dirty in the elevator and it is this and it is that and I think that maybe it isn't that strange that she is so alone, for who has the strength to put up with her so I think that one must, one must give everything in a way … One has to try, I think. (Olivia, 80 years old, without home-help care)

Thus, as expressed by this informant and so many of the other ones that talk about the importance of having a positive outlook in life, successful

aging was believed to be associated with having the kind of attitude that makes life easier just because one approaches things in an open and tolerant manner. These were people that believe in the fact that it was in their power to age well since it was not all a question of how healthy one was and/or what kind of situation one has but also of how one tackles the various difficulties with which aging is associated; how one approaches life. It can therefore be said that this understanding of successful aging brings to the fore the idea that aging well is, to a certain extent, a question of mind over matter.

Lastly, when it came to "the what" of successful aging there were those that thought successful aging was about the various "gains" that the process of aging brings about. For example, one of the men we interviewed said the following when asked what came to mind when he heard the construct in question:

> To be able to remember, to be able to do things in a calmer way, whether it is reading, or writing or taking a walk ... there is a sort of calmness, a sort of relaxation that I don't think one can reach as a younger person and which I don't think a younger person would appreciate ... young people prefer that which is stressful and exciting and not that which is calm and relaxed. And I have to say that it is fun to be able to appreciate this calmness. And that is one of the things that one could count amongst the pros of growing old ... that one can become more relaxed. (Hans, 79 years old, without home-help care)

So whereas successful aging was described in terms of an outlook one has and/or one that is gained as we age, it is clear that some of the older people interviewed thought of aging well in terms of an attitude and/or approach to life in general, and aging as a process in particular.

## *Continuity-related Statements About What Successful Aging Means: When Aging Well is Understood as Not Aging at all*

As mentioned earlier, this particular theme does not have to do with what informants defined as necessary pre-requisites to aging well. Instead, this one theme is about how some of our informants formulated their understandings of successful aging; i.e. the manner in which they talked about what aging well entails. The in-depth analysis of our informants' perspectives on aging well showed that understandings of successful

aging – irrespective of whether or not they were upheld by those that were managing without home-help care services – were often framed in terms of continuing with business as usual so to speak. The underlying message being, in a way, that one ages well if one could "freeze time" and remain the same. Some of our informants seemed, for example, rather tentative when they were first asked what successful aging meant to them. It was as if they were hearing an oxymoron that they needed time to reflect on, and they wanted to have further explained, which is perhaps what one of the men interviewed – Niklas – eloquently expressed when he wondered where the term successful aging came from (as he is cited doing a few pages ago). Irrespective of how our informants reacted when they first heard the term, it is clear that most of them could easily formulate their vision of successful aging as the interview progressed. Few seemed actually to have a problem describing what aging well meant to them despite the initial hesitation and/or tentativeness that accompanied most of their formulations of what aging well means.

In addition to this interesting observation and related to this continuity theme is the fact that some of our informants formulated their definitions of successful aging by referring to the way things were at the moment and the fact that being able to carry on as they were doing was what successful aging was all about. For example, when talking about the importance of health for aging well some of our informants made statements such as "to be able *to remain* as healthy *as I am today*." In this regard it must be added that when our informants talked about having their health they did not mean being "disease free" but rather "not getting worse." In a similar manner, others began to formulate what successful aging meant to them by saying, for example: "Well, above all…that I am able to be *who I am today*" or as one of our informants said:

> A good old age is … in my case it is about having my senses *left* / … / I think that it is very important that I can *continue* to have a fairly normal ability to communicate … (Bo, 86 years old, home-help care recipient)

Thus, the idea that continuity is needed in order to age well permeated the understandings of successful aging that this study brought to fore. As one of our informants said, "if nothing worse happens to me other than what has happened already (which in this informant's case meant the two back

operations she had had) then I will be very grateful'' (Britta, 77 years old, home-help care recipient). The informants that talked about successful aging in terms of continuity suggested that the construct in question seems to have been perceived as a contradiction in terms since aging was about getting to a point where one was no longer able to continue as usual. This makes sense if one takes into account that these were people that seemed to associate the process of growing into old age with ''falling prey'' to the various difficulties that aging seems to have been expected to bring about. For example, after making numerous remarks about having thought about what the various challenges associated with aging would feel like, one of our informants said the following:

> Well, it is clear that years pass by you know and that one just has to you know realize that, sooner or later, one will become a victim of old age as one might maybe say [the interviewer asks him what this means and he responds] well, it can you know ... it means some sort of ... it is probable that one can ... that troubles will increase in one way or another ... Body-wise or spiritual ones or whatever it might be that can crop up ... so it is just that ... I mean that it is because of this that I say this ... one never knows you see ... how it will be so in a way it is just an objective assertion that that is just life. (Fredrik, 82 years old, without home-help care)

The process of growing into old age seemed to have been implicitly assumed to be a threat to continuity in life (cf. Torres & Hammarström 2006, 2007) which is why we are suggesting that some of our informants seemed to draw a parallel between successful aging and not aging at all. This might explain why some of them went as far as saying – in a joke-like manner – that successful aging was about ''being young forever;'' a statement that was not really typical of the statements of most of our informants made but that captured the essence of what all of those that made statements regarding continuity in life seemed to have wanted to convey. Continuity in life is, after all, about wanting things to stay the same and about assuming that the future holds changes that imply deterioration in one way or another. Our informants' understandings of successful aging suggest that the term can be regarded as an oxymoron since aging is believed to be about the kinds of transitions that jeopardize being able to continue as usual and to age well one would need to be able to ''freeze time'' since remaining the same is the only way in which one

could avoid the various deteriorating transitions with which aging seems to have been associated.

## Discussion

The findings hereby presented corroborate previous research on understandings of successful aging since health was found to be central to aging well (cf. Duay & Bryan 2006; Fisher & Specht 1999). Another aspect of successful aging, which previous research has brought to the fore and which our study also shed light on, is the importance of psycho-social resources, i.e. having good social relationships, remaining active in one's social networks of affiliations as well as in social events, and having something meaningful to do. Thus, whether described as social functioning (cf. von Faber 2001); interpersonal behavioral skills (cf. Dorfman & Walsh 1996) and/or interactions with others (cf. Fisher 1992, 1995 as well as Fisher & Specht 1999), our ability to remain active and engaged socially seems to be among the aspects that people deem to be conducive to successful aging along with having a sense of purpose and meaningfulness. Spiritual and financial resources were mentioned by some of our informants even though these were issues that were not brought up as often. The importance of spirituality has been identified as important by others (cf. Ruffing-Rahal & Wallace 2000), as has the issue of finances (cf. Charbonneau-Lyon et al. 2002; Duay & Bryan 2006). Thus, these are also some aspects that our study has in common with previous research, even though one could say that these were issues that were relatively peripheral to most of the understandings of successful aging that our informants expressed.

With respect to the importance of health and physical resources it must be mentioned, however, that this aspect was exclusively brought up by those that indicated – in their responses to the ADL and IADL questions we posed and in comparison with those that were managing without home-help care services (as shown in Table 1) – that there were numerous activities that they were either not able to execute on their own and/or needed help with. Here it seems necessary to reiterate that age did not seem to play a role. The number of activities one had trouble executing on one's own or needed help with was not related to the number of years one

was. Something else worth reiterating is that these were people that were home-help care recipients. Hence that the findings suggest that it might only be those that are relatively healthy and physically able who define successful aging in other terms besides those related to physical resources. The underlying idea being that understandings of successful aging can only "afford" to be about something else besides health when one is still relatively healthy. The size of our sample and our study's design does not allow us to draw the conclusion that home-help care recipients are more prone to think of successful aging in more narrow terms than those who manage without the help of home-help care services because they are still relatively mobile and are not yet hindered by their diminished everyday competence. Future research should, however, explore this further since it might very well be that as people's own physical resources deteriorate and their need for help and assistance with everyday activities increases they begin to think of aging well in health-exclusive terms. Our own research has shown, for example, that there is a relationship between how people think about diminished everyday competence and how they conceive the process of growing into old age (cf. Torres & Hammarström 2006). The question that the findings presented here pose is therefore whether degree of diminished everyday competence is related to how we think about successful aging and what we deemed to be needed to age well.

The importance of attitude toward life in general, and the various changes that aging brings about in particular, were also amongst the issues that some of our informants (those that were not home-help care recipients) associated with aging well. Statements that stressed having a positive approach, being curious, avoiding nagging and dwelling on negative issues, forgiving wrongdoing and remaining stimulated were made by the informants that were managing without the help of home-help care services and these were classified under the umbrella concept of attitude-related statements. It must, however, be stressed that what these statements tap into are, in fact, an issue that has often come up as one of the key aspects of successful aging (cf. Dorfman & Walsh 1996) even though some research refers to this in other terms (such as self-acceptance as in the case of Fisher 1992, 1995 as well as Fisher & Specht 1999 or coping with change as in the case of Duay & Bryan 2006). Related to this is also the fact that our findings suggest that we need to look further into whether

or not there is a relationship between being in need of help and support and how one thinks about the attitude-oriented aspect of successful aging.[7]

Last but not least, there are the findings that show that some of our informants thought of aging well in terms of remaining the same and/or "freezing time;" findings that show that these informants think of aging as deteriorating change which is why they formulated their understandings of successful aging by suggesting that aging well is about not aging at all. This is, of course, in line with the provocative statement that Baltes and Carstensen (1996) once made when they alluded to the fact that "some critics argue that successful aging is an oxymoron; successful aging means not aging at all" (Baltes & Carstensen 1996: 400). Our findings suggest that it might very well be that some older people think of this construct in such a way. Conceived in this manner, successful aging is about remaining the same, i.e. about continuity.

