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RESPONSE TO OLD AGE: A GRIEF REACTION

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RESPONSE TO OLD AGE: A GRIEF REACTION

Demographic changes in the last seventy-five years have resulted in the increase of those over sixty-five in both numbers and in the proportion of the total population which they constitute. Numerous problems in areas such as financial security, health care and use of leisure time have arisen consequently. Although much research has been conducted in recent years on various aspects of aging, existing knowledge is not integrated into one theory of aging. It was speculated that the development of such a comprehensive framework of viewing aging, integrating the diverse research findings and theories of aging, would facilitate understanding of the aging process and the diversity of individuals' reactions to it, thereby facilitating improved professional practice, planning of service delivery, and formulation of future areas of research.

Since loss is often noted as central to the various lifespaces of aging, grief theory, which explains the individual's response to loss, was speculated to be a helpful conceptual framework within which to study aging. As a result, a review of the literature was used to study the

nature and extent of losses in the life-spaces of health, work and social relationships and the individual's response to these losses, in order to ascertain if the reaction to the aging process is in fact similar to that of a grief reaction. The principal findings were that the individual appears to respond to the various losses of aging according to the stages of a grief reaction -- denial, anger, depression and new identity formation. Denial was most evident in response to health losses. The direct expression of anger was noticeably lacking. Depression, high in incidence among the aged population as compared to other age groups, seemed to often be reactive to losses suffered. Many individuals appear to have problems in completing the last stage of a grief reaction -- formation of a new identity, because of lack of socially valued alternatives on which to base their new or revised self-identities.

Various social work interactions were formulated on the basis of these findings. Therapy with the aged would focus on facilitating progress through the four stages of grief, focussing particularly on helping the individual express anger in a direct and functional manner, such as through participation in citizens' groups. The need for professional intervention to modify prejudicial or negative social attitudes and consequently increase alternative sources of identity for the aged, was noted. The need for improved educational preparation for social work with the

aged and for research on the modes of response to aging, particularly those which are nonpathological, was noted.

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CHAPTER I

INTRODUCTION

The Problem Defined

The existence of a numerically significant population group over sixty-five years of age is a relatively recent demographic development which has had multitudinous social implications. Tibbitts attributes this growing aging citizenry to three main factors: growth of the general population accounts for 50 percent of the total increase in the number of older people since 1900; the aging of the large population group which immigrated during the 1800's and up to 1925 explains 20 percent of the increase; and technological progress, resulting in improved environmental conditions, control of disease and consequent increased longevity, explains the remainder of the increase.[1]

Referring to longevity, Tibbitts notes that life expectancy has increased from 40 years in 1850, to 49 years in 1900, to 70 years in 1960.[2] Worthy of note is the

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[1]Clark Tibbitts, "Aging as a Modern Social Achievement," in Aging in Today's Society, eds. Clark Tibbitts and Wilma Donahue (Englewood Cliffs, New Jersey: Prentice Hall Inc., 1960), p. 6.

[2]Ibid.

differential increase in longevity according to sex. In 1900, in the United States, there were 98 women to every 100 men in the age group over 65. From 1900 onward, the longevity of females improved remarkably, so that in 1960, there were about 129 older women to each 100 older men, with the life expectancy of females still increasing more rapidly than that of males.[1] In Canada, male life expectancy has increased from 60 years in 1931 to 68.8 years in 1966, while female life expectancy has increased from 62.1 years in 1931 to 75.2 years in 1966.[2] This "overabundance" of females within the aged population has important implications which have been discussed in later chapters.

The aged have increased not only in numbers, but in the proportion they constitute of the total population. For example, while the 1900 United States census indicated that 4.1 percent of the population was over sixty-five, the 1970 census showed 10 percent to be over sixty-five.[3] In Canada, the total population increased 97 percent between 1936 and 1971, while the population sixty-five or over increased 160

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[1] Ewald Busse, "Theories of Aging," in Behavior and Adaptation in Late Life, eds. Ewald Busse and Eric Pfeiffer (Boston: Little, Brown and Co., 1969), p. 13.

[2] Social Planning Council of Metropolitan Toronto, The Aging-Trends, Problems, Prospects (Toronto, 1973), p. A5.

[3] Bert Kruger Smith, Aging in America (Boston: Beacon Press, 1973), p. 17.

percent in the same time period.[1] Maddox estimates that by the year 2000, about 11 percent of the United States population, or an estimated 28 million people, will be at least 65 years old.[2] A similar increase in the proportion of aged within the total population has been noted in most other economically advanced countries.[3]

Thus, it becomes apparent that considerable demographic changes have occurred within the populations of industrialized societies in the last seventy years. Not only have the actual numbers of the aged increased, but they now constitute a larger proportion of the total population. These demographic changes have had profound effects on many aspects of society. There has been a lack of preparation for the appearance of such a substantial aged population and a lag in adapting social institutions to meet the consequent needs.[4] Numerous problems have arisen in areas such as financial security, living arrangements, health care, and

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[1] Social Planning Council, Aging, p. A5.

[2] George L. Maddox, "Growing Old: Getting Beyond the Stereotypes," in Foundations of Practical Gerontology, 2d ed., rev., eds. Rosamonde R. Boyd and Charles G. Oakes (Columbia, South Carolina: University of South Carolina Press, 1973), p. 5.

[3] Matilda W. Riley and Anne Foner, Aging and Society, Vol. 1: An Inventory of Research Findings (New York: Russell Sage Foundation, 1968), p. 23.

