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CHAPTER 2

Social Gerontology

Nancy Brossoie, PhD
Walter C. Chop, MS, RRT

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SUMMARY

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BEHAVIORAL OBJECTIVES

Upon completion of this chapter, the reader will be able to:

1. Define gerontology and how it differs from geriatrics.
2. Define ageism and explain why it is harmful to the health and well-being of older adults.
3. Identify and describe some of the social roles adults might hold in later life.
4. Describe the importance and focus of social relationships in late life.
5. Define elder abuse and describe the general characteristics of victims and abusers.
6. Define mandated reporter and describe the signs of potential abuse.
7. Explain why some older adults choose to work in late life

KEY TERMS

AARP
Activity theory
Adult Protective Services
Ageism
Bio-psycho-social
Caregiver
Continuity theory
Convoy of support
Discrimination
Disengagement theory
Elder abuse
Fictive kin
Geriatrics
Gerontology
Grandfamilies
Infantilizing
Long-distance caregiver
Long-term care ombudsmen
Mandatory reporters
Older adults
Older Americans Act (OAA)
Polyvictimization
Sandwich generation
Skip-generation household
Self-neglect
Senior Service America (SSA)
Social roles
Social Security
Stereotypes
Trusted individual

Gerontology

The aging process begins the moment we are born. As we age, our bodies and minds grow, develop, and mature. During childhood, the course of our development is influenced by many factors, including our personal characteristics, our family background, how we are raised, where we grow up, and who raises us. Similarly, our development through adulthood continues to be influenced by our health, attitude, and behaviors and our interactions with family, friends, and the environment around us. Therefore, it is shortsighted to limit discussions about aging to matters of physical health and decline. Aging is a complex process influenced not only by health, but also by many other personal and social factors.

Gerontology is the scientific study of aging that examines the biological, psychological, and sociological (**bio-psycho-social**) factors associated with old age and aging. The factors that affect how we age are broad in scope and diverse: biological factors include genetic background and physical health; psychological influences include level of cognition, mental health status, and general well-being; and sociological factors range from personal relationships to the cultures, policies, and infrastructure that organize society.

Although sometimes confused with the term gerontology, **geriatrics** is a medical term for the study, diagnosis, and treatment of diseases and health problems specific to **older adults**. Geriatricians (medical doctors who specialize in geriatrics) increasingly recognize

the importance of social and psychological influences when treating patients. In this chapter, key issues in gerontology are presented to facilitate your understanding about the lifestyles of older adults and how these may influence health status.

In the field of social sciences, the term older adults is used to describe people age 65 years and older and is the preferred term when speaking about older individuals. The term **patient** is medically oriented and can refer to a person of any age. The term **elderly** has the social connotation of being white haired and frail. Because many people age 65 and older do not have gray hair and live vibrant healthy lifestyles, the term **older adult** has a more positive connotation, and therefore is preferred and used in this chapter.

Historical Perspectives on Aging

Throughout history, older adults have been generally valued for the experience, insight, and wisdom they can share with others. Leadership is frequently bestowed upon older adults because of a social belief that wisdom and experience are acquired over time. However, conferring respect and responsibilities to older adults has not been consistent, and tends to occur more in preindustrial or agrarian societies where families are intergenerational and family members are dependent on one another for survival and support. For example, in 2004, hours before a tsunami in the Indian Ocean reached the shore, villagers from small fishing communities followed the leadership of their village elders and fled to safety. The suggestions of the elders were followed because the elders held the respect of the others and possessed the ability to interpret environmental cues that signaled impending danger, cues that were passed down to them from village elders long ago (Associated Press, 2004).

The image of the "wise old person" may be hard for those of us in the West to conceive, but in Eastern and indigenous cultures this is commonplace. West African teacher and author Malidoma Somé relayed the following description: "An elder is a repository for wisdom of the ancestors, the culture and the tribe. He or she is familiar with the various protocols for maintaining relationships with the other world and is keeper of the various 'recipes' that sustain the soul and spirit of the community. When elders are absent there is chaos and instability. The young are in charge but don't know where they are going" (Goodman, 2010, p. 415). Perhaps, we in the West can listen and learn from our elders as these other cultures do.

In industrial societies, older adults are generally less valued than they are in agrarian societies. During the 20th century, as industrialization in the United States expanded, family members became less dependent on each other for support, frequently leaving older adults to manage for themselves, which resulted in many older people living in poverty. In 1964, President Johnson launched the War on Poverty, which fought for institutionalizing civil rights, opportunities, and social services for all poor Americans to help lift them out of poverty. From that initiative, the **Older Americans Act (OAA)** of 1965 was passed into legislation. It specifically included language to address the needs and rights of older adults. The OAA is expected to be reauthorized indefinitely as one piece of legislation that represents the U.S. commitment to promoting the rights and welfare of older adults.

Theories About Aging

Theories are used to guide research and help us make sense of the world around us. By using theory, we can better understand why individual behaviors or actions occur. In the early 1960s, when gerontology was a new field of research, the first psychosocial science theory on aging called **disengagement theory** was

proposed by Cumming and Henry (1961). Guided by their observations of older adults in society, they proposed that older adults recognize that their health and abilities decline over time and their time as industrious citizens is limited before they die. In response, older adults intentionally remove themselves from their **social roles** and responsibilities to allow younger and healthier adults to take their place as productive members in society. At the time it was developed, the theory aligned well with social norms and social expectations of older adults. Society pressured adults to retire from the workplace at a preset age (e.g., mandatory retirement ages) and to relinquish their social responsibilities to younger people. However, the utility of disengagement theory was limited, because it did not it account for differences among individuals and did not accommodate the fact that if social norms were not enforced individuals would be less likely to disengage from life as the theory postulates.

In response to disengagement theory and to develop a better framework for examining old age, Havighurst (1961) attempted to explain aging through the use of **activity theory**. He posited that older adults are happier and healthier when they remain engaged in daily life and social interactions. He also suggested that as opportunities to be active change, older adults simply replace them with new ones to maintain their health and well-being. Although widely accepted as a positive view of aging, critics of activity theory suggest that it discriminates against individuals who do not have the resources to remain engaged or the interest in maintaining an active lifestyle.

The third major psychosocial theory used in gerontology is **continuity theory**. Originally proposed by Maddox (1965), it was further developed by Atchley (1989), who theorized that people remain consistent in how they live their life, manage their relationships, and exhibit their personalities even though they experience changes in their physical, mental, and social status. Continuity theory can be used to help us understand the process by which older adults make decisions throughout adulthood. However, critics of continuity theory suggest it is based upon a healthy, wealthy, and male-oriented social model, and as such does not adequately account for the implicit social constraints placed on women, the chronically ill, or the role of social welfare programs in the lives of impoverished and needy older adults.

Social and behavioral scientists continue to build upon the three core theories to gain a better understanding of aging. Using a bio-psycho-social approach, they combine the theoretical frameworks from the fields of psychology, sociology, and biology. They may also examine an issue utilizing a nuanced perspective (e.g., life course, feminist) or lens (e.g., LGBTQ, immigrant), which can open a window into the experiences and needs of the unique and often hidden populations not identified in other research. Our understanding of social science theories has grown exponentially in the last 50 years and is expected to continue at a fast pace as our aging population grows.

Ageism

How we treat older adults is influenced by many social factors, including our own personal assumptions, expectations, and fears about growing older (Butler, 1969, 2008; Richeson & Shelton, 2006). Fears about aging are often based on our lack of understanding about the aging process. Unfortunately, many people believe that old age means being burdened with or suffering from physical disabilities, poor health, the inability to think clearly and quickly, and possessing a negative outlook on life. These inaccurate assumptions are examples of **ageism**, that is, the systematic labeling and **discrimination** against people who are old.

Ageism is based on **stereotypes**, myths about aging, and language that conjure up negative images of older adults. Ageism is to

old age as racism is to skin color and sexism is to gender. Ageist thinking is detrimental to society and can result in limited opportunities (e.g., employment and workplace discrimination) and reduced access to resources (e.g., healthcare discrimination) for older adults. In its worst form, ageism leads to **elder abuse**, mistreatment, and neglect (Butler, 2008).