## Concluding Remarks

The findings having to do with *what* successful aging is and the aspects believed to be conducive to aging well are in line with what previous qualitative research about older people's understandings of successful aging has identified. The heterogeneous sampling strategy utilized in this study allowed us, however, to make an interesting contribution to the ongoing debate by suggesting that present circumstances – such as being a home-help care recipient and having diminished everyday competence – might have an impact on the way in which older people think about successful aging. The findings having to do with *how* the understandings were formulated are also interesting since they suggest that even though most people can define what this construct means to them, there are some that formulate their understandings in a manner that suggests that this very popular gerontological construct is, in fact, an oxymoron to them.

By unveiling the manner in which understandings of successful aging are formulated we have tapped into how the process of growing into old age can be viewed. Aging seems to have been regarded as a process associated with numerous threats to the way things are at present, which is why some of our informants seemed initially to have a hard time

formulating what aging well entailed. Most of our informants could, however, define rather easily what successful aging meant to them once they began to list the pre-requisites or resources they believed to be needed in order to age well and the type of outlook in life they deemed to be conducive to successful aging. Future research should explore how the understandings in question are mediated by the different circumstances in which older people can find themselves. Our findings suggest (albeit tentatively), after all, that being a home-help care recipient and degree of diminished everyday competence might have an impact on how older people think about successful aging.

## Acknowledgements

The research upon which this article is based was funded through grants from the Swedish Research Council (Vetenskapsrådet) and the Faculty of Social Sciences at Uppsala University. We would also like to thank the members of the Social Gerontology Research Group at the Department of Sociology of Uppsala University for their support throughout this project.

*Notes*

1. When referring to Rowe and Khans' contribution, Strawbridge et al. (2002) have argued that what was innovative about their way of thinking about aging is that it suggested that one could in fact age successfully (i.e. disease-free), which was something totally different from thinking that one could have a good old age despite disease.
2. Hereby we would like to stress what we have already pointed out in the introduction; namely that the idea of aging well has always been an underlying theme for research on adjustment, adaptation and coping (cf. Tornstam 1973) even though the actual term "successful aging" is relatively new. Our interest in this construct is, however, not historical, which is why we deem the discussion regarding the origins of successful aging to be peripheral to our endeavor. Our literature review focuses, therefore, on literature that uses the term successful aging explicitly since our interest lies in the differences there might be between what aging well is believed to be (by the social gerontological literature) and how elderly people define the term.

3. Other results from this project can be found in Hammarström and Torres (2005, 2007, 2009) as well as in Torres and Hammarström (2005, 2006, 2007).
4. A total of 49 interviews were collected during the course of this project. Only 37 interviews qualified, however, as useful data since some of the interview tapes had poor sound quality and some of our informants were deemed to lack lucidity or failed to answer our questions. This particular study is, however, based on the 16 interviews in which we asked about successful aging explicitly.
5. Results of this survey can be found in Hammarström (2001, 2002).
6. The shorter version that we used is composed of 35 items. In this article we focus only on the twelve items that have to do with mobility.
7. Our own research has shown, for example, that being in need of help and assistance does not necessarily mean that one regards oneself as dependent (cf. Hammarström & Torres 2007, 2009), which is why it is important to keep in mind that parallels cannot automatically be drawn between circumstances which might at first glance seem similar (such as being in need of help and assistance and regarding oneself as dependent and/or – for that matter – having such assistance and thinking about successful aging in a given manner).

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International Journal of Ageing and Later Life, 2009 4(1): 55–86. © The Authors

# Living in single person households and the risk of isolation in later life

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## Abstract

Data from the International Social Survey Programme (2001) was used to analyse the social networks of older people and whether living in single person households increased the risk of isolation. When comparing respondents with one or more adult children, there was no significant difference in the likelihood of experiencing familial isolation between people living in single person households and those living in larger households. A majority of those living in single person households had at least regular contact with a sibling, adult child or close friend and participated in a social organisation. Friends compensate to some extent for a lack of support from the family, although in southern and eastern European countries, other relatives appeared to be more important in support networks. People living in single person households were more likely to experience isolation, but this was largely related to advanced age and childlessness. Whilst a very small minority in Japan were living in single person households, they were significantly more likely to be severely isolated than those living in single person households in other countries.

Keywords: isolation, older people, single person households, childlessness, ISSP.

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## Introduction

The International Social Survey Programme (ISSP) is a continuing annual programme of cross-national social science survey activity. In 2001–2002, the agreed standard questions included topics relating to social network contact. The data included accounts of respondents' contacts with relatives and friends, their participation in civic and religious organisations as well as information about where they would be most likely to turn for help if faced with illness. The secondary data analysis in this paper is based on a sub-sample extracted for an international project supported by the Economic and Social Research Council of the UK. The sub-sample of the 2001 ISSP includes individual cases of those aged 50 or over from 18 countries that are members of the Organisation for Economic Co-operation and Development (OECD) (13 of which are European). In some places in the article, the findings are discussed in terms of European regions: where Italy and Spain represent Southern Europe; Britain, France, Germany, Switzerland and Austria represent Western Europe; Denmark, Norway and Finland represent Northern Europe; and Hungary, Poland and Czech Republic represent Eastern Europe.

### *Background*

Concerns around the possible social isolation of older people living in single person households are not new. In the UK, for example, several important post-war studies (Sheldon 1948; Townsend 1957; Tunstall 1966) were carried out which explored the connection between these two variables. Such studies have consistently identified living in single person households as a risk factor for wider social isolation and loneliness (Victor et al. 2004). However, as Victor et al. have pointed out, there have in more recent years been a number of social changes, which may affect the experience of older persons living in single person households, not least the fact that this has become a much common arrangement. Living in a single person household cannot be assumed to lead to social isolation, as older people living without others may have good friendship, neighbourhood and community social networks. Similarly, living with a partner may lead to feelings of social isolation if the relationship is abusive and not of a good psychological quality.

The increasing number of older people living in single person households has often been viewed as a negative development related to a decline in familial solidarity. An interest in the subject of familial obligations towards elders was reawakened towards the end of the 1970s when sociologists started to question assumptions of this simple association (Attias-Donfut & Rozenkier 1996: 51). Such writers have argued a ''myth of abandonment'', through which a stereotype had been created of the lonely older person, neglected by family (Connidis 1983).

A growing government interest in the role of the family in supporting older people has been evident in recent years. This has been fuelled at least in part by a growing interest to maintain a system heavily dependent on informal support due to demographical and political change which have in many states resulted in squeezing public funding in social care for older people (Attias-Donfut & Rozenkier 1996: 51). These issues have been brought to public attention through government departments responsible for healthy ageing agendas, and under the banner of the broader concept of ''social exclusion''. The term ''social exclusion'', first appearing in France in the 1960s, has become official parlance of the European Union (Cavelli et al. 2007: 10). It is a contested notion often used to highlight the multi-dimensional inter-connected elements of social isolation and material deprivation. However, the majority of national government and EU studies on social exclusion have focused on children, adolescents and those of working age, whilst there has been less interest in the exclusion suffered by older people (Scharf et al. 2004: 83–84). Reducing social exclusion among older people has, however, now become a Europe-wide priority (The Council of the European Union 2002).

A recent UK study commissioned by the Social Exclusion Unit has focused on these issues, defining the social exclusion of older people by seven dimensions. The study found living in single person households to be associated with exclusion from social relationships and civic activities. Being female was also associated with social exclusion in cultural and civic activities (but not contact with family and friends). Other risk factors of social exclusion included having no living children, being aged 80 and over, as well as non-White ethnicity, having poor health, low income, rented accommodation, no car and no telephone (Barnes et al. 2006). Kharicha et al. (2007) found living in single person households to increase

the risk of social isolation even when controlling for age, sex, income and educational attainment. Holmen & Furukawa (2002), however, found that with increasing age, ''having a good friend to talk to'' and ''being subjectively healthy'' to be increasingly important in guarding against loneliness, whilst the effect of ''not living in single person households'' remained stable. A study by Scharf et al. (2004) found that the social and material exclusion was related to ethnicity (specific non-White ethnic groups were at greater risk) and age (those aged 75 and over being more likely to be at risk), whilst risk of exclusion was not found to vary significantly by gender.

Research findings are inconclusive over the affect of age on social isolation. Cavelli et al.'s (2007) study in Switzerland, for example, found that family and other social relations remained stable in advanced old age and social activity was only reduced as a result of declining health. Van Tilburg et al. (2004) and Wenger & Burholt (2004) found advancing age to increase the risk of isolation. Jylhä (2004) finds weakening social integration in old age (along with increasing disability) to be a causal factor of increased isolation. Victor et al. (2004), however, found rates of isolation among the older cohort to fall.

If older persons live without others, we cannot assume they are ''lonely''. Cross-cultural studies have found loneliness among older persons to be more frequently reported in more traditionally family-centred countries of southern Europe, despite a lesser prevalence of living in single person households (Andersson & Sundström 1996: 23). This, however, also raises issues around definition of the terms ''social isolation'' and ''loneliness'', and to what extent the psychological experience of loneliness is related to external patterns of social contact and engagement. The degree to which one may feel isolated varies depending on the extent of contact with others, but also with a number of other social and psychological factors including personal temperament. Indeed, it is possible to be lonely without living on your own and vice versa. As found by Wenger & Burholt (2004), caring responsibilities among older persons is one factor that may contribute to loneliness, i.e. where older persons (often women) are themselves the primary carer for their husband or wife and may feel isolated in this role.