[4] Bernice Neugarten, "Patterns of Aging: Past, Present, Future." Social Service Review 47 (December 1973): 572.

use of leisure time.[1] This lag in adapting social institutions to meet changing needs can be illustrated by reference to social work, a profession which, although dedicated to helping individuals with psychosocial problems, has been particularly negligent of its role with respect to the aged. Morris states that "as society in general has been late to admit responsibility for the living conditions of the elderly, so has that comparatively new profession of social work."[2] For example, although the aged constitute 10 percent of the population, they comprise less than half of one per cent of the average caseload in family service agencies.[3]

Growing awareness of these problems attendant to the demographic changes cited has resulted in a proliferation of research related to numerous aspects of aging, conducted by various disciplines such as medicine, sociology, psychology and social work. This has produced voluminous, and sometimes contradictory, findings, but little unification of existing knowledge into a general theory of aging. Riley and Foner point to the lack of unification of existing knowledge into a general theory of aging and state this causes serious difficulty in terms of translating the results of research

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[1]Clark Tibbitts and Wilma Donahue, Preface to Aging in Today's Society, eds. Clark Tibbitts and Wilma Donahue (Englewood Cliffs, New Jersey: Prentice Hall Inc., 1960), p. xix.

[2]Robert Morris, "Aging and the Field of Social Work," in Aging and Society, Vol. 2: Aging and the Professions (New York: Russell Sage Foundation, 1969), p. 20.

[3]Ibid., p. 22.

into coordinated, comprehensive, professional planning or practice.[1] Bengston refers to the lack of a theory of social gerontology that serves the functions of integrating the various current findings, offering a system of explanation for the various phenomena reviewed, and predicting future trends on the basis of existing conditions.[2]

It is speculated that the formulation of a conceptual framework within which to analyze aging, encompassing the present theories and approaches, would be helpful in remedying the lag between the needs of the aged and services for them. To be more specific, a comprehensive framework of viewing aging which allows for the diversity of patterns of aging, would greatly facilitate analysis of the needs of the elderly. It would be particularly relevant to the profession of social work, enabling improved practice in the areas of therapeutic intervention, policy planning and research.

Loss: A Theme in Aging

Reviewing the literature, one aspect of aging frequently noted is that of loss. Verwoerdt notes that

> longevity brings inevitable loss. Those who survive to old age must, of necessity, outlive many contemporaries. Loss and grief (the psychological reaction to loss) are integral components of late life. In

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[1] Riley and Foner, Aging and Society, Vol. 1, p. 1.

[2] Vern L. Bengston, The Social Psychology of Aging (New York: Bobbs-Merrill Co., 1973), p. 42.

> addition to interpersonal losses, there are loss of occupation, role changes in the family constellation, loss of status and prestige, as well as loss of real income.[1]

Finch, Verwoerdt, Smith, Weg, and others refer to the physiological losses of aging, such as loss of elasticity of skin and connective tissue, loss of muscle power, and impaired efficiency of vital systems such as the cardiovascular, respiratory and gastrointestinal systems.[2] In reference to psychological functioning, Atchley comments on the apparent decline in the speed with which the perceptual processes can organize and evaluate stimuli; Carp refers to the reduced accuracy of kinesthesis (perception of changes in body position and of orientation in space) and to the results of some studies which point to a decline in intelligence in old age.[3]

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[1]Adriaan Verwoerdt, "Biological Characteristics of the Elderly," in Foundations of Practical Gerontology, 2d ed., rev., eds. Rosamonde R. Boyd and Charles G. Oakes (Columbia, South Carolina: University of South Carolina Press, 1969), p. 52.

[2]Caleb Finch, "The Physiology of Aging," in Aging: Prospects and Issues, eds. Richard H. David and Margaret Neiswender (Ethel Percy Andrus Gerontology Centre: University of Southern California, 1973), pp. 37-39; E. D. Smith, Handbook of Aging (New York: Barnes and Noble, 1972), pp. 6-7; Verwoerdt, "Biological Characteristics," pp. 56-60; Ruth B. Weg, "Changing Physiology of Aging," in Aging: Prospects and Issues, eds. Richard H. Davis and Margaret Neiswender (Ethel Percy Andrus Gerontology Centre: University of Southern California, 1973), pp. 47-49.

[3]Robert Atchley, The Social Forces in Later Life: An Introduction to Social Gerontology (Belmont, California: Wadsworth Publishing Co., 1972), p. 57; Frances M. Carp, "The Psychology of Aging," in Foundations of Practical Gerontology, 2d ed. rev., eds. Rosamonde R. Boyd and Charles G. Oakes (Columbia, South Carolina: University of South Carolina Press, 1969), pp. 113, 120.

Rosow refers to role loss as the critical stress of aging, depriving the aged of social identity.[1] Heyman and Polansky comment on the importance of loss to social work intervention with the aged: "Personal adjustment to actual and threatened changes and losses . . . are areas in which help is frequently requested."[2] Burnside has analyzed loss as a dominant theme in the lives of older people who go to service agencies for help.[3]

Thus, theorists of various disciplines such as psychology, sociology, medicine and social work all refer to loss in their discussions of aging. However, none of these theorists were noted to explicitly study aging within the framework of loss. Berezin refers to the scantiness of literature dealing with loss, grief and depression in the aged, despite the general recognition of the prevalence of these phenomena.[4] For example, in Birren's standard

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[1]Irving Rosow, "The Social Context of the Aging Self." The Gerontologist 13 (Spring 1973): 82-83.

[2]Dorothy K. Heyman and Grace H. Polansky, "Social Casework and Community Services for the Aged," in Behavior and Adaptation in Late Life, eds. Ewald Busse and Eric Pfeiffer (Boston: Little, Brown and Co., 1969), p. 325.

[3]Irene Burnside, "Loss: A Constant Theme in Groupwork with the Aging." Hospital and Community Psychiatry 21 (6) 1970: 173.

[4]Martin A. Berezin, "Introduction," in Geriatric Psychiatry: Grief, Loss and Emotional Disorders in the Aging Process, eds. Martin A. Berezin and Stanley Cath (New York: International Universities Press, 1965), p. 14.

sourcebook on aging, the words "grief" and "loss" do not appear at all in the index.[1] Thus, loss, when referred to, is seldom explicitly analyzed.