Ageist Stereotypes

Ageist comments place older adults into set roles or categories called stereotypes. For example, older adults are sometimes characterized as senile, grumpy, set in their ways and mannerisms, and slow to accept new ideas and learn new skills (**FIGURE 2-1**). Similarly, older adults also may be portrayed as eccentric or overly happy about life, perceiving it as rosy and carefree. When young family members witness ageist stereotyping in their own families and communities, they are likely to engage in ageist practices and thoughts themselves, as it can lead them to believe that older adults are different and perhaps unworthy of respect and kindness. Similarly, older adults who are subjected to ageist stereotyping often begin to accept the stereotypes as true, which consequently compromises their health, well-being, and longevity (Levy, Slade, Kunkel, & Kasl, 2002).

FIGURE 2-1 Most older adults are active, productive and enjoy their lives.

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Ageist attitudes permeate all facets of society, especially when money is involved. Negative connotations about older adults being "greedy geezers" first surfaced in the March 1988 issue of the magazine *The New Republic*. In that issue, older adults were described as wealthy with financial and social advantages, yet eager to siphon public money (e.g., **Social Security**) that should be dedicated to poor and needy children (Tagliareni & Waters, 1995). However, it must be realized that older adults paid into Social Security their entire working lifetime, and thus expect and are owed remuneration. Over the last 50 years, there has been a gradual improvement in attitudes toward older adults in the United States, thanks to greater public education and awareness, the OAA, and increased media attention. This, however, has done little to reverse deep undercurrents that run below the surface of ageism, as some people continue to view older adults as drains on public resources.

Myths about Aging

Older adults are not a homogeneous group. Even though collectively they may represent the same ideals and have shared the same historical experiences, they do not all look, think, or act alike. Older adults are as unique as members in any other group of people. Therefore, making blanket assumptions and generalizations about older adults simply perpetuates myths. The following statements are examples of myths that promote ageism. Although the statements may be accurate for some individuals, they are not true for older adults as a cohesive group (Butler, 2008; Richeson & Shelton, 2006; Palmore, 1990):

Myth 1: Older adults are either very rich or very poor.

Myth 2: Older adults are senile (have defective memory or are disoriented or demented).

Myth 3: Older adults are neither interested in nor have the capacity for sexual relations.

Myth 4: Older adults are miserable and unhappy with the state of their lives.
Myth 5: Older adults are very religious.
Myth 6: Older adults are unable to adapt to change.
Myth 7: Older adults are unable to learn new things.
Myth 8: Older adults generally want to live in nursing homes.
Myth 9: Older adults urinate on their clothing.
Myth 10: Older adults tend to be pretty much alike.

Ageist Language

Ageist language is insensitive to older adults, because it is used without much thought or understanding of how ageist terms hurt and degrade the individual. Some ageist terms include:

Geezer
Hag
Q-tip
Boroi (Japanese slang for old and worn)
Old duffer
Dirty old man
Old coot
Biddy
Fossil
Blue hair/Q tip
Old buck/codger
Old battleax
Little (or dirty) old lady

Ageist phrases used in conversation also disparage older adults:

Over the hill
Old school
Out to pasture
Older than dirt
Gone senile
Set in their ways
One foot in the grave
Ol' man ____ (fill in name)

Ageist Attitudes of Healthcare Professionals

Unfortunately, healthcare professionals are not immune to promoting ageist attitudes when treating their older patients (Alliance for Aging Research, 2003; Simkins, 2007). Providers who view older adult patients sympathetically as "poor old dears," who can do little to care for themselves, are actually placing little value on their patients' abilities. Calling an older patient "honey" or "dear" may be socially acceptable in some cultures, but generally carries a negative connotation. **Infantilizing** older adults by talking to them as if they were children with limited understanding, immature, or weak actually encourages dependency, because it devalues personal autonomy and individuality and does not promote person-centered care.

Other ageist terms used by medical professionals in describing patients in conversation or in medical charts include (Anti-Ageism Task Force, 2006):

"The wheelchair (or the stroke, hip fracture, etc.) in room number. . . ."
MFP (measure for pine box)
VAC (vultures are circling)
Bed blocker
GOMER (get out of my emergency room)
TMB (too many birthdays)

Research has shown that healthcare professionals are significantly more negative in their attitudes toward older patients than they are toward younger patients (Simkins, 2007). Although not appropriate, their negative attitudes can be attributed to several reasons:

- A need to justify why the medical needs of their older patient were not addressed or met.
- Feelings of frustration about not being able to manage the demands of the job.
- Feelings of helplessness due to not being able to save or cure patients' medical problems.
- Increased awareness or reminder of one's own life and mortality.

Awareness is the first step in overcoming an ageist attitude. To avoid making ageist comments and remarks as a healthcare professional, it is important to recognize and explore your personal feelings and attitudes about growing older. Stopping the spread of ageism is everyone's responsibility and starts at home.

Media Stereotyping of Older Adults

The media regularly perpetuate the stereotypes of older adults through inaccurate and sometimes demeaning portrayals of older adults in print, advertising, and entertainment. This is puzzling considering that older adults have the ability to purchase the products supporting the media, and thus should be able to facilitate changing attitudes in the industry. Yet, limited efforts have been made to alter how older adults are depicted. Perhaps, as more members of the baby boom generation reach old age, positive changes will emerge.

The entertainment industry plays a major role in perpetuating stereotypes. More often than not, older adults are portrayed as comical, stubborn, eccentric, and foolish. They are also often depicted as narrow-minded, sickly, poor, sexually dissatisfied, and slow to respond (Hilt & Lipshultz, 2016). Movie scripts tend to feature older adult characters only when they are reclusive (*Finding Forrester*), offer some extraordinary skill (*Space Cowboys*), dying (*The Notebook*), or facing their own mortality (*The Bucket List*). It is uncommon to watch older adult characters on the big screen portraying everyday people (*Return to Me*) in a manner that does not romanticize their lives (*Cocoon*), portray them as behaving comically (*Grumpy Old Men*), or proliferate the expectation that most people will get dementia (*Nebraska, Iris, On Golden Pond*).

Television show scripting is no different. Although we do see older adults on special programming, it is unusual to see a realistic portrayal of an older person on a television show (Hilt & Lipshultz, 2016). Again, this network programming decision is puzzling, considering that television shows are targeted for specific demographic audiences who are apt to buy the sponsors' products. Older adults watch television more than any other age group and generally have the discretionary income to buy the products advertised during commercials (Hilt & Lipshultz, 2016). Yet, limited efforts have been made to accurately depict the lives of older adults on television, with the exception of selected actors such as Jane Fonda, Lily Tomlin, Judi Dench, Betty White, Maggie Smith, and a few noteworthy others.

Print and television advertisements also tend to portray older adults at their worst—when they have some kind of physical ailment or have the desire to look and feel younger. We see older actors in commercials for laxatives, skin moisturizers, gas elimination medications, analgesics, and hair coloring products, just to name a few. This would not be as detrimental to the image of the older adult if we also saw older adults in other types of commercials advertising general use products.

Social Roles in the Second Half of Life

Social roles are useful in identifying, defining, and validating each member of a society. A social role not only defines a position, but also supports social norms and expectations that dictate behaviors and attitudes within social groups such as families, workplaces, and communities. Some social roles remain with us throughout our lives (e.g., friend, cousin, daughter), whereas other roles change or transform as new levels of accomplishment or development are reached. For example, a person may transition from being a student to a teacher or from a worker to a retiree. In late life, social roles are more apt to remain constant (e.g., neighbor, club member, and community resident); however, the level of participation in those roles may fluctuate as changes in health, finances, and mobility occur. Nonetheless, older adults continue to participate in many of their social roles, even when faced with diminished capacities and capabilities (Ferraro, 2001). Three new roles often taken on in the second half of life include retiree, grandparent, and **caregiver**.