Social isolation is defined in this study with reference to three dimensions. These are the number and regularity of reported social contacts with: family relatives (separate to any partner or spouse); friends; and the wider community. The concept of "severe isolation" is used to describe those who lack a quantity of contact in all these different social networks. No attempt is made to control for social psychological, self-reported accounts of feelings and personal experiences of isolation and loneliness. Such data was not available to this study. Social isolation is defined and explored with reference to the quantity of contacts that older people have with other people, and measurement is based on the self-reporting of such contacts. It is also beyond this study and dataset to explore a more multifaceted definition of social exclusion and the focus of this study is on the quantity of social contacts.

## Research Questions

- Are older people living in single person households at a significantly greater risk of social isolation than those living in a two or more person household?
- What influence do the factors of childlessness, age, gender and social class have upon the risk of social isolation among older persons who live in single person households?
- What are the differences in social and support patterns between countries by household structure? In particular, do countries with a larger proportion of older people living in single person households also have a larger proportion at risk of isolation?

## Method

The ISSP is a random sample drawn from each host country's population. All samples include sample response rates of over 900 and most have final response samples of between 1000 and 2000. The ISSP social network data (2001–2002) was collected in 30 countries. We reduced the sample study to 18 countries, by only using those countries that are also members of the OECD ($N = 9942$). The final sample included 13 European countries. Our analysis was only applied to a sub-sample of those aged 50 and over.

Klein & Harkness (2001) indicate that response rates are difficult to estimate precisely and vary considerably between countries taking part in the ISSP owing to different quota procedures used and the use of substitution in some countries (see also Park & Jowell 1997). Data has been analysed with SPSS, using cross-tabulations and Pearson Chi Square significance testing. Significance values when quoted reflect these tests. Country aggregate data has also been explored using bivariate correlations.

## Findings

### *Household Structure and Number of Adult Children by Country*

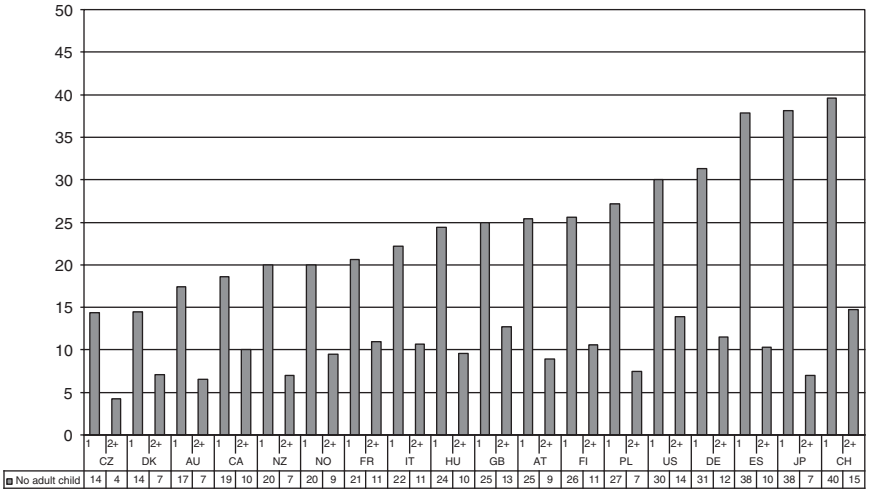
Those living in single person households were more than twice as likely to have no children than those living with one or more other persons. Around a quarter of those living in single person households were childless, which compared to just over 9% of respondents living in a two or more person household. However, as shown in Figure 1, this difference varied between countries, most notably Spain and Poland in which those living in single person households were nearly four times as likely to have no adult children, and in particular Japan, where almost 40% of people living in single person households were childless.

### *Family Members*

The dataset included information on how often respondents see their close family members: sibling; son or daughter (who they have most contact with); mother and father. Data on contact with extended family members is also available and will be discussed briefly.

*Adult child*. A large majority of the sample (85%) had one or more adult children. However, those in the sample without children were more than twice as likely to live in a single person household (46%) than those who had one or more offspring (21%). However, less than 25% of people living in single person households in the sample were childless. Therefore an important indicator of the extent to which living in single person

**Figure 1.** Proportion with no adult children by household structure (living alone/2+ household).




households may increase the general risk of social isolation, may be frequency of contact with their adult child. This variable refers to contact with the adult child the respondent sees the most (where they have more than one). In the majority (53%) of cases, respondents stated this adult child (the one which they either saw most often or was their lone child) was a daughter.

As shown in Table 1, the data showed that, overall, people living in single person households (excluding those with no children) were slightly less likely to see their adult child at least once a month (83%) than those living in a two or more person household (89%). This pattern was true for all countries except for Great Britain which had a relatively high rate of monthly contact with their adult child amongst its people living in single person households (89%), despite, as shown in Figure 2, also having a comparatively high proportion living in single person households (34%). For the sample as a whole, living in single person households was found to make a significant difference to the percentage seeing their adult child on a

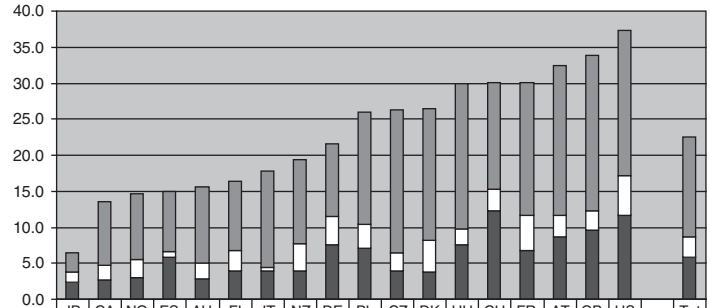
**Table 1.** Proportion having weekly/monthly face-to-face contact with their adult child by household size and country

| | At least once a week (%) | | | | At least once a month (%) | | | |
|---|---|---|---|---|---|---|---|---|
| | Household size | | | | Household size | | | |
| Country | 1 | 2+ | All | Sig. | 1 | 2+ | All | Sig. |
| Australia | 64.2 | 71.7 | 70.5 | NS | 82.6 | 86.6 | 85.9 | NS |
| Austria | 72.9 | 84.0 | 80.8 | ** | 87.2 | 95.7 | 93.2 | ** |
| Canada | 65.4 | 71.2 | 70.4 | NS | 80.8 | 83.0 | 82.7 | NS |
| Czech Republic | 68.9 | 86.8 | 82.3 | *** | 88.3 | 96.8 | 94.7 | ** |
| Denmark | 50.4 | 63.0 | 59.7 | * | 80.7 | 90.9 | 88.2 | ** |
| Finland | 60.6 | 66.7 | 65.7 | NS | 77.5 | 84.0 | 83.0 | NS |
| France | 58.9 | 57.5 | 57.9 | NS | 79.1 | 79.7 | 79.5 | NS |
| Germany | 57.1 | 73.4 | 70.1 | ** | 72.7 | 87.7 | 84.7 | ** |
| Great Britain | 75.2 | 70.4 | 72.1 | NS | 89.1 | 85.5 | 86.8 | NS |
| Hungary | 76.0 | 86.0 | 83.3 | ** | 90.2 | 95.2 | 93.9 | * |
| Italy | 84.0 | 91.5 | 90.3 | NV | 96.0 | 96.5 | 96.4 | NV |
| Japan | 42.3 | 71.8 | 70.5 | ** | 65.4 | 87.3 | 86.4 | NV |
| New Zealand | 58.1 | 65.1 | 63.9 | NS | 75.6 | 77.7 | 77.3 | NS |
| Norway | 63.2 | 67.9 | 67.2 | NS | 79.4 | 84.1 | 83.4 | NS |
| Poland | 68.4 | 86.8 | 82.6 | *** | 82.7 | 94.0 | 91.4 | *** |
| Spain | 86.7 | 92.6 | 91.9 | NV | 91.1 | 97.3 | 96.6 | NV |
| Switzerland | 69.4 | 75.2 | 73.8 | NS | 83.5 | 92.7 | 90.5 | * |
| United States | 58.9 | 70.7 | 66.8 | * | 78.6 | 82.2 | 81.0 | NS |
| Total | 65.8 | 74.9 | 73.0 | *** | 83.0 | 88.7 | 87.5 | *** |

*$p < 0.5$; **$p < 0.01$; ***$p < 0.001$.
Note: $n = 8426$ (excludes those with no adult child), NV = not valid since $> 20\%$ of cells have expected counts $< 5$, NS = not significant.

weekly or monthly basis ($p < 0.0005$). However, as shown in Table 1, this difference was only statistically significant for seven of the 18 countries, i.e. the Eastern (Poland, Hungary and Czech) and Central (Austria, Switzerland and Germany) European countries and Denmark. When those who live with an adult child were excluded from analysis, those living in a two or more person household were only slightly more likely to see their adult child once a month ($p = 0.044$).