Freud, Bowlby, Parkes and others have formulated theories of grief, which is recognized as the normal psychological reaction to loss. Bowlby states that grief is "a peculiar amalgam of anxiety, anger, and despair following the experience of what is feared to be irretrievable loss."[2] According to Bowlby, this sequence of subjective states of grief following loss is accompanied by mourning.[3] Freud refers to mourning as "the reaction to the loss of a loved person, or to the loss of some abstraction which has taken the place of one, such as fatherland, liberty, an ideal, and so on."[4]

It is hypothesized by the researcher that, if one assumes, on the basis of literature such as that cited earlier, that loss is a dominant theme of aging, then one could analyze aging in the framework of theories of grief. The latter describe the dynamics of various types of reaction to loss and formulate methods of helping those suffering

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[1] J. Birren, Handbook of Aging and the Individual (Chicago: University of Chicago Press, 1959).

[2] John Bowlby, "Processes of Mourning." International Journal of Psycho-analysis 42 (1961): 331.

[3] Bowlby, "Processes of Mourning," p. 318.

[4] Sigmund Freud, "Mourning and Melancholia," in Collected Papers, Vol. 4 (London: Hogarth Press, 1956), p. 153.

loss. It is therefore expected that an analysis of aging in the framework of theories of grief and loss would enable one to better explain the dynamics of individual responses to aging and to consequently intervene more effectively to prevent or treat maladaptive responses.

Thus, the purpose of this study is to analyze aging, with particular focus on the aspect of loss, in order to determine if, in fact, theories of grief can be effectively utilized to study aging. In view of the lack of unifying theory, it is felt that such an analysis would be fruitful in terms of offering practitioners such as social workers a framework within which to more effectively base treatment, formulate policy and plan further research. Further, it would seem to have the potential of being applicable at the levels of both microcosm -- the individual and his interpersonal network of friends and family, and of macrocosm -- the social institutions of work, education and the family within which the individual functions.

Definitions

For the purposes of this paper, the researcher has defined those sixty-five years of age and over as constituting the "aged". However, vast differences among individuals in the nature and extent of the aging process must be acknowledged. Field states, "there is no fixed age at which

one suddenly becomes old. It is a gradual process."[1]

From a review of the literature, the researcher has categorized present theories of aging into three main groups -- disengagement, activity and developmental theory. These theoretical frameworks have been incorporated into discussion of the losses of aging.

Disengagement theory was originally formulated by Cumming and Henry as a result of their Kansas City Study. Damianopoulos defines disengagement as "an inevitable process in which many of the relationships between a person and other members of society are severed, and those remaining are altered in quality."[2] Disengagement theorists regard aging as an inevitable, mutually satisfying withdrawal of the individual and society, resulting in decreased interaction between the two. This process of disengagement may be initiated by either the individual or the society in which he functions. When the aging process is complete, the equilibrium which existed between the individual and his society in middle life has given way to a new equilibrium, characterized by a change in quantity and quality of relationships, usually in the form of decreased number and

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[1]Minna Field, The Aged, the Family, and the Community (New York: Columbia University Press, 1972), p. 12.

[2]Ernest Damianopoulos, "A Formal Statement of Disengagement Theory," in Growing Old, by Elaine Cumming and William E. Henry, with a Forword by Talcott Parsons (New York: Basic Books, 1961), p. 211.

intensity of interactions.[1]

Activity theory, on the other hand, is characterized by an almost polar viewpoint. It should be noted that while disengagement theory is formally articulated by specific theorists, activity theory could be termed an "implicit" one. In other words, it has not been formally presented, but is rather an implicit orientation common to various theorists. These theorists advocate the maintenance of fairly constant levels of physical, mental and social activity through the individual's life. Losses which occur with aging, such as those of job or spouse, should be compensated for by new activities, interests or social relationships, or by increased participation in existing ones.

The final category of theory is developmental or life span theory. Developmental theorists view aging as a normal, inevitable stage of the life cycle and recognize the interaction of past life experience, biological changes, and social expectations and values as salient to an analysis of the individual response to aging. Growth and adaptation are seen as possible throughout the life cycle, particularly if the individual's strengths and potentials are recognized and and reinforced by the social environment.[2] Thus,

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[1]Elaine Cumming and William E. Henry, Growing Old, with a Forword by Talcott Parsons (New York: Basic Books, 1961), passim.

[2]Robert N. Butler and Myrna I. Lewis, Aging and Mental Health: Positive Psychosocial Approaches (St. Louis: The C. V. Mosby Co., 1973), p. 18.

developmental theorists would view neither the mutual withdrawal of individual and society from one another, nor a constant level of interaction between individual and society, as characteristic of optimal aging. Rather, the optimal pattern of aging would be dependent on factors such as the individual's personality needs and values and the socio-cultural context.

Data Collection and Chapter Divisions

The method of study has been a selective review of the literature. The primary focus has been on material related to the theories of grief formulated by Lindeman, Parkes, Bowlby, Freud and Kubler-Ross; the three theories of aging -- disengagement, activity and developmental theory; and the losses of aging and the individual's response to these losses.

Chapters have been divided in relation to the individual's main life spaces. Kurt Lewin defines life space as "the entire set of phenomena constituting the world of actuality for a person or group of persons."[1] Williams and Loeb propose the social life space as a helpful conceptual framework in which to view aging, stating that such a perspective is advantageous because it clarifies the

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[1] H. B. English and Ava C. English, A Comprehensive Dictionary of Psychological and Psycho-analytical Terms (New York: Longmans, Green and Co., 1958).

relationships among personality variables, social situation variables, normative concepts, and age.[1] Thus, aging has been analyzed in relation to the three life spaces of health, work and leisure, and family and friends. Chapters II, III and IV are consequently entitled, "Health," "Work and Leisure," and "Family and Friends," respectively. Within these chapters, the particular life-space has been analyzed with reference to the nature and extent of those losses which occur with aging; how these losses are viewed from the perspectives of disengagement, activity and developmental theorists; and various individual patterns of response to these losses. In Chapter V, "Conclusions and Implications for Social Work," the researcher has formulated conclusions based on the analysis in Chapters II to IV and has elaborated on the implications of these findings to social work. In Chapter VI, the research paper is summarized.