Retiree

For many retirees, adjusting to changes in social role and status that accompany leaving the workforce can be difficult. When they were employed, they were granted a status that provided them with respect and support from their colleagues, friends, and acquaintances. However, transitioning from a position of daily recognition and involvement to one with limited recognition and possible isolation from other individuals can be psychologically difficult (Wang, 2007). Although no single solution exists for making the social adjustment into retirement, it can be made easier with planning and preparation. Retirement planning advisors strongly suggest that in addition to financial planning, older workers plan their retirement routines, hobbies, habits, and social interactions, so that they can remain engaged and socially connected, which will enhance their quality of life. Additional information about retirement planning is provided in this chapter under the heading Employment and Civic Engagement.

Grandparent

Grandparenting is a social role that many adults look forward to once their children leave home and establish their own lives. Because people are living longer, it is not uncommon for older adults to take on the role of great-grandparent or even great-great-grandparent. The U.S. Census Bureau estimated that approximately one in four adults in the United States were grandparents in 2010 (MetLife Mature Market Institute, 2011).

Grandparents generally welcome interactions with their grandchildren as a chance to relive their early years without balancing the stresses and responsibilities of caring for their own children the first time around. Grandparenting also offers them the possibility for sharing their wisdom and lived experiences with their grandchildren. A new grandchild can also be like a booster shot for some older couples, reawakening early days of marriage and the enthusiasm of early parenting (Berkman & Breslow, 1983).

Not surprisingly, the role of a grandparent is as varied as any other social role. Grandparents share multiple roles and responsibilities within families, and as such can be described as one of five distinct types (Neugarten & Weinstein, 1964):

- Distance figures (live far away and visit infrequently)
- Fun seekers (provide and engage in exciting opportunities)
- Surrogate parents (take on a parenting role)
- Formal (as patriarch or matriarch of the family)
- Reservoirs of family wisdom (sources of knowledge and expertise)

Yet, the role of a grandparent is not static. The role of a grandparent today needs to be responsive to the needs of the extended family. In the United States, one of the most important roles of a grandparent is that of a caregiver (**FIGURE 2-2**). Grandparents can support grandchildren in the broadest sense by providing child care, paying educational costs, and sometimes providing the deposit for large expenses such as a new house. The toy industry, especially, likes grandparents because they purchase approxi-

FIGURE 2-2 Grandparents often take on a surrogate parent role.

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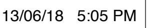

mately 25% of all toys, 40% of all children's books, and 20% of all children's video games (Howe, 2016).

Surrogate Parent

Increasingly, more grandparents are assuming a primary parental role in raising their grandchildren. In 2015, the U.S. Census estimated that 2.6 million grandparents had full responsibility for providing for their grandchildren's basic needs. Among them, one million children did not have a parent actively involved in their lives (U.S. Census Bureau, 2017a). These **grandfamilies** or **skip-generation households** are largely formed due to substance misuse (e.g., opioid addiction and alcohol dependence) and incarceration of parents (i.e., the grandparents' adult children).

The role of becoming a surrogate parent in late life can be demanding because it requires engaging in all aspects of a child's life, including associating with teachers and other parents who are much younger. This new social role can be quite fulfilling and simultaneously challenging—especially when undertaken with a fixed retirement income, managing personal health problems, balancing personal needs with parenting demands, and having to cope with the social stigma attached to the adult child's inability to parent. More and more communities are establishing community support programs for grandparents in an effort to provide a way to connect grandfamilies, help grandparents learn how to navigate social service systems, and provide needed counseling and legal resources.

Caregiver

Becoming a caregiver for a spouse, family member, or friend is another social role most people do not think about until they find themselves faced with providing care. An estimated 14.3% of all U.S. adults are a caregiver to person age 50+ (National Alliance for Caregiving & AARP Public Policy Institute, 2015). Caregiving responsibilities can emerge slowly or start suddenly after an illness or accident. Sometimes, the need for assistance is so imperceptible that neither the caregiver nor the care recipient recognizes the full extent of decline over time. For example, providing care to a spouse can be a lengthy and subtle process with the tasks gradually increasing in intensity before transitioning into a full time job and before other family members are even aware of the need.

When that time comes, adult children are apt to intervene, even though they are ill-prepared to take on the caregiving role. Although each family is different, researchers have found a common pattern in family caregiving within the United States. Generally, older adults depend on the oldest daughter (or daughter-in-law) to provide assistance with activities of daily living and rely on the eldest son for support with financial and estate matters (Suitor, Pillemer, Keeton, & Robison, 1996). This does not mean that other family members will not be asked to help or will not offer to help. It simply means that, culturally, older adults expect specific assistance from these offspring.

In many families, adult children are unaware of the daily routines, habits, and needs of their parents until a health crisis arises and additional support in the home is needed. Like their children, most older adults want to live independently and do not want to live with other family members (Bursack, n.d.). They also do not want to share their financial information or include their children in their decision-making processes. Older adults want to retain control over their lives. So, it comes as no surprise that many older adults resist accepting the role of care recipient. They are unwilling to relinquish their roles and responsibilities to other people, even when they know they could use help. Out of pride, some older adults remain adamant about not accepting support until they reach a point where they cannot function without it.

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When additional support or care is needed, approximately 83% of support received comes from family members (National Alliance for Caregiving, 2005). One study estimated that 24% of caregivers of older adults lived with the person they were caring for, 42% lived within 20 minutes away, and 15% lived more than 1 hour away—referred to as **long-distance caregivers**. Nearly 7 million Americans are long-distance caregivers for an older relative (MetLife & National Alliance for Caregiving, 2008).

As family caregiving evolves and continues over time, it can demand more of the adult child caregivers' time, leaving less time for family care involving their own children. This can be especially challenging for caregivers simultaneously providing care to two or more generations. Adults found in this position are often referred to as the **sandwich generation**, because they are caught between two caregiving roles—caring for a child and caring for a parent (or even a grandparent).

Social Roles in Context

Most Western societies, including the United States and Western Europe, stress individualism (i.e., the needs of the individual are addressed before the needs of the group). Other cultures such as those found in Asia and the Pacific Islands are collectivist societies; that is, members place the needs of the family or collective group (which may be an intergenerational family) before the needs of the individual. Differences between individual and collective perspectives naturally inform how groups perceive older adults and place responsibility for providing care and support. Understanding how groups differ can assist in the planning and provision of effective healthcare services, no matter where the care is provided.

In an individualistic society, older adults are generally free to remain living independently and managing life as they see fit as long as they can afford it and they are not placing themselves or others in immediate danger. In a collectivist society, the resources of the older adults are pooled with other family resources. The activities of daily life are shared rather than lived separately. As a result, living expenses are reduced because the older adult lives with other family members. For example, in India, when a parent joins a young household, he or she is welcomed as a member of the household. Even though the household may not have planned to include the older adult, family members willingly make accommodations for the aging family member (Pinto & Sahur, 2001). In a Filipino household, the youngest daughter is expected to care for the older adult at home until she marries, and then moves the older adult with her to her husband's home (Torres, 2002).

The social role of the older adult within the household also varies by social expectations. Ethnic groups that revere elders as authority figures enable the older adults to reside in positions of power within the family and community. Other ethnic groups take an almost opposite view and see older adults in terms of added responsibility, if not burden, to family and society.

In the Vietnamese culture, a grandparent shares household authority with the father of the household. His or her place in the family is highly regarded (Hunt, 2002). In contrast, in the old Athabascan Indian culture in Alaska, older adults were seen as burdens—a drain on food and resources in the harsh and demanding climate. Older adults were expected to contribute as much as possible until the day when the chief of the tribe would leave them to die in the wilderness in an effort to preserve resources for the healthy and strong members of the tribe (Wallis, 1993).

Family life and respect for the knowledge and wisdom of elders are central to Asian culture. This has, however, decreased somewhat in the Asian American population with

modernization and assimilation into American society. However, Asian cultures remain strongly collectivistic and believe family life is central to their existence (Brightman & Subedi, 2007; Kim-Rupnow, 2001).

Even though collectivism may appear to be an effective approach to managing family and social resources, sometimes it has not been perceived as beneficial to people with disabilities, including dementia. They are often viewed as an embarrassment to the family because they are not strong enough to contribute their fair share of family responsibilities. As a result, they are frequently disowned, abandoned, and left to beg on the streets to get their needs met, further increasing the collectivist society's disdain for them. Because individuals with special needs (i.e., physical, cognitive, and/or behavioral) generally do not have strong support from within the collectivist society to lead a productive and successful life, they are challenged to determine their own life course (Jezewski & Sotnik, 2001).