**Figure 2.** Bar chart showing proportion living alone, by contact with adult child.




| | JP | CA | NO | ES | AU | FI | IT | NZ | DE | PL | CZ | DK | HU | CH | FR | AT | GB | US | | Tot |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| See child ≥ once a month | 2.6 | 8.8 | 9.2 | 8.4 | 10.4 | 9.7 | 13.3 | 11.6 | 10.2 | 15.5 | 19.8 | 18.2 | 20.3 | 14.8 | 18.5 | 20.8 | 21.6 | 20.2 | | 13.9 |
| See child < once a month | 1.4 | 2.1 | 2.4 | 0.8 | 2.2 | 2.8 | 0.6 | 3.8 | 3.8 | 3.3 | 2.6 | 4.3 | 2.2 | 2.9 | 4.9 | 3.1 | 2.6 | 5.5 | | 2.8 |
| Have no child | 2.4 | 2.7 | 3.1 | 5.7 | 2.9 | 3.9 | 3.9 | 3.9 | 7.6 | 7.1 | 3.9 | 3.8 | 7.5 | 12.3 | 6.7 | 8.6 | 9.6 | 11.7 | | 5.8 |

When the analysis was conducted by social class, working/lower middle class respondents were more likely to see their adult child once weekly or monthly than upper middle/upper class respondents ($p < 0.0005$). Likelihood of monthly contact increased with age for those living in single person households but decreased for those living with one or more other persons. With increasing age, therefore, the gap in frequency of contact narrowed between those living in single person households and those living in a two or more person household. The greater proportion of women in the older age groups may be one reason for this, since for all age groups, household types and social classifications, women were more likely than men to see their adult child at least weekly/monthly.

Table 1 shows there is some variation in face-to-face contact between the countries, such as the comparatively high levels of contact evident in the Southern European countries. However, the data shows that the large majority see their adult child at least once a month, and the norm for people living in single person households in all countries (excluding Japan, where to live apart from one's adult child is less common) is to retain a minimum of weekly face-to-face contact.

The majority of respondents had other contact (besides visiting) with their adult child at least once a week. In fact, if those who were living in the same household as their adult child are excluded, only 20% of respondents reported to have no form of distance contact with their adult child at least once a week. Most of those (63%) who saw their adult child less than once a week were in remote contact with him or her at least once a week, and 21% at least several times a week. The majority (52%) of those in face-to-face contact less than once a month were also in remote contact at least once a week. As has been found by findings from the previous ISSP dataset on social networks (Finch 1989), contact from a distance does not therefore appear to reflect a straightforward pattern of compensation for lack of face-to-face contact. In fact, there was a strong positive correlation (by country) between the proportion who see their adult child at least weekly and the proportion who have weekly distance contact ($r = 0.899$, $p < 0.0005$). Thus, those who reported to see their adult child more often were also more likely to be in more frequent contact by remote means. The proportion of those who saw their adult child at least once a week (but didn't live with them) and also kept in touch through another form of contact on a weekly (or more often) basis was particularly high (89%) and in fact most of these (66%) were in remote contact with their adult child at least several times a week.

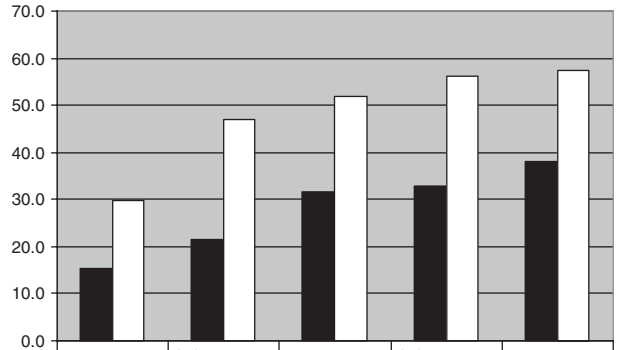
Japan stands out from the overall pattern since a very low proportion of its respondents were in touch by remote means on a weekly basis. In fact, among those who see their adult child less than once a week in Japan, less than a quarter (24%) were in contact through other means. This suggests that where Japanese older persons do not live with their adult child, they may be less likely to stay in regular contact. This may be to some extent explained by the traditional family pattern, whereby a married daughter may have little contact with adult parents as she would be considered part of her husband's family (Martin & Noriko 1991).

*Sibling*. Although siblings are less likely than children and spouses to provide instrumental support, they have been found to be important providers of support in times of crisis for older persons in general, and as particularly important sources of help for those who are single, widowed and childless (Campbell et al. 1999). The ISSP data supports this finding

showing that among those with a living sibling, people living in single person households were significantly more likely to see him/her on a weekly basis than those living in a multiple person household ($p = 0.006$). The difference was, however, more acute between those with and without children with childless respondents significantly more likely to regularly see their brother or sister than those who had one or more adult child ($p < 0.0005$) (Figure 3). In fact, when childlessness was controlled for, no significant difference was found in contact levels by household type. Higher levels of contact amongst those living in single person households therefore appears to be a confounding factor of childlessness, i.e. since those living in single person households are more likely to have no children.

Greater weekly contact was particularly significant for the childless group, with a greater proportion of childless respondents reporting weekly contact with a sibling in each of the 18 countries. However, this

**Figure 3.** Proportion seeing sibling at least weekly/monthly by frequency of contact with adult child. $n = 7131$ (71.7%), $p < 0.0005$.




| | Daily/live in same hhd | At least once a week/sev times a week | At least once a month | At least once a year/sev times a year | No adult child |
|---|---|---|---|---|---|
| ■ At least once a week | 15.4 | 21.4 | 31.8 | 33.0 | 38.2 |
| □ At least once a month | 29.8 | 47.0 | 52.0 | 56.3 | 57.3 |

difference was only statistically significant for Hungary, New Zealand and Denmark. Nevertheless, as is shown in the chart below (for the whole sample), the data suggests that childlessness, and less frequent contact with an adult child may to a small extent be compensated for by greater contact with a brother or sister.

*Distance contact*. Among all respondents with a living sibling, 39% were in touch with him or her at least once a week and 69% at least once a month. Seventy-seven percent of those who saw their sibling at least once a week were also in contact by remote means and 26% of those who did not see their sibling at least once a week were in touch through another means. Therefore, nearly half (43%) of those with a sibling were in some form of contact (either remote or face-to-face) at least once a week and the majority (69%) were in touch with, or saw their sibling at least once a month.

Those living in single person households were more likely to have regular distance contact with a brother or sister than those living with others. Forty-six percent of people living in single person households had (at least) weekly contact, compared to 38% of those living with others ($p < 0.0005$) and 71% were in touch at least once a month compared to 68% of those living in bigger households ($p = 0.041$). Those without children were also more likely to have regular remote contact with their sibling, although this was only statistically significant at a weekly level ($p < 0.0005$).

Regular remote contact declined by age. Women were more likely than men to be in touch with their sibling at least once a week ($p < 0.0005$) or once a month ($p < 0.0005$), but for both genders contact was greater for those who had no adult children. Contact was also greater for those living in single person households when controlling for gender and childlessness, i.e. for both men and women, with or without children, contact was greater when living in single person households. No significant difference was found by social class. When comparing weekly remote contact with sibling by country, the variation was greater than for adult child, ranging from over half in Italy, Spain and Hungary to only 18% in Japan.

## *Isolation from Family Contact*

Although the frequency of face-to-face contact with close family members was greatest in Southern and Eastern Europe, the similarities in level of

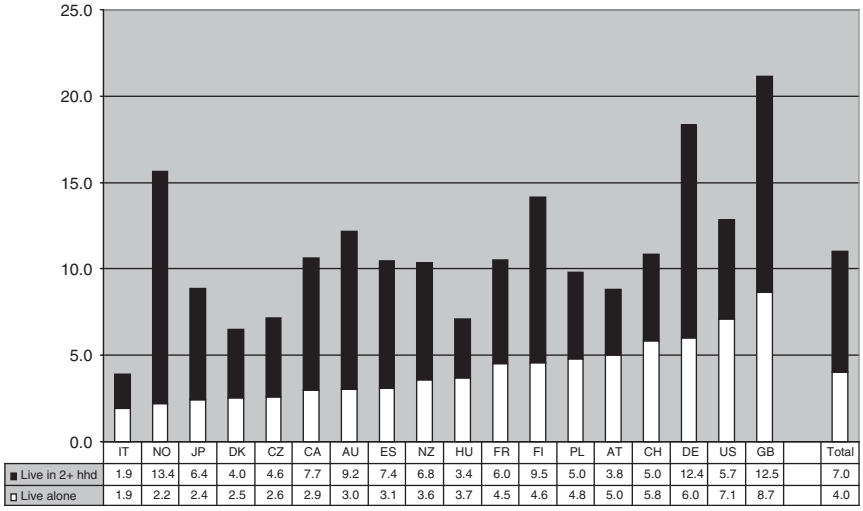
contact are perhaps most interesting with the majority of respondents from each of the 18 countries seeing an adult child or sibling at least once a week, and 89% of the whole sample reporting to have either (or both) face-to-face or distance contact with an adult child or sibling at least once a month. The remaining 11% of respondents reporting no contact with either of these relatives during an average month are, for the purpose of this analysis here defined as ''isolated''.

As shown in Figure 4, the proportion seeing either an adult child or sibling less than once a month, was smallest in Italy (1.9%) and largest in Great Britain (8.7%). There was no significant difference in the likelihood of seeing an adult child or sibling at least once a month by number in household (one or more) or by marital status. Only 4% of all respondents in the total sample lived in a single person household and fitted the criteria of the ''isolated'' family contact variable (2.8% did not have an adult child or sibling).

When the ''isolated'' group was compared with the majority group by age, gender and class, it was found that men were more likely to be isolated, since 13% of men reported no monthly contact with an adult child or sibling, which compared to 9% of women ($p < 0.0005$). Middle to upper class respondents were less likely to be isolated. However, this is largely due to the lower proportion having no living relative. The likelihood of being in the isolated group significantly increased with age for women, from 8% of those aged below 70 to 14% of those aged 70 and above.