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[1]Richard H. Williams and Martin B. Loeb, "The Adult's Social Life Space and Successful Aging: Some Suggestions for a Conceptual Framework," in Middle Age and Aging, ed. Bernice L. Neugarten (Chicago: University of Chicago Press, 1968), p. 379.

CHAPTER II

HEALTH

Introduction

Various health losses occur with aging. These include declines in the areas of psychological, physical and mental functioning. Disengagement, activity and developmental theorists view these losses from differing perspectives. The grief theories of Freud, Lindeman, Bowlby, Kubler-Ross and Parkes have been used to analyze the aged individual's responses to health losses.

Although the writer has categorized health into the areas of psychological, physical and mental functioning, it should be noted that this division is arbitrarily defined for purposes of organization. In fact, there is a great degree of overlap among the three areas. Peck states that "In no other phase of the human life cycle is there as much interrelationship of the biological and emotional states of being, as in that of the aged."[1] The issue of whether these losses are intrinsic to the aging process or primarily

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[1]Arthur Peck, "Psychiatric Aspects of the Geriatric Problem," in Depth and Extent of the Geriatric Problem, ed. Minna Field (Springfield, Illinois: Charles C. Thomas, 1970), p. 137.

related to extrinsic or environmental variables is another issue central to the discussion of health in the elderly. Verwoerdt, referring to health and illness as relative and dynamic concepts, recognizes the importance of extrinsic factors. He says that health exists when there is a state of dynamic equilibrium between individual and environmental stress, while disease develops when biological or psychological coping mechanisms are over-taxed.[1] Also important to note is the heterogeneity among aged individuals regarding physical, psychological and mental changes and the response to these changes. Thus, the various health losses noted do not apply equally to the entire aged population.[2]

Health Losses

Psychological Losses

Tests of intellectual and cognitive changes with age reveal confusing and contradictory results. Schaie and Strother state that these discrepant results can be explained in part by the various experimental designs used.[3]

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[1] Verwoerdt, "Biological Characteristics of the Elderly," p. 52.

[2] Idem, "Psychiatric Aspects of Aging," in Foundations of Practical Gerontology, 2d ed., rev., eds. Rosamonde R. Boyd and Charles G. Oakes (Columbia, South Carolina: University of South Carolina, 1969), p. 124.

[3] Carl Eisdorfer, "Intellectual and Cognitive Changes in the Aged," in Behavior and Adaptation in Late Life, eds. Ewald W. Busse and Eric Pfeiffer (Boston: Little, Brown and Company, 1969), p. 239.

Eisdorfer notes the additional effects of variables such as education, employment history, physical health, test experience and attitudes to tests, on test results.[1] Despite these difficulties, various changes with age have been discerned in relation to intellectual functioning, learning and memory.

Intellectual functioning

Numerous studies have been conducted on intellectual functioning in old age. Wechsler's study indicated that intelligence tests scores on the Wechsler-Belview Intelligence Test reached a maximum at about age twenty-five, followed by an uninterrupted decline thereafter.[2] He found that some abilities declined at different rates than others. For example, there was less decline in the Vocabulary and Comprehension subtests of the Wechsler Adult Intelligence Scale than in the Substitution, Similarities and Memory Span tests.[3]

Other studies have revealed less decline of intellectual functioning with age. Eisdorfer, in a three to four year follow-up of the Duke longitudinal study, found no

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[1]K. Warner Schaie and Charles R. Strother, "A Cross-Sequential Study of Age Changes in Cognitive Behavior," in Human Aging, ed. Sheila M. Chown (Harmondsworth, England: Penguin Books Inc., 1972), pp. 50-51.

[2]D. Wechsler, "'Hold' and 'Don't Hold' Tests," in Human Aging, ed. Sheila M. Chown (Harmondsworth, England: Penguin Books Inc., 1972), p. 27.

[3]Idem, p. 31.

decline in a group of subjects aged sixty to ninety-four; another follow-up study, by Eisdorfer and Wilkie, of the survivors of the original Duke group found the decade from age sixty-two to seventy-two not to be associated with rapid intellectual decline. Changes in the seventy-four to eighty-six age range were not striking.[1] Schaie and Strother's study, using a cross-sequential design, similarly revealed little decrease in intellectual functioning over time.[2]

Various studies indicate the relevance of factors such as health status to intellectual capacities in old age. Wilkie and Eisdorfer found a significantly high correlation between intellectual decrement and elevated bloor pressure; Botwinick and Birren, in their sample pre-selected for good health, found that those subjects with even mild and asymptomatic health problems performed less well on the Wechsler Adult Intelligence Scale and other cognitive tasks than very healthy peers; Carp notes that a clear drop in IQ precedes death fairly often.[3]

Thus, gross intellectual decline as intrinsic to aging is not adequately supported by the literature, although

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[1]Eisdorfer, "Intellectual and Cognitive Changes," p. 242.

[2]Schaie and Strother, "Cross-Sequential Study," p. 50.

[3]Eisdorfer, "Intellectual and Cognitive Changes," pp. 245-245; Ibid., p. 245; Carp, "The Psychology of Aging," p. 120.

a small amount of decrement is not unusual. Factors such as poor health seem to be positively associated with lessened intellectual capacities. There is a differential rate of decline for various aspects of intellectual functioning, as indicated by Wechsler.

Learning

There have also been numerous studies of learning and memory. Wimer and Wigdor conclude that the primary deficit in old age seems to be in learning ability, not retention. In other words, the older take longer to learn data, but once learned, can retain it as well as the younger.[1] Shooter et al similarly conclude that the aged can be trained to new tasks, given more time than the younger worker.[2] Canestrari and Eisdorfer in their respective studies tested paired-associate and serial rote learning, finding that the older did better at more slowly paced or self-paced tasks than at more rapidly paced ones. This improved learning which resulted when given more time to respond involved an increase in the total number of responses, rather than an increase in

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[1]R. E. Wimer and Blossom T. Wigdor, "Age Differences in the Retention of Learning," in Human Aging, ed. Sheila M. Chown (Harmondsworth, England: Penguin Books Inc., 1972), p. 188.