In the United States and in other individualistic societies, the strong belief in individualism has produced legislation that has protected the rights of people with long-term disabilities (e.g., the Americans with Disabilities Act) and has provided accommodations for people with physical and mental health needs in communities and the workplace. Coupled with legislation through the OAA, significant strides have continued to be made to ensure that older adults are legally protected to lead full and productive lives.

A great deal of research has been conducted in the United States on family dynamics and the roles and responsibilities of family members. The United States has become a mobile and independent society in which intergenerational households and the strong reliance on family as a source of sole support are no longer the norm. Yet, among some racial groups such as African Americans, families still tend to maintain extensive kin networks to provide help, especially to young family members and neighbors. Community-based institutions such as the church are also viewed as very important sources of physical and emotional support. Similarly, Hispanic Americans, who make up 17.8% of the U.S. population (U. S. Census Bureau, 2017b) maintain close family relationships that promote family solidarity. They have more contact with their children than their non-Hispanic counterparts (Garcia, 2001). As the number of older adults surpassing age 65 increases, additional studies will need to be conducted to examine how different ethnic groups are coping and meeting the needs of their aging parents.

Social Relationships

Personal Relationships

Maintaining social relationships contribute to better physical health and provide emotional and psychological benefits, including better sense of belonging, increased self-worth, and feelings of security—all of which contribute to improved psychological well-being (Qualls, 2014). The importance of retaining personal relationships does not diminish as one ages. Older adults desire and engage in social relationships like younger adults, although their relationships are likely to reduce in number and type. Opportunities to socialize are also likely to lessen when personal health declines or mobility becomes more difficult.

Research on personal relationships has also shown that as we age and our health declines, we intentionally distance ourselves from some of our relationships, retaining only the ones from which we can benefit and know we can maintain (Berkman & Breslow, 1983). We do this because we recognize that relationships should be reciprocal. If we no longer have the ability, energy, or resources to exchange support, we let go of those relationships. The people we choose to retain in our

social circle in late life tend to be people from whom we draw strength and value the most, like family members. Kahn and Antonucci (1980) aptly described the evolution of personal social network as a **convoy of support**, moving with the individual through life challenges and transitions. Relationships maintained in late life can serve a variety of purposes and take place within a variety of contexts. The following sections provide additional insights into some of the different types of relationships older adults enjoy and how they maintain them.

Computers and Social Media

Computers play a large role in keeping older adults connected to family and friends, reconnecting old friends, and developing new relationships. Accessing the Internet is gaining popularity as friends encourage friends to "get connected." A 2017 study by the Pew Research Center (2017a) indicated that 67% of adults age 65+ used the Internet, and among them 75% went online daily. Fifty-one percent of all older Internet users had Internet service in their home. All older Internet users tended to be more educated with higher incomes than nonusers. Similarly, owning a tablet or eReader (e.g., Nook, Kindle) was associated with advanced education and high income. In 2015, 25% of older adult users also reported playing online video games, an activity largely pursued by younger adults.

Like their younger counterparts, older adults are increasingly keeping in touch through email and social media rather than relying on letters and telephone calls, as their parents did. Computers have enabled older adults to remain in touch and stay current with activities in the lives of children, grandchildren, and friends who have moved away (**FIGURE 2-3**). In 2017, 34% of older adults reported using Facebook or Twitter, a 7% increase over the past 4 years (Pew Research Center, 2017a). Similarly, chat rooms and online dating services have also increased and enabled older adults to establish new relationships for companionship and love (Malta, 2007).

FIGURE 2-3 E-mail is an easy way for interested older adults to maintain communication with family and friends.

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For older adults who have never used a computer, learning to operate one may be initially challenging. Among adults age 65+ who reported getting a new digital device, 73% reported needing someone else to set it up for them (Pew Research Center, 2017a). However, many community centers and libraries provide periodic classes on how to send email, surf the web, access social media sites, play games, and use word processing programs.

The Aging Couple

Like other adult couples, some older adults have been married or in a committed relationship for decades, whereas others have more recently become a couple later in life (**FIGURE 2-4**). Older men who find themselves single generally have no problem finding female companionship because, statistically, women continue to outlive men. The 2010 United States Census Bureau confirmed that assumption by reporting that by age 85 there were 100 women for every 54 men (U.S. Census Bureau, 2011).

FIGURE 2-4 Expressions of love and affection.

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Couple relationships that have endured into old age have probably experienced and overcome many challenges and crises along the way. Health problems aside, one of the earliest challenges faced in later life occurs during transition into retirement. For some couples, it is a time of deep soul searching, redefining social roles as individuals, and wondering what the future of the couple relationship will be like (Silverstone & Hyman, 1992).

If a couple can successfully weather the challenges associated with retirement, their feelings for each other can actually become enriched and strengthened. However, problems can arise when each person struggles with the change at different times. For example, if one person is ready to retire while the other one is not or one wants to sell the family home and move to a warmer climate and the other does not, problems in the relationship often arise. Subsequently, some couples spend considerable time reflecting on the value, purpose, and usefulness of their relationship during this stage of life. For many, this is just another one of life's challenges that they will share and work through together. Others, however, will see it as a reason and opportunity to dissolve their relationship.

Many other couples choose not to grow old together. Maybe they have stayed together for the sake of the children or perhaps they became absorbed in work or other activities over the years to avoid having to deal with underlying relationship issues. These couples may share their lives but might not be emotionally engaged. They may be genuinely fond of each other but view their relationship as more of a business partnership than a marriage. Similar to a marriage of convenience, each partner "does his or her own thing." Sometimes, one or both partners engage in extramarital affairs (even into late life), which can bring about the final unraveling of the marriage.

The Pew Research Center (2017b) reports that, in 2016, 61% of adults ages 50+ were married and the rate of divorce has been steadily rising. In 1990, only 5% of older adults were divorced, yet by 2015 more than 10% were divorced. Research has shown that divorce rates are higher among second, third, or subsequent marriages, which are reflected in this data. However, it is important to note that divorce cannot be only attributed to persons with multiple marriages. Among the couples divorced in 2015, 34% had been in a first marriage lasting at least 30 years and 10% had a marriage lasting at least 40 years. Cohabitation with a sexual partner is also on the rise among older adults and corresponds to the divorce rate. Older adults ages 50+ represent 23% of all cohabitating adults—a rate increase of 75% since 2007. Unlike their younger counterparts, older cohabitants have a history of marriage and are often older. Thirteen percent of older adult cohabiters are aged 70+.

Although some relationships worsen or dissolve with age, others actually get better and experience a renewal or rebirth. Communication often improves and affection and intimacy can become recharged. Late life can be the most satisfying years of a marriage for the couple who finds contentment in their relationship and has come to accept one another for who they are (Silverstone & Hyman, 1992).

In many ways, late-life relationships among same-sex couples are no different than for opposite-sex couples. Aside from sexual orientation, the main difference is public visibility. For many lesbian (i.e., a woman is sexually attracted to women), gay (i.e., a man is sexually attracted to men), and bisexual (i.e., an individual has a sexual attraction to both men and women) elders born more than 65 years ago, a lifetime of social marginalization, persecution, and denial of civil rights because of sexual orientation has forced them to keep their partnerships secret. Even though many lesbian, gay, bisexual, and transgendered (LGBT) couples have built lives that contradict negative social identities, many remain reluctant to reach out to the greater community for support services in late life (Meisner & Hynie, 2009; National Resource Center on LGBT Aging, 2013). The challenge for healthcare professionals in offering services to members of the LGBT community is gaining access and providing care that respects their personal choice and right to self-determine care, just like those afforded members of the heterosexual community.

Aging Parent and Adult Child

Relationships between aging parents and adult children also tend to be as varied as spousal relationships. Within most families, there is a fair degree of positive involvement between generations. Many parents continue to provide emotional, physical, and financial support to their adult children and grandchildren to help them manage their lives. Ideally, support would be provided with good intentions with "no strings attached." However, an underlying reason for helping out younger family members may include a hope or unspoken agreement that help will be reciprocated in later years when needed (Silverstone & Hyman, 1992).