If contact with extended family members (i.e. cousins, brothers and sisters-in-law, and nieces and nephews) are taken into account, the proportion with no monthly contact reduces to just 5.5% of the whole sample. Almost half of those with no monthly contact with a sibling or child had some contact with one of these extended relatives. However, people living in single person households were less likely to have seen an extended family member in the last four weeks ($p < 0.0005$). This was the case even when controlling for age, gender and childlessness, and this pattern was reflected in each of the 18 countries in the sample. The lowest proportion with no monthly contact with a close or extended family relative was amongst Italian respondents (2.5%) and the highest amongst those from Great Britain (11.8%). The majority of

**Figure 4.** Proportion of all respondents having infrequent (less than monthly) contact with an adult child or sibling, by household type and country. $n = 9942$ (includes those with no living relative and missing cases as no contact).



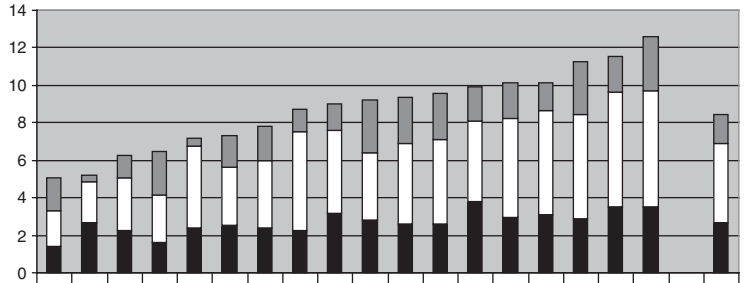

| | IT | NO | JP | DK | CZ | CA | AU | ES | NZ | HU | FR | FI | PL | AT | CH | DE | US | GB | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ■ Live in 2+ hhd | 1.9 | 13.4 | 6.4 | 4.0 | 4.6 | 7.7 | 9.2 | 7.4 | 6.8 | 3.4 | 6.0 | 9.5 | 5.0 | 3.8 | 5.0 | 12.4 | 5.7 | 12.5 | | 7.0 |
| □ Live alone | 1.9 | 2.2 | 2.4 | 2.5 | 2.6 | 2.9 | 3.0 | 3.1 | 3.6 | 3.7 | 4.5 | 4.6 | 4.8 | 5.0 | 5.8 | 6.0 | 7.1 | 8.7 | | 4.0 |

total respondents (67%) and over half of people living in single person households (58%) had some monthly contact with at least one of these extended family members.

## *Friends*

The questionnaire asks respondents about numbers of close friends in several categories, including those within the same locality, from the workplace and other friends. It also asks about frequency of contact with closest friend. These two measurements of friendship ties are discussed below.

**Figure 5.** Average number of close friends by type and country.




| | HU | ES | CZ | IT | FR | PL | DE | DK | GB | AT | FI | CH | JP | CA | NZ | US | AU | NO | | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Workplace | 1.8 | 0.4 | 1.2 | 2.3 | 0.5 | 1.7 | 1.8 | 1.2 | 1.4 | 2.8 | 2.4 | 2.4 | 1.9 | 1.9 | 1.5 | 2.8 | 1.9 | 2.9 | | 1.6 |
| Other | 1.9 | 2.2 | 2.8 | 2.5 | 4.4 | 3.1 | 3.6 | 5.3 | 4.4 | 3.6 | 4.3 | 4.5 | 4.3 | 5.2 | 5.6 | 5.5 | 6.1 | 6.2 | | 4.2 |
| Neighbourhood | 1.4 | 2.6 | 2.3 | 1.7 | 2.4 | 2.5 | 2.4 | 2.2 | 3.2 | 2.8 | 2.6 | 2.6 | 3.8 | 3.0 | 3.1 | 2.9 | 3.5 | 3.5 | | 2.7 |

*Number of close friends.* As shown in Figure 5, the average reported number of total close friends ranged from 5.1 in Hungary to 12.6 in Norway. In contrast with family contact levels, average number of close friends was found to be lowest in Southern (7.4) and Eastern European countries (7.0). In fact, there was a significant negative association between number of non-work based friends and weekly family contact (adult child and sibling) by country ($r = -0.654$, $p = 0.003$). Thus, respondents in countries with an average greater level of family contact tended to report on average a smaller number of close friends in their network.

Previous research has found a greater likelihood of older persons living in single person households or with only a spouse, to include more friends and neighbours in their social networks (Wenger 1989). The ISSP data shows little difference in overall average number of close friends between those living in single person households or in a two person household (11.4) and those in a 3+ person household (11.7), although those living in a one or two person household had a slightly greater average number of non-work based friends than those in 3+ person households. Those living in single person households had on average a slightly smaller number of close friends, but childless respondents living in single person households

had in fact more friends on average than childless persons living in a two or more person household.

The average number of close friends declined with age. However, this appears to be primarily related to the inclusion of workplace friendships held by those of working age. If total friends are compared, those aged below 70 had on average 11.8 close friends which declined to 9.4 among those aged 70 and over. However, the difference was very slight if workplace friends were omitted, with an average of 9.4 for those aged below 70 and 9.2 for the older age group. And those aged 70 and over reported to have more close friends living in their neighbourhood. The most notable decline of average number of friends was in the age group those aged 80 and over (7.7).

In terms of gender and social class, there was a reversal in the pattern identified for family contact where higher levels were found among women and those from the lower social class groups. When average numbers of close friends were compared, those in the higher strata (middle to upper class) reported to have a greater number of close friends in each category, than those in the lower social classes (working to lower middle class). Male respondents on average reported to have a greater number of close friends than women even when controlling for age, marital status, social class, household type and childlessness.

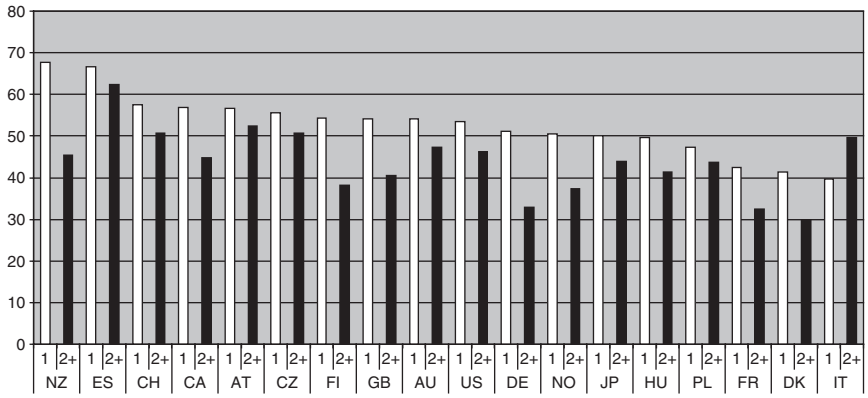
When comparing the number of average friends by country or groups of countries, issues around the cultural interpretation of such a subjective concept should be considered (Hollinger & Haller 1990: 114). There may also be gender differences in interpretation of this concept. Another issue related to this is that simply counting the number of reported friends may also not be an accurate measurement of the strength of non-kin networks because the size of the network gives no information as to the actual level of contact or support received (Keating et al. 2003: 118). Although information of this type is not fully provided in the ISSP dataset, it does include an additional measurement of the strength of friendship ties: frequency of contact with closest friend.

*Frequency of contact with close friend.* There was no significant association between number of close friends and frequency of contact with closest friend. But, countries in which respondents had on average more frequent family contact also tended to report more frequent contact with their

closest friend.[1] The higher frequency of best friend contact may indicate that respondents in the more "family-centred" countries, may be more likely to have a smaller number of more intense friendships. Indeed, Southern and Eastern Europeans were the most likely to see both their closest friend and their adult child or sibling on a daily basis.[2] However, those from the Southern and Eastern European countries were also on average most likely to report having no close friend.

People living in single person households were more likely to have reported frequent face-to-face contact with their closest friend. Over half (52%) of those who lived alone saw their closest friend at least once a week, which compared to 44% of those in a two or more person households ($p < 0.0005$). In fact as is shown in Figure 6 below, in all countries except Italy, people living in single person households had higher levels of weekly contact with a best friend than people living in larger households, and the difference was significant regardless of age and sex. A similar pattern was identified when comparing contact by marital status in that the unmarried were more likely to have regular contact with their close friend (except in Italy). Women were more likely to have weekly contact with their best friend than were male respondents ($p < 0.0005$),

**Figure 6.** Proportion of respondents who see their closest friend at least once a week by household type (living alone/2+ household) and country.



whilst middle to upper class respondents were less likely to see a close friend on a weekly basis than those classified as working to lower middle class. Employment status made little difference to levels of weekly contact.

## *Social Participation*

Participation in social and community groups has been shown to be an important indicator of non-kin network size (Burholt et al. 2003: 14) and of relational inclusion (Cavelli et al. 2007). In order to measure social participation amongst the ISSP respondents, a binary variable of participation (do/do not participate) was used in relation to participation in a political party, church or religious organisation, sports group, charitable organisation, neighbourhood group or other organisation.

The pattern of social participation by country contrasted with that of family contact in that respondents from Eastern and Southern European countries were less likely to participate in a social group or organisation than other respondents. There was a strong negative correlation by country between weekly close family contact and the percent that participate by country ($r = -0.823$, $p < 0.0005$). This suggests some support to the theory that close-knit family ties may militate against community linkages (Keating et al. 2005: 29).