[2]Antonia Shooter et al, "Some Field Data on the Training of Older People," in Human Aging, ed. Sheila M. Chown (Harmondsworth, England: Penguin Books Inc., 1972), p. 149.

the number of right answers.[1]

Eisdorfer speculates that part of the reason why the older take longer to respond in a learning situation may be fear of failure. He suggests that the older individual, when in a test situation, may shift from the aggressive stance of Western culture to a defensive one, in which, rather than risk failure, he limits his response.[2] The finding of Canestrari and Eisdorfer that improved learning was associated with more answers, rather than an increase in the number of right answers, would seem to support this view. Thus, most studies indicate that learning ability is diminished with aging, in the sense that a longer learning period is necessary. This decline can be complicated by adverse environmental factors.

Memory

There are believed to be at least two types of memory systems -- short-term memory (STM) and long-term memory (LTM). STM lasts from thirty seconds to fifteen minutes and deals with the initial reception of material. From the STM, material passes into LTM, where it is stored until recalled.[3] Most

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[1]Eisdorfer, "Intellectual and Cognitive Changes," p. 246.

[2]Ibid.

[3]Sheila Chown, "Learning and Memory," in Human Aging, ed. Sheila M. Chown (Harmondsworth, England: Penguin Books Inc., 1972), p. 131.

experimental work on memory in the aged has been in relation to STM. Various theorists, such as Welford, Clay and Jerome, agree that STM declines with age.[1] Some studies indicate this decline can be compensated for in various ways. For example, Chapman, McGhie and Lawson found short-term memory to be less impaired when information was presented in auditory form, while it was most affected when information was presented in visual form.[2] Lawrence found that the presentation of cue cards increased scores on short-term memory tasks.[3]

Theories of aging and psychological losses

Literature on the disengagement, activity and developmental theories of aging does not directly refer to the psychological losses of aging. However, the researcher speculates that the respective theorists would advocate differing approaches to these losses.

Disengagement theorists might view the intellectual, learning and memory losses that occur with age to be of

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[1]Andrew McGhie, James Chapman and J. S. Lawson, "Changes in Immediate Memory with Age," in Human Aging, ed. Sheila M. Chown (Harmondsworth, England: Penguin Books Inc., 1972), p. 154.

[2]Ibid., p. 154.

[3]Mary W. Lawrence, "Short Term Memory Loss with Age: A Test of Two Strategies for Its Retardation," in Human Aging, ed. Sheila M. Chown (Harmondsworth, England: Penguin Books Inc., 1972), p. 163.

minimal importance. Since the individual interacts little with his environment, learning new things or remembering data would have minimal relevance to his lifestyle.

Activity theorists might view the psychological losses from a different perspective. These losses might be considered as potentially disruptive to optimal aging, interfering with the individual's sustained interaction with society. For example, activity theorists advocate the substitution of new activities, or increased involvement in present activities, to replace lost ones. Losses of memory, learning ability and intellectual functioning would have dysfunctional impact on the individual's efforts to continue to interact with his environment. For example, meeting social appointments, engaging in intellectual pursuits or learning new skills would be hampered by the psychological deficits of aging. Activity theorists might advocate the use of accommodating techniques to minimize the isolating effects of the psychological losses and to render the individual's continued involvement feasible.

Developmental theorists might view the psychological losses from yet another perspective. These losses would be seen as a source of both stress and potential growth. The researcher speculates that the developmental task would be that of adjusting to the losses and of seeing their positive aspects. For example, the individual might accept losses in memory and learning, while at the same time using various

accommodating techniques to help him adjust to them. The potential for growth presented by the losses would be stressed. The individual could "grow" to become more appreciative of the different, but perhaps equally satisfying, experience of learning at a slower pace.

To summarize, findings as to the nature and extent of losses in psychological functioning are at present inconclusive. Studies indicate some intellectual decline is concomittant with aging. This decline can be exaggerated by the presence of factors independent of the aging process. Learning capacity does not appear diminished by aging, although the rate at which learning occurs does decline. Some losses in memory occur. Various measures exist whereby the individual can compensate for these psychological deficits. The researcher has speculated that the respective theorists would view these losses from differing perspectives and would define different individual responses as indicative of optimal aging.

Physical Losses

A discussion of the physical losses characteristic of aging raises issues similar to those raised in relation to the psychological losses. In other words, differing experimental designs can yield incompatible results, while attributing the etiology of the losses to either the aging process or environmental factors is difficult.

Despite these problems, numerous conclusions have been reached about the physical losses of aging. It has been established that the old are less affected by acute illness than the younger, while the incidence of chronic disease rises steadily with advancing years.[1] However, the debilitating effect of chronic illness is often overestimated. Butler and Lewis refer to the fact that only 5 per cent of the elderly live in institutions, while 95 per cent can remain in the community.[2] When disability is defined as the elderly person considering himself limited in one or more daily activities, disability due to chronic illness rises to 30 per cent. This incapacity is usually minimal, consisting primarily of discomfort or inconvenience, with few individuals requiring assistance from others.[3]

Loss of perceptual abilities is a common physical loss. Changes in the eye result in the elderly needing twice as much light to see as do youths of twenty. In addition, optical responses are slower, so that longer time is required to accommodate to changes in lighting. These optical losses cause a contraction of the field of visual perception, which

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[1]Eisdorfer, "Intellectual and Cognitive Changes," p. 117.

[2]Butler and Lewis, Aging and Mental Health, p. 3.