Unfortunately, strained relations can develop between a parent and child in adulthood. Verbal finger pointing—unfair fighting with "you never" or "you always" statements—can upset relationships, as can favoritism toward some family members over others. Sometimes, parental disapproval of a lifestyle or friends generates family disharmony. Feelings of disappointment coupled with shame may lead older parents to preserve their own public image instead of their sons' or daughters' needs and feelings. However, if affection and communication remain open between a parent and adult child, their psychological well-being will benefit and their relationship will grow stronger (Silverstone & Hyman, 1992).

One relatively recent challenge faced by many older adults has been the increased prevalence of substance misuse (i.e., dependence on alcohol and drugs) and incarceration rates among their adult children. Subsequently, many older adults are forced to deal with the addictive behaviors of their adult child (or grandchild), a task many are ill-prepared to undertake. Studies indicate that the problems of adult children are a significant cause of depression in older adults—the greater the child's problem, the greater the parent's depression. Older adults continue to want the best for their children, no matter what their age, and are often emotionally affected by the challenges and failures their offspring encounter (Dunham, 1995).

Never Married or Childless in Late Life

Approximately, 4% of the population in the United States age 65 and older has never married (Tamborinia, 2007). Also notable is the increase of women in the United States who have never borne a child (nearly 20%)—a rate that has nearly doubled since the 1970s (Tamborinia, 2007).

The reasons for remaining single and for not bearing children are numerous and

personal. Still, social roles and expectations of older adults are often centered on being coupled and having families. This narrow perspective leads some people to wonder how never married and childless people receive support later in life and from whom.

Although some people may assume that never married and childless couples have been deprived of the emotional support of family in late life, research suggests otherwise. Happiness, life satisfaction, loneliness, and self-esteem appear to be unrelated to contact with adult children during late life (Connidis & McMullin, 1993). Many never married and childless couples have adjusted by adapting their social network to include relationships generally thought to be held by partners and children. These **fictive kin** are treated as family and linked by close emotional bonds (Jordan-Marsh & Harden, 2005). Sometimes, a niece or a nephew takes on the social role of a child or a sibling takes on some of the traditional roles of a spouse. Despite the social pressure to marry and bear children, individuals who do not conform to social pressure are not emotionally unstable in later life (**FIGURE 2-5**). Never marrying or remaining childless is not something to be pitied or viewed as a curiosity. It is simply another way of life.

FIGURE 2-5 Friendships are sources of emotional and motivational support.

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Friendships

Friendships established early in life often continue into old age, especially if they begin during midlife. Unlike relationships with family members who are connected by blood ties and replete with social roles and expectations, friendships exist because the individuals involved share similar interests and want to maintain the relationship. Like younger adults, older adults tend to establish friendships with people similar to themselves: same gender, similar social and economic status, and from the same town or community. However, as friendships deteriorate as a result of increased distance, poor health, or death, new ones are formed if the older adult has the access and opportunity to build a new connection. The ability to form new relationships is essential because an important outcome of friendship is enhanced psychological well-being. Research indicates that friendships have an even stronger influence on well-being than do familial relationships, although the precise relationship remains unclear (Adams, Leibbrandt, & Moon, 2011).

Studies have also shown that women have more friends than men do, because they view and engage in friendships differently (Antonucci, 2001). Women perceive friendships to be sources of ongoing emotional and physical support and prefer to surround themselves with friends who can help them address the daily challenges they face. When a friendship ends, it is replaced with a new one. Thus, women are intentional about managing their friendships so that they maintain the desired complement of friends to help them process the events in their life. Men, however, prefer to rely on their spouse, partner, or close family members for help and emotional support rather than friends. Males' friendships are based on specific activities such as a sport or a project rather than sharing feelings and processing a particular situation or event. As a result, men tend to require fewer friends than women do.

Like young adults, older adults nurture their friendships and feel a sense of loss when a friendship dissolves or becomes inactive. Poor health, new living arrangements, and loss in mobility frequently change the course of friendships and make sustaining them that much more difficult. As Kahn and Antonucci (1980) proposed in their "convoy of support" when maintaining relationships becomes too difficult to manage, older adults will break off some relationships because they recognize they cannot reciprocate support. Instead, they choose to place their energy and resources into their most valued relationships—those with their closest family and friends.

Elder Abuse

Elder abuse is an insidious and often hidden problem, which is expected to increase as baby boomers reach old age. Elder abuse is a form of family or domestic violence, which can be defined as "intentional or neglectful acts by a caregiver or **trusted individual** that lead to, or may lead to, harm of a vulnerable elder" (Center for Disease Control and Prevention [CDC], 2016). For some victims, their abuse is a continuation of abuse or violence that began years earlier, and for other victims, their abuse started in late life after they became more dependent on someone else for help, support, and care (Rennison, 2001).

Accurate statistics on the prevalence of elder abuse are hard to find because incidents are rarely reported, and when they are, how they are recorded varies by the reporting agency. In 2016, the CDC convened a panel of experts to come up with definitions to streamline the process. The first challenge they faced was determining who qualifies as an elder. Most organizations, like the American Medical Association (AMA), do not specify the age of an elder, whereas the OAA which funds aging services defines an elder as a person age 60 or older. The second challenge was identifying how abuse is categorized. The AMA categorizes and reports abuse by physical or mental injury, sexual abuse, and withholding of necessary food, clothing, and medical care. The National Center on Elder Abuse (NCEA) advocates for more precise categorization that includes physical abuse, psychological abuse, sexual abuse, exploitation, neglect, abandonment, and **self-neglect** (**TABLE 2-1**). Regardless of the typology of abuse utilized, research indicates that each type of abuse does not necessarily occur in isolation. Rather, abuse may expand to include multiple forms of abuse known as **polyvictimization** (Ramsey-Klawsnik, 2017; Roberto, 2017).

In light of the data analysis challenges, a research team in New York triangulated data collected by agencies and programs responsible for serving victims with information collected by citizens age 60+. The team estimated that approximately 7% of the older population has experienced some form of abuse in the previous year; an estimate slightly lower than other research has indicated (Acierno et al., 2010). For every case reported in New York, approximately 24 cases went unreported. The rates of abuse vary by type of abuse, with the most frequent type of abuse reported being financial (Lifespan of Greater Rochester, Inc., Weill Cornell Medical Center of Cornell University, & New York City Department for the Aging, 2011).

Victims of Abuse

Like individual victims of domestic violence, victims of elder abuse are unique but share common characteristics. Many victims are isolated from their social networks and communities. Their isolation may be of their own choosing or may occur because their abusers have systematically isolated them to maintain more power and control over them. Many victims experience physical and mental health

TABLE 2-1 NCEA Definitions of the Seven Types of Elder Abuse[a]

Type	Definition
Physical	Use of force to threaten or physically injure a vulnerable elder.
Psychological	Verbal attacks, threats, rejection, isolation, or belittling acts that cause or could cause mental anguish, pain, or distress to an elder.
Sexual	Sexual contact that is forced, tricked, threatened, or otherwise coerced upon another person, including anyone who is unable to grant consent.
Exploitation	Theft, fraud, misuse or neglect of authority, and use of "undue influence" as a lever to gain control over an older person's money or property.
Neglect	Failure or refusal by a caregiver to provide for a vulnerable elder's safety, physical, or emotional needs.
Abandonment	Desertion of a frail or vulnerable elder by anyone with a duty of care.
Self-neglect	Inability to understand the consequences of one's own actions or inaction, which leads to, or may lead to, harm or endangerment.

[a]National Center on Elder Abuse (n.d.).

problems, some of which are exacerbated by ongoing abuse.

A typical victim of elder abuse is female, age 75+, lives alone, has physical or cognitive impairments, lacks a network of social support, and is reliant on other people for care and support. A victim's hesitancy to challenge or confront a perpetrator or report abuse to persons in a position to stop the abuse can be difficult for someone outside the relationship to understand. However, the victim's need for care and reliance on the perpetrator for support is so great that they tend to not report problems out of fear that they will be without services and support if they speak up. Moreover, they do not want other people to know they are in their current situation, they do not want to get the perpetrator in trouble (especially if the abuser is a close relative or friend), or they fear how the perpetrator might treat them after being reported. For many victims, the inconvenience of being abused outweighs the perceived consequences of reporting; so they remain silent (Lafferty, 2009).