However, the overall participation rate was lower among people living in single person households than those living in a two or more person household ($p < 0.0005$) even when controlling for gender. There was some variation between the countries, with Great Britain, for example, having higher participation rates among those living in single person households ($p = 0.022$). There was little difference in participation rates between the 50–64 (59%) and 65–79 (58%) age groups, but level of participation declined (48%) amongst the oldest age (80+) group ($p < 0.0005$).

For all age groups, married persons had higher participation rates, than the unmarried, although participation rates were higher for the ''never married'' than for the ''widowed, divorced or separated''. Although there were some country differences in this pattern, overall, men (61%) were more likely to participate than women (55%) even when controlling for marital status and age. Middle to upper class respondents were significantly more likely to participate ($p < 0.0005$) even when controlling for age, gender and household type and childlessness.

Although there are issues around the subjectivity of the concept of close friendship which may have an influence upon the number of friends respondents included in their network, as Hollinger & Haller (1990) note the proportion reporting they have no close friend is likely to be a significant measure of isolation. When asked how about frequency of contact with closest friend, 17% reported to have no close friend, and this group was more likely not to participate in any social organisation ($p < 0.0005$). About 13.4% of all respondents neither had a close friend nor participated in any social organisation.

Under both definitions (i.e. whether including those with no close friends or having less than monthly contact) Eastern Europeans were most likely to be socially isolated. There were, however, differences between the Eastern European countries, with Hungarians in particular being likely to report having both no close friends (a finding that was also noted by Hollinger and Haller) and no participation (32%), followed by Poles (23%), whilst those from Czech Republic were much less likely to do so (12%). Under both definitions, the Southern European region also had higher levels of "social isolation" than those from the other European and non-European countries in the sample, whilst the lowest rates of social isolation were found in Australia, New Zealand and North America.

If "social isolation" is here defined as those reported to neither have monthly contact with a close friend nor any participation in a social organisation, people living in single person households were no more likely to be socially isolated, whilst childless respondents were slightly more likely to be in this group ($p = 0.005$). The risk of isolation increased with age with 30% of those aged 80 and over in the socially isolated group compared to 23% of those aged 65–79 and 19% of those in the youngest age group ($p < 0.0005$). Working and lower middle class respondents were over two and a half times more likely to be isolated when using this definition than middle to upper class respondents ($p < 0.0005$) and the difference remained even when controlling for age and gender.

## *Severe Isolation*

The influences of various social characteristics upon the likelihood of being "isolated" from family or friendship contact and social participation have been discussed above. This section now explores the occurrence of severe

isolation, which is here defined by a combination of ''isolation'' in all three dimensions.

Only a very small proportion of respondents (3.5%) in the international sample could be defined as ''severely isolated'' in terms of reporting no monthly contact (face-to-face or remote) with either a close relative (sibling or adult child), a close friend or any involvement in social groups and organisations. This however ranged from under 1% in Italy to 6.5% in Great Britain. Nearly a quarter (23%) were found to be isolated in two of the three dimensions.

Overall, a greater risk of severe isolation (all three dimensions), was apparent for men than women ($p < 0.0005$) although the gap narrowed in the older age groups. Being unmarried increased the risk of severe isolation more for men than for women. Those from rural areas were slightly more likely to be severely isolated than those from suburban/urban areas ($p = 0.040$). For all types of areas and for both genders, working/lower middle class respondents were more likely to be severely isolated than those defined as middle/upper class. Those on a relatively low household income[3] were also slightly more likely to be in the severely isolated group ($p = 0.004$).

Risk of severe isolation increased with age, with those aged 80 and over more than twice as likely to be in this category than younger respondents ($p < 0.0005$). Those with no adult children, however, were eight times more likely to be characterised by all three aspects of isolation ($p < 0.0005$). The data suggests that the risk of isolation is not increased by living in single person households per se, but due to the confounding factors of greater likelihood of advanced age, and primarily of childlessness among those living in single person households.

Few respondents were ''isolated'' in all three dimensions, or even in the two dimensions of apparent weak family and weak non-kin ties. A large majority (almost 90%) of the sample had either at least above average contact with sibling, adult child, close friend or social participation. However, the data does not appear to suggest that those who are isolated in one dimension significantly compensate in another. Those who were isolated in family contact were in fact more likely to also be isolated in terms of social contact and participation ($p < 0.0005$). This was true for all countries in the sample, except Italy. There may, however, be some degree

of substitution for low family contact through friendship networks as those with below average frequency of family contact, reported to have a larger number of friends on average ($p < 0.0005$).

When comparing countries by regional groupings, no significant differences were found in the overall risk of severe isolation. However, the Japanese were much more likely to be severely isolated if living in single person households. Risk of severe isolation among people living in single person households was also relatively high among Eastern Europeans and almost one in five childless Eastern Europeans were severely isolated, which compared with 13% of the sample population as a whole.

## *Support Networks*

The ISSP questionnaire asks some key questions about who the respondent would turn in three hypothetical scenarios which give an indication of sources of support accessed in three different areas: emotional; practical; and financial. The questionnaire asks who the respondent would turn to supposing s/he: (a) were ill for a few days and needed some practical help; (b) were a bit down or depressed and wanted someone to talk to; and (c) needed to borrow a large sum of money. This section will compare the reported primary support networks of those living in single person households and/or have no children with other respondents, and it will also consider the impact of country, age, gender and social class. However, for want of space, this section will focus primarily on the first variable (who to turn to when ill).

Thus far, we have discussed data relating to the social networks of the participants and how these differ between people living in single person households and those living in larger households, as well as looking at differences based on other social criteria. However, one problematic issue with such social network analysis is that information regarding the size of networks and frequency of contact, tell us little about how that equates to actual support. As Walker has argued: ''One truism of network analysis is that mere presence of a tie between two people does not equate with the provision of support'' (Walker et al. 1993 cited in Keating et al. 2005: 25). Therefore, although we have shown, for example, how people living in single person households had on average more frequent contact with a

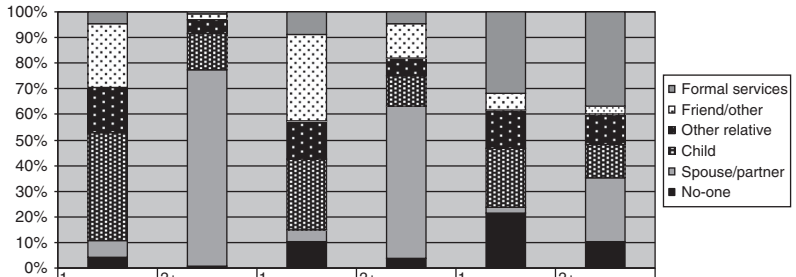
close friend, this tells us little about the role of that friendship in terms of supporting that person in everyday life. And in particular, such social network data gives us little clue about the potential caring capacity of informal ties should need arise, and the extent to which family and friends may ''rally round'' in a crisis (Cavelli et al. 2007: 23; Keating et al. 2003).

Social network analysis has found that older people tend not to mobilise the whole of their social networks for support but rather turn to their ''core network'', which is usually constituted of close kin (Keating et al. 2005; Phillips et al. 2000; Phillipson et al. 2001). Frequency of contact with close family gives one indication of the strength of these potential support networks. However, as Hollinger & Haller (1990) argue, the reduced frequency of face-to-face family contacts in Northern and Western European countries does not necessarily imply a reduction of support. As Hollinger and Haller's study of previous ISSP data found, informal support networks continue to be much more important than formal sources of support in all countries (except for borrowing money). Indeed, the 2001 ISSP data shows that formal services would only be turned to in the first instance in a very small number of cases if the respondents were ill (although more common in Western Europe).

As was found in relation to the 1986 ISSP module on social networks (Finch, 1989: 87), first impressions are that the data on sources of support, reveal more similarities between the countries than differences. Past research has found older persons to prefer to receive support from spouses than from children, other family members or friends and neighbours (Ajrouch et al. 2001). This universal importance of the role of the spouse is indeed most noticeable in the ISSP data. The data suggests that respondents are most likely to turn first to a spouse for practical and emotional support in each of the 18 countries in the sample. Nevertheless, as (Finch, 1989: 101) found in regard to Italy, respondents from Southern and Eastern Europe and Austria, were less likely to look to a spouse and more likely to state they would turn to an adult child than were other respondents. In addition, when first and second choices were combined, adult children were more commonly selected than a spouse or partner in Southern and Eastern Europe.

As shown in Figure 7, non-kinship informal contacts were more important as primary providers of emotional than practical support. In

**Figure 7.** Bar chart showing who the respondent would turn to first for support, by household type (living alone/2+ household).




| | 1 | 2+ | 1 | 2+ | 1 | 2+ |
|---|---|---|---|---|---|---|
| | Practical | | Emotional | | Financial | |
| Formal services | 5 | 1 | 9 | 4 | 32 | 37 |
| Friend/other | 25 | 2 | 34 | 13 | 7 | 3 |
| Other relative | 18 | 5 | 15 | 7 | 15 | 12 |
| Child | 42 | 14 | 27 | 12 | 23 | 13 |
| Spouse/partner | 6 | 77 | 5 | 59 | 2 | 25 |
| No-one | 4 | 1 | 10 | 4 | 21 | 10 |

fact, 18% reported they would turn to a friend first when depressed which compared with 16% who stated they would turn to a daughter or son. Again, Southern and Eastern Europeans were the least likely to select a friend (as a first or second choice), whilst non-Europeans were the most likely. Although non-kin ties may be less dependable than close family in terms of providing more intensive practical and care support, their importance in terms of contributing to the mental health and well-being of older persons in particular should not be under-estimated. Indeed, as research in the UK has suggested, the importance of friendship ties in the ''personal communities'' of older people may be increasing (Phillipson et al. 2001). The importance of support from friends was particularly evident for people living in single person households without children. Nearly half of this group (43%) said they would turn first to a friend or other non-kin informal contact (e.g. neighbour or colleague) for support when either ill or depressed. Those with more regular contact with a close friend were more likely to turn to a close friend for support and were more likely to have a larger number of close friends on average. This suggests

that stronger non-kin social ties are more likely to translate into support. It is important, however, to better understand the role of non-kin ''weak ties'', as there has been little research around their importance in the lives of older people (Keating et al. 2005: 29).