[3]E. Harvey Estes, "Health Experience in the Elderly," in Behavior and Adaptation in Late Life, eds. Ewald L. Busse and Eric Pfeiffer (Boston: Little, Brown and Co., 1969), p. 118.

in turn contributes to the problems of learning and memory cited earlier.[1] However, it should be noted that 80 per cent of the elderly have reasonably good vision.[2] Furthermore, the aged individual often can accommodate to these losses by such measures as using more light to read and being careful when driving at night.[3]

Hearing also declines, with loss being more common in men. Butler and Lewis state that 30 per cent of the older suffer hearing loss.[4] Particular difficulty is evident with high-pitched sounds and those of low intensity.[5] Hearing loss may inhibit perception of background noises, so that the person often has a feeling of loss and the sensation that the world is dead. In addition, the individual tends to withdraw from others in response to his loss of perceptual cues. As a result of this loss of perceptual cues and reduced reality testing, suspiciousness and paranoid behavior is sometimes associated with hearing loss.[6] The use of a hearing aid can

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[1]Smith, Handbook of Aging, pp. 6-7.

[2]Butler and Lewis, Aging and Mental Health, p. 98.

[3]Atchley, Social Forces in Later Life, p. 54.

[4]Butler and Lewis, Aging and Mental Health, p. 32.

[5]Atchley, Social Forces in Later Life, p. 55.

[6]Ewald W. Busse, "Research on Aging: Some Methods and Findings," in Geriatric Psychiatry: Grief, Loss and Emotional Disorders in the Aging Process (New York: International Universities Press, 1965), pp. 88-89.

help individuals accommodate to this loss.

Kinesthetic perception -- awareness of body position and orientation in space, is also thought to become less accurate, contributing to the frequency of falls in older persons. The individual may try to compensate by use of auditory or visual cues, but this may amplify the difficulty, due to deficits in these perceptual abilities as well.[1]

In addition to the above perceptual losses, losses in the various body systems occur. Skin and connective tissue lose their elasticity and resilience, causing skin to become dry and fragile, susceptible to chronic skin sores.[2] Changes in the muscular system, such as loss of muscle tone and strength, result in slower reaction times and decreased flexibility, making daily tasks more difficult and impairing the efficiency of vital functions such as breathing, urination and defecation.[3] Alterations in the skeletal system cause stiffened joints and changes in bone structure. These are demonstrated in reduced height and stooped posture. As a result, one sees a high incidence of chronic diseases such

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[1]Carp, "Psychology of Aging," pp. 111-114.

[2]Smith, Handbook of Aging, p. 6.

[3]Verwoerdt, "Biological Characteristics," p. 57.

as arthritis, and of fractures.[1]

Changes in the cardiovascular system result in heart disease, such as hypertensive heart disease, coronary heart disease, and cardiovascular attacks being common.[2] The respiratory system becomes less efficient due to changes in the muscles and joints of the ribs and chest. There may be arteriosclerosis of the lung vessels as well as alterations in the elastic fibres of the lung. Resulting problems are emphysema, lung cancer and shortness of breath.[3] Deterioration in the gastrointestinal system, such as reduced mobility of the stomach and intestines and decreased production of digestive juices by the stomach, accompanied by factors such as loss of teeth and decreased taste, result in problems of constipation and hemorrhoids.[4]

Changes in the genito-urinary system cause problems such as frequent urination, enlargement of the prostate gland in men, and infections of the urethra and bladder in women.[5] Loss of sexual desire and activity have been overestimated by many. Masters and Johnson's studies, the Duke

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[1]Estes, "Health Experience," p. 117; Weg, "Changing Physiology," p. 50.

[2]Estes, "Health Experience," p. 117.

[3]Verwoerdt, "Biological Characteristics," p. 59.

[4]Ibid., p. 60.

[5]Ibid., p. 62.

study, and others refer to the possibility of continued satisfactory sexual activity into old age although sexual drive and the frequency of sexual activity may diminish.[1] Many attribute sexual problems such as impotence to primarily psychological, rather than physical causes.[2]

It appears that many of these losses in the body systems are environmentally induced or, if intrinsic to aging, may be compensated for or alleviated. For example, changes in the muscular skeletal system can be reduced by moderate and regular exercise; while exercise, diet regulation and decreased stress are thought to help prevent cardiovascular disease. Problems of the gastrointestinal system may be alleviated by attention to proper diet and suitable dentures or, if psychosocial in origin, by treatment of depression or other dysfunctional affective states.[3] Problems of the genito-urinary system may be remedied by medical or psychosocial intervention, depending on the cause.[4]

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[1]Eric Pfeiffer, "Sexual Behavior in Old Age," in Behavior and Adaptation in Late Life, eds. Ewald Busse and Eric Pfeiffer (Boston: Little, Brown and Co., 1969), pp. 155-161.

[2]Butler and Lewis, Aging and Mental Health, p. 101.

[3]Verwoerdt, "Biological Characteristics," pp. 57-61.

[4]Pfeiffer, "Sexual Behavior," p. 153.

Theories of aging and physical losses

Although there is minimal reference in the literature to how disengagement, activity and developmental theorists view these physical losses, the researcher has formulated some speculations as to how they might view them.

Disengagement theorists might not view the physical losses as a major crisis for the aging individual. Cumming and Henry state that the successfully disengaged individual would see problems of health as less bothersome as age increases.[1] Losses of hearing, vision and mobility would not be devastating, in view of the individual's decreased interaction with others. It is interesting to note, however, that, although the Kansas City study sample excluded those with chronic illness, the most frequent response to the question of what was the worst thing about the individual's present age was complaints of health. For example, two-thirds of the women and over one half of the men mentioned poor or failing health.[2]

Activity theorists might regard the physical losses as problematic, as they would impede the individual from maintaining prior levels of activity and of interaction with others. Measures such as attention to adequate diet and exercise, and use of assistive devices such as hearing aids

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[1]Cumming and Henry, Growing Old, p. 73.