Self-Neglect Among Older Adults

A very challenging type of elder abuse to address and eliminate is self-neglect. The behaviors exhibited by individuals who self-neglect (e.g., not bathing, wearing clothes inappropriate for the weather, poor nutrition) challenge the social norms and values shared by the general population. Self-neglecting behaviors left unchecked can permeate all facets of life, including personal care, home environment, and personal relationships. Interventions that strive to reduce problems or alleviate conditions related to self-neglect are difficult to initiate and sustain because

participants decide not to participate. When supporting individuals who self-neglect, it is imperative to honor their personal autonomy and legal right to live as they choose, if they are competent to make this decision, no matter how difficult or frustrating it may appear to you.

Perpetrators of Abuse

There is limited information available about perpetrators of elder abuse because victims are hesitant to identify them and file legal charges against them. In most cases, the relationship between a victim and a perpetrator has been established long before the abuse begins. Perpetrators present themselves to the elder and the elder's family as a good caring person or a supportive resource. Even if they did not initially plan to abuse their victim, perpetrators become savvy in manipulating how they present themselves, making it hard for individuals outside the victim/perpetrator relationship to recognize problems.

Although general public opinion is that most perpetrators are male offspring, available evidence suggests not all perpetrators are alike (Roberto, 2017). Among family members who provided care and perpetrated abuse, many typically relied on the elder for housing, financial support, and emotional support (Jackson & Hafemesiter, 2012). Substance misuse (alcohol and drugs) is another characteristic among perpetrators (Jackson & Hafemesiter, 2012). But, as found in cases of domestic violence, substance misuse may contribute to lowered inhibitions and poor decision-making but does not cause the abuse inflicted. The complex interdependent relationship between family perpetrators and their victims can be even more difficult to understand when the victim is cognitively impaired (Wiglesworth et al., 2010). Such abuse can be easily hidden or explained as the victim is unlikely to be believed if abuse is reported.

Perpetrators of financial abuse tend to be professionals (e.g., attorneys, financial planners, and conservators) entrusted with fiduciary care (MetLife Mature Market Institute, 2009). Legal guardians are also often involved with misappropriating assets and money through schemes that benefit themselves at the expense of the elders (United States Government Accountability Office, 2010). Healthcare providers can also be perpetrators of abuse. Reports of physical abuse, including use of physical restraint in feeding and toileting, hitting, beating, kicking, and sexual abuse, have been reported. Teaster and Roberto (2004) further found that having a diagnosis of Alzheimer's disease predicted physical abuse of an elder by staff. Moreover, residents perpetuated sexual abuse on other residents over 90% of the time. The forms of sexual abuse initiated included unwelcomed sexual interest in the body, sexualized kissing, fondling, and unwelcomed discussion of sexual activity (Teaster & Roberto, 2004).

Signs of Abuse

Because elder abuse can be a hidden problem that is easily overlooked or explained by health-related problems, the NCEA developed a list of signs of abuse to promote awareness among families and healthcare providers (**TABLE 2-2**).

Mandated Reporting

There is no federal law against elder abuse; however, all states have some form of law or laws against acts of elder abuse. These laws also provide for the reporting of suspected elder abuse. Depending on the state law, healthcare professionals, including doctors, nurses, rehabilitation therapists, and social workers, may be **mandatory reporters**. Therefore, it is vital that healthcare professionals continually assess for signs of abuse and report when they suspect a problem.

Some organizations have a protocol for reporting suspected abuse of children

TABLE 2-2 NCEA Signs of Abuse[a]

Type of Abuse	Signs of Abuse
Physical & Sexual	■ Inadequately explained fractures, bruises, welts, cuts, sores, or burns. ■ Unexplained sexually transmitted diseases.
Psychological	■ Unexplained or uncharacteristic changes in behavior such as withdrawal from normal activities, unexplained changes in alertness, etc. ■ Caregiver isolates elder (does not let anyone into the home or speak to the elder). ■ Caregiver is verbally aggressive or demeaning, controlling, overly concerned about spending money, or uncaring.
Exploitation	■ Lack of amenities a victim could afford. ■ Vulnerable elder/adult "voluntarily" giving uncharacteristically excessive financial reimbursement/gifts for needed care and companionship. ■ Caregiver has control of elder's money but is failing to provide for the elder's needs. ■ Vulnerable elder/adult has signed property transfers (power of attorney, new will, etc.) but is unable to comprehend the transaction or what it means.
Neglect	■ Lack of basic hygiene, adequate food, or clean and appropriate clothing. ■ Lack of medical aids (glasses, walker, teeth, hearing aid, medications). ■ Person with dementia is left unsupervised. ■ Person confined to bed is left without care. ■ Home cluttered, filthy, in disrepair, or having fire and safety hazards. ■ Home without adequate facilities (stove, refrigerator, heat, cooling, plumbing, electricity, and parking). ■ Untreated pressure "bed" sores (pressure ulcers).

[a]National Center on Elder Abuse (n.d.).

and elders, and healthcare professionals are encouraged to utilize the system at their workplace. Ultimately, the state and local **Adult Protective Service** (APS) agencies are the frontline responders investigating reports of abuse. Reports to law enforcement will eventually be connected to APS in most states, so either contact should be appropriate. APS missions vary state to state, but generally focus on protecting the rights of vulnerable adults and adults with disabilities. **Long-term care ombudsmen** (LTCO) are advocates for residents in long-term care facilities and are responsible for care provided within a geographic region. The LTCO can directly receive reports of suspected abuse or work with APS to resolve elder abuse problems within a facility. For more information about the roles and responsibilities of a LTCO, visit ltcombudsman.org/about/about-ombudsman.

Reporting typically involves giving the name and contact information of the person suspected of being abused as well as specific details related to the suspected abuse. Reporting may also include the reporter giving his or her own contact information. Some states allow for anonymous reporting, in which the states protect the confidentiality of reporters.

Employment and Civic Engagement

The U.S. Bureau of Labor Statistics projects that from 2014 to 2024, the fastest growing segments of the labor force will include workers age 65–74 and age 75+ (Toossi & Torpey, 2017). Although the number of older workers will be fewer than the number of younger workers, their participation rate (i.e., people working or actively seeking work) will exceed that of the entire labor force. The rationale for continuing to work is multifold. People are living longer and want to continue to work because they enjoy it, they want something interesting to do, they want to stay physically and mentally active, and they want to financially support themselves (AARP, 2014). Older workers who remain in the workforce generally occupy management and professional positions, followed by sales and office work, service work, production, and manual labor (Toossi & Torpey, 2017). Not surprisingly, jobs that place wear and tear on the body are less likely to appeal to an aging worker.

Older workers want to remain in the labor force (AARP, 2014). If not for financial gain, they want to engage in productive pursuits that provide meaning and validation to their lives. When asked about the ideal job, workers age 45–74 indicated that their ideal jobs were personally meaningful to them. Specifically, the ideal job would provide the opportunity to use personal skills and talents (92%), include a friendly work environment (92%), offer the chance to do something worthwhile (88%), offer respect from coworkers (82%), and respect from the boss (81%). The ability to work from home (36%), ethnic and racial diversity (40%), opportunity to work part-time (43%), and the opportunity to phase into retirement (53%) were ranked lowest in terms of requirements for an ideal job (AARP, 2014). Clearly, the benefits older workers look for in their work are personal and provide validation for the knowledge and skills they bring into the workplace.

Among workers age 65+, 40% work part-time (Toossi & Torpey, 2017). Ever more employers are now viewing older workers as an untapped resource to share experience and expertise with younger workers. The method of utilizing the skills and leadership of older workers is through "bridge employment," which typically occurs as the older worker transitions from full-time work to part-time work and then into full retirement. Many businesses and professions, now facing skills shortages, are beginning to view the retention of older workers as making good business sense. A retiring person who has been with an organization a long time possesses valuable institutional memory (i.e., understanding of the processes and decisions made in the past), which needs to be passed on to new personnel. Preserving organizational history is prompting some employers to seriously consider allowing loyal older workers to continue on a part-time basis, at least as they transition into retirement (Ng & Law, 2014).