In the case of illness, people living in single person households were most likely to turn to an adult child for support than to friends and other relatives, although a daughter (29%) was more than twice as likely to be called upon as a son (14%). However, where the lone person had no adult child to turn to, a friend, neighbour or colleague was reported to be either a first or second choice contact (44%) followed by other relatives (37%) – although the reverse was true in Southern Europe where extended kin appeared to have a greater role in providing support. Childless respondents living with one or more other persons were more than twice as likely to turn first to another relative, than to a friend, perhaps due in part to the greater likelihood of co-residence with an extended family member.

When controlling for marital status, the greater likelihood of childless respondents turning to a close relative, is strongly influenced by cultural differences, particularly noticeable among those from Southern Europe. Among Southern Europeans who were married without children, only 60% reported they would turn first to their spouse (compared with 86% overall) when ill, and over a quarter (26%) to another relative (compared to less than 6% of the sample as a whole). Over three quarters of lone unmarried Southern Europeans with an adult child stated they would turn to him/her (52% to a daughter) and only 7% to a friend. In contrast, almost a quarter (23%) of Western Europeans turned first to a friend and just over half to a daughter or son (51%). People living in single person households with no adult child were also most likely to turn to another relative in Southern Europe (48%), whilst Western Europeans were the most likely to turn to an informal non-kin contact (48%). North Americans in this group were the most likely to say they would turn to no-one (13%), whilst Japanese (19%) and Northern Europeans (13%) were the most likely to state they would turn to formal services or pay someone to help.

Few persons, whether living in single person households or with others, stated they had no-one to turn to for practical (1.5%), emotional (6%) or financial (13%) help. However, the likelihood of having no-one to turn to, was greater for people living in single person households. This was

especially true for those in the ''severely isolated'' group, 15% of whom stated they would have no-one to turn to when ill, 27% if depressed and 44% if in need of a large loan. The likelihood of having no-one to turn to differed little between those who were severely isolated (i.e. in all three dimensions) and had an adult child or not (since by definition they had little contact with their adult child). Severely isolated persons also tended to be more likely to turn to formal services for help. In terms of gender, there was little difference in the proportion stating they would have no-one to turn to, despite the greater preponderance of widowhood among women. Even among married persons it is notable that females were more likely to turn to someone other than their spouse for support than males. In terms of emotional support it was particularly evident that married women were more than four times as likely to turn to a daughter and more than twice as likely to turn to another relative or close friend ($p < 0.0005$). As has been found in past research, the data suggests that support networks may differ less for women by marital status than for men (Scott & Wenger 1995: 160). Those who had no informal contact to turn to (i.e. stated they would turn either to no-one or a formal service) when either ill or when depressed were more than twice as likely to be aged 80 or over (15%) than under 80 (7%). Women over 80 were nearly twice as likely to state they had no-one to turn to when ill than men in this age group ($p = 0.018$), but there was no difference between the genders in terms of the emotional support variable. In all the age groups, males were significantly less likely to state they would turn to an informal contact to borrow a large sum of money even when controlling for household type ($p < 0.0005$).

Despite the greater likelihood of having no-one to turn to, the large majority of people living in single person households, with or without adult children could state at least two informal contacts they could turn to. As Keating et al. note, the question thus remains as to ''whether the non-married have smaller support networks because of the absence of members with normative obligations or larger networks because, in the absence of a spouse or children, they invest more in diverse supportive relationships'' (Keating et al. 2003: 119). The ISSP data does suggest though, that childless unmarried respondents compensate at least to some extent for lack of support from offspring by turning to other relatives (particularly siblings) and friends (with those living in single person

households depending to a greater extent on friends). The ISSP data also shows, however, that the make-up of support networks varies between countries. There are some broad similarities such as how, across the board most were primarily dependent on a spouse and few people stated they would have no-one to turn to for support, or that they would turn to formal services. However, the most notable difference suggested by the data is a lesser dependence on spousal support in Southern Europe even where there are no adult children to turn to. Although married Eastern Europeans and Japanese were also more likely to turn to an adult child, childless married persons were much more likely to be dependent on a spouse than in Southern Europe. This was particularly evident in Italy, where there was no significant difference by household type in having an informal contact to turn to for practical or emotional support (this was also surprisingly true of Norway where despite high dependence on spousal support in a two or more person households, very few stated they would turn to formal services or have no-one to turn to if they were ill).

The greater likelihood among Southern Europeans of married persons in a two or more person household, turning to someone other than a spouse, may be in part related to a greater likelihood of co-residence with another family member. The proportion by country turning to an adult child for support, and the proportion having their offspring living with them is, for example, strongly correlated, particularly when including only married persons ($r = 0.837$, $p < 0.0005$). However, the greater proportion turning to another family member in Southern Europe (particularly Italy) and also (to a lesser extent) in Eastern Europe and Japan, even when married and co-residing with an adult child, is perhaps indicative of differences in closeness of extended kinship ties (meaning the person requiring care is less dependent on a partner), and differing cultural expectations concerning the role of spouse, children and other kin (Attias-Donfut et al. 2005; Hollinger & Haller 1990)

## Conclusion

People living in single person households were no less likely to see their adult child than those living in a two or more person household where the respondent's adult child did not reside. People living in single person

households were more likely to have frequent face-to-face contact with a sibling, although this was due to the confounding factor of childlessness, i.e. childless respondents were more likely to have frequent contact with a sibling and people living in single person households were more likely to be childless than those living with a spouse and/or others. In addition, those living in single person households were more likely to have frequent distance contact with a sibling and no less likely to have distance contact with an adult child when controlling for age. People living in single person households were, however, less likely to have seen another extended family member in the previous four weeks. Overall, those living in single person households were more likely to be isolated from family contact when all the different family relationships were considered together. However, there was no significant difference when controlling for childlessness. Thus, people living in single person households were at a greater risk of familial isolation in terms of lack of contact with an adult child or sibling but this is mainly due to the greater likelihood of having no adult child, and the limited extent to which sibling contact compensates for this.

There was no evidence that people living in single person households were any more likely to be socially isolated on the other dimensions of friendships and social participation. They were no less likely to have a smaller number of friends when controlling for age, and in fact were more likely to have frequent contact with a close friend. They were less likely to participate in social organisations overall, but when comparing the oldest group (over 80s) there was no significant difference. For many people with below average family contact, social contact seems to compensate to a limited extent. Friends also appear to play a more important role in the support networks of people living in single person households, especially among those with no adult child. Friendship ties may compensate for the lack of close family support available to people who live in single person households and do not have children. However, there remained a small minority of people living in single person households who were severely isolated in both the family and the social sphere and stating they would have no-one to turn to when in need of support.

Overall, people living in single person households were no more likely to experience severe isolation (i.e. combined social and familial isolation). There were, however, some country differences which should be

emphasised, most notably the different pattern evident in Japan, where people living in single person households were at a much greater risk of severe isolation even when controlling for childlessness.

For the unmarried, in particular, the data also reveals the important role of non-spousal kinship ties in providing practical and emotional support, particularly in Southern and Eastern Europe, whilst non-kinship ties tended to be relied upon to a greater extent elsewhere. Again Japan differed from this pattern, clustering with Southern and Eastern Europe on the variable showing type of support preferred when ill, but being top of the ''league table'' in turning to a friend for emotional support.

This study raises some concerns about the small sub-section of severely isolated people living in single person households who were cut off from contact with both a family member, or friend, as well as having no participation in social organisations. Although living in single person households in itself does not appear to increase the risk of severe isolation, the combination of factors associated with living in single person households, such as advanced age (and worsening health), lower social class, low income and most importantly, childlessness, means that those living in single person households are likely to be at a greater risk. The fact that the data shows the small number of older people who are living in single person households and severely isolated to be more likely to have ''no-one to turn to'' for practical, emotional or financial support, remains a cause for concern. This study therefore highlights the need for policy initiatives to target this most isolated of groups and to find ways of supporting and developing their social networks. Befriending schemes through which volunteers visit isolated older people in their homes, are one example of a practical intervention which aims to address this need and combat social exclusion (Fyvie-Gauld & de Podesta 2007).

## Acknowledgements

This work is supported by an Economic and Social Research Council (ESRC) research grant: RES-000-22-2114. The findings represent the views of the authors and do not necessarily represent the views of the ERSC.

Notes

1. When correlating weekly contact for seeing adult child or sibling (valid percentage) against weekly contact with closest friend $r = 0.626$, $p = 0.005$.
2. The Japanese also scored highly on daily contact with close relative, but were much less likely to see a close friend daily.
3. However, it should be noted that household income data is relative to each specific country and not therefore strictly comparable – i.e. ''low income'' persons are computed as those whose household income falls within the bottom third of the distribution for each country.