[2]Ibid., p. 67.

and glasses, would be encouraged to assist the individual to maintain his previous functioning. When such accommodating techniques were unsuccessful in alleviating the effects of the losses, substitution of new activities would be recommended. For example, the individual might be encouraged to give up more physically taxing sports for less tiring ones.

Developmental theorists might view the physical losses of aging as presenting a developmental task to the individual. As with the psychological losses, the aged person might be encouraged to accept the losses, making adjustments to accommodate to them, while the possibility for growth would be maximized. For example, the individual might view his loss in mobility as an opportunity to learn to appreciate more fully his immediate surroundings.

Mental Health

Discussion of the mental illnesses associated with aging leads to recognition of the difficulty in separating physical and mental illness, and intrinsic and extrinsic etiology. Verwoerdt refers to the presence of psychological factors in most physical illnesses, either as a contributing or complicating factor. He states that geriatric illnesses "represent psychosomatic problems par excellence."[1] Wang refers to the fact that few, if any, of the psychiatric

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[1]Verwoerdt, "Psychiatric Aspects," p. 138.

disorders in old age can be viewed as either exclusively organic or exclusively psychogenic.[1]

Mental illness occurs with increasing frequency with age. One study of the incidence of functional and organic psychoses for a population of 100,000 revealed that the incidence increased from 45 per 100,000 in the 15 to 24 year old age group; to 112, for the 35 to 44 group; to 137 for the 65 to 74 group; and to 228 for the age group over 75.[2]

Mental disorders in old age are of two types, organic and functional. Of those mental illnesses resulting in hospitalization, it is estimated that about 30 to 40 per cent are composed of functional disorders; of the remaining 70 per cent which are organic, about 50 per cent may be reversible. As the names imply, the organic disorders have a mainly physical cause, while the functional disorders have no readily apparent physical cause and seem to have emotional origins.[3]

Organic mental disorders

Butler and Lewis state that Organic Brain Syndromes

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[1]Hsioh-Shan Wang, "Organic Brain Syndromes," in Behavior and Adaptation in Late Life, eds. Ewald W. Busse and Eric Pfeiffer (Boston: Little, Brown and Co., 1969), p. 265.

[2]Butler and Lewis, Aging and Mental Health, pp. 49-50.

[3]Ibid., p. 50.

(OBS) may be either acute and reversible (RBS) or chronic (CBS). Both are associated with memory disturbance; impairment of intellectual function, comprehension, judgement and orientation; and shallow or labile effect. RBS are caused by such factors as congestive heart failure, malnutrition, anemia, infection and drug reactions, while CBS are caused by irreversible brain damage.[1]

When the etiology of RBS and CBS are as noted above, proper medical intervention and compensatory techniques can produce good results. Often, however, OBS are accompanied by emotional symptoms and behavior reactions. These may result from the deficit itself, as in senile dementia; may be emotional reactions and adaptations to the deficit itself; or may be reactions of release phenomena, such as the appearance of latent personality traits and tendencies as a result of brain damage.[2] In these cases, treatment is more difficult. Various authors stress a hopeful prognosis if both medical and psychosocial intervention is implemented.[3] In the past, psychiatric and mental problems of the aged have been primarily attributed to cerebral changes, so that treatment has been minimal, mainly of a custodial nature. However, the role of environmental stress is increasingly being seen as

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[1]Ibid., pp. 72-75.

[2]Ibid., p. 70.

[3]Ibid., p. 257; Weg, "Changing Physiology," p. 54.

central to even the "organic" brain disorders of the older.[1]

Functional mental disorders

Functional mental disorders are the second category of disorders. These include psychoses and neuroses. Of the psychoses, those most relevant to the aged include late life schizophrenia; affective psychoses, such as involutional melancholia and manic depression; psychotic depression; and paranoia.[2]

As with the other aspects of aging discussed, the relevance of extrinsic factors to mental illness is seen. Roth and Kay, in their study of patients admitted to a mental hospital in England, noted that exogenous factors were more related to affective psychoses and schizophrenia in old age than to those corresponding disorders occurring in early life.[3] They found that factors such as physical illness, bereavement, social dislocation, family strife and somatic symptoms were often seen at the time of illness.[4]

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[1]Butler and Lewis, Aging and Mental Health, pp. 75-76; Verwoerdt, "Psychiatric Aspects," pp. 138-139; Wang, "Organic Brain Syndromes," p. 269.

[2]Butler and Lewis, Aging and Mental Health, pp. 49-52.

[3]Martin Roth and D. W. K. Kay, "Psychoses among the Aged," in Medical and Clinical Aspects of Aging, ed. Herman T. Blumenthal (New York: Columbia University Press, 1962), p. 90.

[4]Ibid., p. 80.

Paranoia is fairly common among the aged.[1] The relationship between hearing loss and paranoia has already been noted.[2] Neugarten, using projective tests to study ego function in the aged, found differences among the middle-aged and old in how they view the environment. For example, while the middle-aged perceived themselves as assertive and energetic, the aged tended to see the world as complex and dangerous, to be dealt with in a conforming and accommodating way.[3] It is possible that the aged are unable to express their anger and fear at this environment which, realistically, is often complex and dangerous.[4] Instead, they may hide these repressed emotions behind a conforming response. Such a pattern might result in paranoia.

Neuroses, such as anxiety neurosis, hysterical neurosis, obsessive-compulsive and phobic neuroses, and depressive neurosis, are very common among the aged. Of these, depression is the most frequent.[5]

Numerous authors attest to the difficulty in

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[1]Butler and Lewis, Aging and Mental Health, p. 52.

[2]Supra, p. 24.

[3]Bernice L. Neugarten, "Personality and the Aging Process." The Gerontologist 12 (Spring 1972): 10.

[4]The researcher has noted the apparent absence of direct expression of anger by the aged. Infra, pp. 44-45.

[5]Butler and Lewis, Aging and Mental Health, p. 54.

diagnosing depression in the aged. The apathetic, vacant look characterizing the older depressed person may be attributed to organic changes rather than to depression. Irritability, a common symptom of depression at any age, may be related to organic deficit when seen in the aged.[1] As a result of these difficulties in diagnosis, depression in the aged may frequently go undetected as such.