Workplace Discrimination

The U.S. Age Discrimination in Employment Act (1967) prohibits employment discrimination against people age 40+. Yet, despite its existence, at least 60% of workers (age 45+) report being discriminated against in the workplace because of their age (AARP, 2014). Extensive research has been conducted on social attitudes toward older workers. Many employers and employees inaccurately perceive older workers to be rigid, inflexible, incapable of learning new skills, unproductive, and overpaid. It should, therefore, come as no surprise that the most common type of economic discrimination against older adults has been work related (AARP, 2014; Palmore, 1990). Research indicates that 80% of adults believe that most employers discriminate against older workers in hiring or on the

job, and 61% of employers admit to doing so (AARP, 2014; U.S. Senate Special Committee on Aging, 1991). Discrimination against older workers ignores several overall advantages to hiring them, including low absentee rates, less turnover, low accident rates, less alcohol- and drug addiction-related issues, increased job satisfaction, and company loyalty (Palmore, 1990). Additionally, the experiences, knowledge, and insight older workers bring to the workplace are invaluable and cannot be easily replaced by a younger person with a limited work history who is working for lower wages.

Some employers believe that older workers are unable to keep pace with change and learn new technologies (AARP, 2014). For example, they may think that computers and computer software are far too difficult for older adults to learn to operate proficiently. Based on this assumption, employers are less likely to consider hiring older workers. However, evidence exists that older adults can and do learn new technological skills, including computer technology. According to adult learning theory, the learning strategies and styles of older adults may be different from younger adults, but they have the ability to learn and can become quite accomplished when given the opportunity to learn and study in a way that works for them (Knowles, 1984).

Work discrimination against older adults is most obvious when companies attempt to reduce costs by asking older workers to take early retirement, even seducing them into it by offering a tempting retirement package. The offer may initially appear to be a good financial move but may shortchange the worker of retirement income if not invested and managed wisely.

Retirement

Before the industrial revolution, retirement as a phase of life did not exist. Individuals worked until they became either disabled or too frail or infirm to do otherwise. They generally died shortly afterward. If they did live a long life, they were usually supported by family or by some charitable organization such as the local church. It was only in 1889 that Chancellor Bismarck of Germany established retirement for individuals reaching age 65. He chose the age of 65 as the beginning of retirement by adding 20 years to the then normal life expectancy of 45 years. Other European countries soon followed with similar retirement systems. In 1935, the United States was the first country to establish a nationalized pension system for people age 65 and older (Dewitt, 2010). Since then, other countries have followed suit, and today most offer a national pension to adults age 65 and older. Variations in the age of eligibility range about 5 years, with most notable differences between males and females. Some cultures stipulate that women cannot occupy the same positions as men or are required to step down from such positions at a younger age than a man, thus explaining differences in retirement (AARP International, 2013).

Until 1967, retirement was compulsory for workers in the United States who reached age 65, regardless of their health status or abilities. Here again, we see another myth of aging that implies there is a general loss of ability that begins around age 65 or even earlier. However, in typically aging adults, there exists no sudden or general loss of ability at age 65 or at any other age (Palmore, 1990). Any losses that may occur among those aging typically generally do so gradually over many years. Even some disorders considered inevitable as we age (such as visual and hearing impairments) are now reversible or at least amenable to correction. Because of better health status, today's retirees can potentially spend 20 or more years in retirement (AARP International, 2013). Many older adults continue working in the same or some new capacity, even after reaching retirement age. In sum, retirement is a stage of life that for some people begins with a change in employment status.

FIGURE 2-6 Many older adults continue to share their skills and expertise with the community after they retire.

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Preparing for retirement is not a task that should be taken lightly or without preparation (**FIGURE 2-6**). Retirement requires planning, planning, and more planning. And despite what the television commercials may say, it is not all about finances. Important considerations in the retirement decision-making process include:

- Financial and social resources
- Spouse's/partner's retirement plans
- Desire to continue working (e.g., part-time, full time, or on a flexible schedule)
- Need or desire to remain active in one's current profession
- Interest in starting a new career (reinventing one's self)
- Desire to volunteer and potential volunteer opportunities
- Desire to remain living in the same community (or to move)

Prior to retirement, some older adults begin developing hobbies or spare time occupations to engage in during retirement. Many daydream about being able to putter around their home and spend considerable time in their gardens, although good ideas, hobbies, and household activities are generally not intensive enough to fill the hours in a day (Allison, 1996). As many older adults with a few years of retirement behind them frequently offer, you cannot just retire; you have to retire to something. Some older adults are determined to challenge themselves in pursuit of some activity that few, regardless of age, would choose to follow. Mary Harper, a 79-year-old great-grandmother, is one person who rose to such a challenge. Ms. Harper became the oldest person to sail across the Atlantic single-handedly. Although she broke a rib in severe weather, she later said, "The whole trip was worth it just to see the waves." In answer to why she did it alone, she explained that "it was something I wanted to do … but didn't want to be responsible for a crew" (Bennett, 1994). Another older adult who has refused to settle down to "quiet old age" is former U.S. President George H. W. Bush, who completed a skydive jump on his 80th, 85th, and 90th birthdays (Dooley, 2014). Some individuals continue to engage in lifelong passions. Such is the case for long-distance swimmer Diana Nyad. At age 64, she became the first person to complete the 110 mile ocean swim from Florida to Cuba (Associated Press, 2013). David Morrison of Milgrove, Ontario, Canada, had earlier in life performed folk music in local coffeehouses with friends Judy Lanza and the now famous actor Eugene Levy. A year prior to retirement, Morrison bought a new guitar and took up singing lessons. Three weeks after retiring as vice president of executive development for TD Bank, Morrison was on the verge of becoming a public performer again (Clements, 1993).

Advocacy Groups

Advocating for the rights and needs of older adults at the local, state, and national levels can be a daunting task. However, as increasing numbers of individuals reach the age of 65, the voices of advocates are becoming louder and stronger. This should come as no surprise because older baby boomers fought for the rights of disempowered groups in the 1960s

and 1970s. Their involvement in civil rights, gay rights, and the feminist movement was generation shaping.

Three advocacy groups that help represent the needs of older adults are profiled in this section. The most recognizable organization that has demonstrated considerable success in representing the needs of adults age 50 and older is **AARP**, a nonprofit, nonpartisan organization. It was founded in 1958 as the American Association for Retired Persons with the agenda of addressing the social needs of retirees. Today, known as AARP (2017), it has expanded its scope of interests to include all aspects of life. In 2017, it boasted a membership of nearly 38 million people. The mission of AARP is simple: "To enhance the quality of life for all of us as we age." AARP advocates for social change through information, advocacy, and service as it represents adults of all ethnicities and cultures within the United States. All its publications (magazine, bulletins, and website) are instilled with the attitude that age is merely a number and life is what you make of it. Together with the AARP Foundation, research on topics of current interest, including prescription drug costs, grandparents raising grandchildren, and civic participation, is funded to generate information that can be used to promote positive social change.

The Gray Panthers was founded in 1970 by Maggie Kuhn and six other women who came together to discuss and address the issue of forced retirement at age 65. However, the first issue taken on by the fledgling organization was not age discrimination but rather opposition to the war in Vietnam. This was because the Gray Panthers did not want to be perceived as an organization that was only dedicated to fighting ageism. The Panthers believed philosophically that "gray power" should be on the cutting edge of social change by working with other organizations to "work for social and economic justice and peace for all people" (Gray Panthers Twin Cities, 2017). In 2015, the Gray Panthers reorganized and became the National Council of Gray Panthers Networks—a coalition of informal groups armed with national intergenerational support and organizational values that continue to honor maturity, unify generations, and actively engage in democracy to "create a humane society that puts the needs of people over profits, responsibility over power, and democracy over institutions" (Gray Panthers Twin Cities, 2017).