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International Journal of Ageing and Later Life, 2009 4(1): 87–92. © The Author

# Ricca Edmondson and Hans-Joachim von Kondratowitz (eds.) (2009). *Valuing Older People. A Humanist Approach to Ageing*. Bristol: The Policy Press, Ageing and the Lifecourse Series, 312 pp. incl. comprehensive 10 pp. index. ISBN 978 1 84742 291 0 (paperback)

*Reviewed by Anita Pincas**

*Valuing Older People* is key reading for those working or intending to work with older people in any capacity, and has become a set text in my course on Issues in Educating and Training Mature Adults (50+). A short review cannot do justice to the richness of ideas, knowledge and inspiration that the volume provides.

This important book makes a much needed fervent and effective case for a humanist approach to older people. It is a pivotal work because of its contribution to the very concept of later life. The humanist vision goes beyond simplistic calls for more "personalized" approaches that focus merely on the different conditions and predilections of older persons. Edmondson and von Kondratowitz have put together a set of essays that provide a deeper rationale. Humanism encompasses spiritual and moral needs. It is fundamental to this viewpoint that there is no cut-off point at which we can be herded into a decaying older generation, however kindly; our lives are a continuous process of human development where we retain

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the element of striving towards a meaningful life, as well as a meaningful understanding of our past and future.

This is a positive view of older people, and the essays emphasise strongly that older people have developed great resources during their earlier lives, especially various forms of wisdom. In the terms of the brief *Afterwords* by Eileen Fairhurst, Sue Baines and Ronald J. Manheimer, the book explores positive images of ageing and is thus a gateway to a more humanistic gerontology than has been evident heretofore.

Therefore, the editors' opening introduction addresses *ageing* rather than gerontology or old age, and thus sets the scene for an exploration of debates about what is meant by our social understandings of the later part of the life course. They present a broad definition of what the book's title refers to, i.e. what it means to value older people: ''comprehending them *as* people, not treating them as strangers whose predicaments are foreign to those of others'' (p. 1). This implies making good the ''deficit in attention to norms and values pursued by older people ... situating (them) as equals in a human predicament we share'' (p. 2). Further, ''if ageing is to involve a process of continual negotiation about ways in which capacities and world views are bound together, this negotiation needs to be shaped by humanistic standards ... and by a commitment to older people as *co-equal members of society*'' (p. 2, reviewer's italics). Above all, we need to remember that the later years do not entail losing our spiritual search for the significance of life: ''Questions of meaning associated with the life course are not additions to gerontology, but should lie at its heart'' (p. 3).

The book argues for serious change in public policy and private attitudes, towards accepting ageing as an integral part of the life course. It is not enough to recognise that older people are as diverse as younger people (which seems to be all that personalisation asserts), but that they continue to be as spiritual and goal-directed in their individual ways as they were when younger. Their psycho-spiritual well-being is as crucial for them as personalised care. The introduction ranges very widely over common approaches to older people. One of the most significant sections describes the failure of *critical gerontology* to move beyond critique of how older people are treated by mistaken cultural–historical or politico-economic polities. Thus it fails to acknowledge ''ageing as a process of creating meaning, one carried out by older people but affecting those

around them, and affected by the norms and values of societies in which they live'' (p. 13).

After the Introduction, the book falls into three parts that take up a variety of approaches to the humanist theme, illustrating their case with numerous instances from their research. All chapters have a common thread running through them, emphasising the need for more humanist social theory and principles for engagement with older people.

Part One – **Religion, spirituality, cultural resources and creating meaning** – contrasts Western European religious perspectives on ageing and religion (Peter G. Coleman) with the role of spirituality in ''an ageing Singapore'' that is multicultural and multi-religious (Kalyani K. Mehta). The third chapter gives a revealing insight into the findings of a longitudinal California study, describing how ''the sacred'' is integrated into ''creative ageing'' for some Americans (Michele Dillon). This is followed by a strong counterpoint with the overview of secularisation in the former East Germany, where a reawakening to ''agnostic spirituality'' has been taking place, especially among younger family members, while the older generations have largely held on to more traditional views (Monika Wohlrab-Sahr). The final essay in this section (Haim Hazan) is a passionate denunciation of the ''continuous process of constructing ageing, highlighted by landmarks such as retirement, resignation to sociopsychological disengagement, the rise in structural dependency and the growing awareness of ageist exclusionary messages...shifting the linearly narrated plot of a meaning-driven life course to a lateral, present-bound world, governed by activities of daily risk management'' (p. 96). Baurdrillard's suggestion (*Symbolic Exchange and Death* 1993, p. 163) that the Third Age is like the ''economically parasitised'' Third World is accepted with the proviso that we need to add to it a perception of ''the colonizing condition where boundaries are blurred, but domination prevails'' (p. 97).

Part Two – **Norms, values and gerontology** – opens with von Kondratowitz' superb historical account of how old age has become ''increasingly generalized'' by ''an implicitly dominant normative agenda (that) consists in the invention of the category of 'generation' '' (p. 115). The new category has ''its foundation in ageing, mortality and reproduction'' (p. 115) and obviously underlies the principles and practices of our

educational system. Although von Kondratowitz does not make this inference, it seems evident that the age-driven educational hierarchy directly leads to the current hold-all category ''adult education'' that fails to differentiate meaningfully beyond post-school learning. However, von Kondratowitz sees hope in today's ''emergence of new normative frameworks such as 'successful ageing' and ... 'active ageing'" (p. 120).

The other chapters take up various humanistic themes related to generational treatment of older people. Intergenerational balances, contacts and relationships in Europe show the current ambivalences towards responsibilities for family care (Svein Olav Daatland) while the ''double crisis'' of pension systems and the challenge of reform is discussed in the light of European public opinion surveys that point to far more support for raising contributions than policy makers expected (Dina Frommert, Dirk Hofäcker, Thorsten Heien and Hans-Jürgen Andreß). A recent study of ''residents' and staff's perceptions of quality-of-life issues in residential care settings'' (p. 161) presents evidence related to a range of significant issues: autonomy, personalisation, sense of self, personal appearance, individuality, privacy and self-respect (Adeline Cooney and Kathy Murphy). In the penetrating final chapter here, Peter Derkx discusses the moral dilemma of extending the human lifespan in the light of clinical advances and asks us to consider that a ''technological fix for existential problems will not work and might make matters worse'' (p. 190). This whole set of chapters can be seen as a humanist contribution to publications such as those of the *Journal of Population Ageing* where, for instance, different ways of forecasting future demographic patterns can lead to different economic strategies.

Part Three – **Ageing and wisdom? Conflicts and contested developments** – brings to the fore the dominant achievement that all societies value in older people: a higher degree of wisdom. Starting from the wonderful insight that ''the idea that it is *possible* to become wiser today than yesterday could offer meaning and purpose to personal survival, to the presence in society of older people in general and to the practice of respecting them'' (p. 201), Edmondson explores the topic of wisdom with its implications for policy and behaviour, and shows what a fundamental role it has played in many if not all cultures. Regrettably, it is too often ignored or played down in western societies, and is not acknowledged in

the literature and discussions of ageing. A humanist approach to valuing older people would recognise the success of wise individuals or interactions ''in moving others to positions in which they can see, feel or act in new ways'' (p. 211). Edmondson points out that wisdom should be understood as a more strongly social phenomenon than has been imagined heretofore – a claim with considerable social and political consequences.

The opening chapter is followed by an outline of ''wise social practices'' (p. 217) and moral frameworks with religious values in the lives of older people in Ireland. It investigates the role of churchgoing in developing strong communal values and in maintaining spirituality, quite often without religious beliefs (Carmel Gallagher). In a particularly revealing essay on active ageing, Lorna Warren and Amanda Clarke analyse older individuals' views in comparison with those implicit in policy slogans, and conclude that ''active ageing as it is thought about by our interviewees actually depends on a perceived sense of freedom that older people may subsequently choose to use in helping others'' (pp. 234–235), particularly through passing on their experience and wisdom (p. 242). James Nichol deals with issues of wisdom while investigating the question: ''Does eldership mean anything in the contemporary West?'' The term is not commonly used in discussions of ageing, having its origins principally in contexts where an elder is an older, influential member of a family, tribe, or community, e.g. ''an elder of the Church'', though generally indicating an experienced, wiser person. Interestingly, the participant interviewees (British people aged 65 to 81) rejected eldership as an identification, preferring ''a conception of 'mature' peership and of mature peer groups as potential spaces for mutual recognition, reflection and a sense of shared experience, yet also affirming a belief in later-life development and contribution'' (p. 249). It was clear that ''they believed ... that they had something distinctive to offer'' (p. 258).

For some readers, the final chapter might well have come earlier, since it describes how a situated discourse analysis can unpack ambivalent attitudes held by and towards older people. Real life discourse about ageing is often self-contradictory, thus showing up the confusion that talk about old age, health and morality reveals. This method of analysis looks as closely at the ''ways in which people converse'' (p. 261) as at the

meaning they seem to convey. The findings were that the older people interviewed were not confident about their own wisdom, but this might be because their social milieu did not reinforce it. The chapter is a useful introduction to the special edition of *Ageing and Society* (2009) Volume 29 Issue 6, where all papers analyse spoken discourse (Outi Jolanki).

To conclude, the humanist enterprise heralded by this book is an on-going project. If it tells us anything, it is that all of us, both as sociologists of ageing and as members of society, need to pursue such an approach.

# IJAL

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**eISSN 1652-8670**