A third organization founded to address workplace and retirement issues is **Senior Service America (SSA)**, once known as the National Council of Senior Citizens, founded by the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) in 1961. Today, the organization's fundamental purpose is broader than the scope of retirement because the group advocates for political and legislative issues that affect older adults. Legislative issues that received the organization's attention in past years have included the OAA, Medicare, Medicaid, and employment training opportunities. Today, the SSA updates members through newsletters that report on how Congress is addressing the needs of older adults. The SSA and its partner organizations also provide employment and training opportunities to more than 10,000 adults nationwide (Senior Service America, 2017).

Summary

The aging process begins the moment we are born and continues as our bodies and minds grow, develop, change, and mature. Gerontology is the scientific study of aging that examines the biological, psychological, and sociological (bio-psycho-social) factors associated with old age and aging. The foundation for social science research in gerontology includes three theories about aging: disengagement theory, activity theory, and continuity theory. While none of the theories

can explain social aging completely, each one helps inform our historical perspectives.

Ageism, a systematic stereotyping of and discrimination against people who are old, fosters the notion that older adults are not useful or valued. Ageism is fueled by numerous myths regarding aging and older adults as well as by language that conjures negative images of old persons. Ageism limits opportunities (employment and workplace discrimination) and access to health care and in its worst form can lead to elder abuse, mistreatment, and neglect.

Research has shown that healthcare professionals are significantly more negative in their attitudes toward older patients than they are toward younger patients. To avoid, even inadvertently, making ageist comments and remarks, it is important to recognize and explore your own feelings and attitudes as a healthcare professional. Stopping the spread of ageism is everyone's responsibility, and starts at the individual level.

The media regularly perpetuate the stereotypes of older adults through inaccurate and sometimes demeaning portrayals of older adults in print, advertising, and entertainment. This is puzzling, considering that older adults have the ability to purchase the advertisers' products that sponsor these media activities. Nonetheless, limited efforts continue to be made to accurately depict the daily lives of older adults through the media.

Social roles continue to be important in later life. However, relationships are sometimes dissolved as a result of poor health, limited mobility, and the inability to reciprocate support. Relationships with close family and friends are maintained before others because they are the source of most support. Some couples find later life to be a time of closeness after weathering life's storms together, some choose to separate and go their own ways, and some remain single and seek support from fictive kin. Relationships between aging parents and adult children tend to be as varied and challenging as spousal relationships, yet families can generally be counted on to provide support. Maintaining friendships continue to promote psychological well-being well into old age. Grandparenting has been, and remains, a rewarding and fulfilling experience in later life.

Attitudes toward work and retirement vary greatly as do the lifestyles of older adults. Many older adults choose to continue to work after retirement age because it not only provides a source of income, but also allows them to engage in productive pursuits that provide meaning and validation to their lives. For other individuals, retirement heralds the chance to pursue a special interest or hobby they never had time to do while working. Some people see it as an opportunity to travel or return to school to pursue a second career, whereas others view it with a bit of disappointment, especially if they previously held an influential position. For most individuals, however, retirement is a time of relaxation to be spent with spouse, children, grandchildren, and/or friends.

Several organizations advocate for the rights and needs of older adults at the local, state, and national levels: AARP, National Council of Gray Panthers Networks, and SSA. All three organizations were founded more than 40 years ago with the mission of bringing about social changes for older adults.

Understanding the social factors that affect older adults is essential when providing care. By developing an appreciation for the diverse backgrounds of older adults, we can better tailor interventions and meet clients' or patients' needs. Moreover, appreciation for social gerontology can only enhance how we interact with our own family members and think about our personal needs as we age.

CASE STUDIES

Case 1: John and Jason are both 68 years old and have been an exclusive couple for 33 years. Although they cannot legally marry in their state, their lives are inextricably interwoven, even though many people are not aware of their relationship—only a handful of close friends know. John is a banker and commutes daily into the city to work. Jason is an instructor at a local community college and generally walks to his office. They have kept their relationship relatively secret because they fear that others will "out" them, which they fear will force them to leave the careers they adore. One day, Jason suffers a severe stroke and their carefully constructed world begins to unravel. As gay men, neither is provided the rights of a spouse in terms of overseeing medical care, and John is quickly pushed aside at the hospital as the staff ask who the next of kin is. As days go by, John remains at Jason's side, and one nurse in particular repeatedly makes comments about the two old gay guys and how they don't deserve her time or care. A doctor pulls John aside and advises him to start looking for a nursing home for Jason. The thought of losing Jason and placing him in a nursing home is more than John can bear. He believes the nursing home staff would be no different than the hospital staff and would not accept the men's relationship. John decides to quit his job to care for Jason at home. When his boss asks him why he is leaving, John lies and says his mother's health is failing and she needs him. The first 3 months of care go relatively well, but as Jason's health declines, John recognizes he needs help and a break from caregiving, but feels he has no one to turn to.

1. **How are John and Jason's challenges in providing Jason with care different from the challenges faced by a heterosexual couple?**
2. **What challenges do healthcare professionals face in providing care to same-sex couples?**
3. **What can healthcare professionals do to help couples like John and Jason successfully manage their healthcare challenges?**

Case 2: Barbara, age 42, is a lucky woman, or at least that is what everyone tells her. She has an adoring husband, smart children, a career as a store manager, and impeccable taste in fashion. Barbara has always been an excellent multitasker and has successfully balanced her marriage, family, and career for 20 years. She makes every task look effortless. So, when her mother started having health problems, Barbara was sure to set aside the time needed to help. She always assumed she would be the best one to help her mother, even though she lived 200 miles away, because she was reliable and dependable. Barbara has a brother and sister who could probably help, but they have their own careers and families and they are just fine letting Barbara take over. They trust Barbara. After a few months, Barbara thought that being a long-distance caregiver was not that hard. She struggled a bit at first, but soon organized all the information she needed about her mother's health problems and care. She was in touch with doctors on a regular basis and authorized whatever care was needed. Soon, she started managing her mother's finances. It did not cross Barbara's mind to call her siblings to update them, and they did not think to call her. Barbara was pleased that she could provide for her mother from a distance. Although long-distance caregiving was not convenient and often forced her to change her plans, she could not imagine not being available for her mom. One day, Barbara received a call that her mother had been hospitalized. She called her sister and they agreed to meet at their mother's home and travel together to the hospital. Secretly, Barbara was glad to meet with her sister because she was getting tired of having the extra burden of her mother's life on her shoulders alone. Last week at work, the regional manager told her that her enthusiasm and work performance had started to slip. Even her husband had made a few comments that she did not seem to have the time for him and their children anymore. Barbara knew things needed to change, but just was not sure what to do.

1. **What should Barbara do and why?**
2. **What steps does Barbara need to take to ensure her own needs are being cared for?**

TEST YOUR KNOWLEDGE

Review Questions

1. ________________ is the scientific study of aging that examines the biological, psychological, and sociological factors associated with old age and aging.
   a. Geriatrics
   b. Pediatrics
   c. Oncology
   d. Gerontology
2. The first psychosocial science theories on aging included
   a. Activity theory and disengagement theory
   b. Continuity theory and social role theory
   c. Activity theory and social role theory
   d. Disengagement theory and caregiving theory
3. Providers who view older adult patients sympathetically as “poor old dears,” who can do little to care for themselves, are diminishing the value they place on their patients’ abilities.
   a. True
   b. False
4. Skip-generation households refer to
   a. Teenagers caring for their ailing parents
   b. Parents caring for children as well as aging parents
   c. Grandparents acting as surrogate parents to their grandchildren
   d. Grandchildren caring for ailing grandparents
5. A typical victim of elder abuse is
   a. Female and over the age of 75
   b. Living alone and lacking a network of social support
   c. A & B
   d. None of the above

Learning Activities

1. Using your own experiences and observations, formulate a social theory on aging. How does it compare with the social theories described in this chapter?
2. Provide examples of ageism you have seen in your own family, in your community, in the media, in your travels, and/or in your workplace.
3. Explain the value of social connections in late life and provide examples of how an older adult can maintain connections to other people.
4. Discuss some of the issues and concerns of a grandparent raising a grandchild. What steps, if any, can a healthcare professional take to support them?
5. Develop a scenario in which a vulnerable older adult could potentially become a victim of two or more types of elder abuse. Describe the steps a healthcare professional can take to uncover a potential problem.

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