There is disagreement concerning the etiology of depression in the aged. Some feel that the classic psychoanalytic concept of intrapsychic conflict causing feelings of guilt and self-contempt is more relevant to depression before senescence. Depressions in the elderly are seen as reactive, resulting from real losses and stresses in biological, psychological and social aspects of life.[2] Others disagree with this departure from the psychoanalytic explanation of depression.[3]

Sainsbury refers to the increasingly positive relationship between suicide and mental illness, particularly

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[1]Sidney Levin, "Depression in the Aged," in Geriatric Psychiatry: Grief, Loss and Emotional Disorders in the Aging Process, eds. Martin A. Berezin and Stanley Cath (New York: International Universities Press, 1965), p. 205.

[2]Gordon S. Krauss, "The Phenomenon of Depression in Old Age," The Gerontologist 13 (Spring 1973): 100; Busse, "Research on Aging," p. 81; Verwoerdt, "Psychiatric Aspects," p. 136.

[3]Butler and Lewis, Aging and Mental Health, p. 55.

depression, with age.[1] The elderly, comprising ten per cent of the population of the United States in 1970, account for twenty-five per cent of the reported suicides.[2]

Hypochondriacal neurosis, preoccupation with one's physical and emotional health, is also common. This over-attention to the normally unconscious functioning of one's internal organs can sometimes interfere with their effective operation and cause psychosomatic disorders.[3] Krauss cites Stern's study, in which the elderly were found to exhibit "somatic equivalents" rather than depression.[4] Common psychophysiological disorders in the elderly are psychogenic rheumatism, hyperventilation, cardiac neuroses with fear of sudden death, chronic indigestion and dizziness.[5]

Theories of aging and mental health

It would seem logical that those mental disorders which are organic in etiology would be viewed by

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[1]Peter Sainsbury, "Suicide in the Middle and Later Years," in Social and Psychological Aspects of Aging, eds. Clark Tibbitts and Wilma Donahue (New York: Columbia University Press, 1962), p. 104.

[2]Butler and Lewis, Aging and Mental Health, p. 61.

[3]Smith, Handbook of Aging, p. 14.

[4]Krauss, "Depression," p. 103.

[5]Butler and Lewis, Aging and Mental Health, p. 59; Smith, Handbook of Aging, p. 14.

disengagement, activity and developmental theorists in the manner postulated for the physical losses of aging.[1] The researcher speculates that the functional mental disorders might be regarded in different ways by the respective theories.

Disengagement theorists postulate that the lessening of bonds between the aged individual and others will result in the increased freedom of the former from the control of norms which govern daily behavior.[2] Thus, Cumming and Henry might view some mental disorders as indicative of the individual's release from normative controls. In fact, Cumming and Henry refer to the increased tendency to personal whimsy and eccentricity in the aged female subjects in their study and attribute this behavior to the lessening of normative controls.[3]

Thus, it is inferred that disengagement theorists might regard many of the functional mental disorders as indicative of the process of disengagement by the individual and society. The high incidence of suicide in the aged would be the ultimate disengagement of individual and society. Cumming and Henry do not define what degree of disengagement is representative of optimal aging. The researcher surmises that even the proponents of disengagement would not recommend total

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[1]Supra, pp. 28-29.

[2]Damianopoulos, "Formal Statement of Disengagement," p. 211.

[3]Cumming and Henry, Growing Old, p. 125.

disengagement, in the forms of psychosis or suicide.

Activity and developmental theorists might view mental disorders as reactive to the losses of aging. For example, activity theorists advocate the substitution of new activities or interests to replace lost ones. Cath refers to restitution, efforts to compensate for increasing losses, occurring in the middle and later years. However, restitution or new starts become increasingly difficult in the later years, due to decreased opportunities open to the older person and to less energy available to negotiate new activities or interests. Cath speculates that neurotic traits in the elderly thus may be a defense against anxiety about further depletion.[1] The researcher hypothesizes, on this basis, that many mental disorders, not only neurotic traits, may derive from anxiety about the possibility of replacing lost activities or objects. Thus, activity theorists might point to the external stresses often preceding mental illness in the aged and attribute many mental disorders to anxiety about, or failure to, substitute new activities or objects for lost ones.[2]

Developmental theorists might view mental disorders in the aged as symptomatic of difficulty in, or failure to, resolve the developmental tasks of aging. Cath states that

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[1]Stanley H. Cath, "Some Dynamics of the Middle and Later Years," in Crisis Intervention: Selected Readings, ed. Howard J. Parad (New York: Family Service Association of America, 1967), pp. 183-185.

[2]Supra, pp. 32; 34.

at each time of stress, the individual may either master the stress and integrate it, resulting in growth and maturity, or he may be caught in serious conflict, producing regression.[1] Butler refers to the pathological forms the life review can take, such as extreme depression or suicide, and speculates that the increased mental disorders in late life are related to poor resolution of the life review.[2]

To conclude, the aged as a group have a high incidence of mental illnesses. While most mental illnesses in the aged were formerly attributed to organic deterioration and managed in a custodial manner, current findings indicate the importance of psychosocial factors to the etiology of both functional and organic brain syndromes. Various theorists of aging are speculated to view mental illness in the aged from differing perspectives.

Response to Health Losses as a Grief Reaction

The researcher has analysed individual responses to health losses in old age in order to ascertain if there are similarities between the aged individual's response and grief reactions. Reference is concentrated on the theories of grief formulated by Parkes, Bowlby, Lindeman, Kubler-Ross and Freud. The researcher has combined the grief reactions

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[1] Cath, "Dynamics of Middle and Later Years," p. 175.

[2] Butler and Lewis, Aging and Mental Health, pp. 68, 73; Infra, p. 51.

conceptualized by these theorists, resulting in a grief reaction of four stages -- denial, anger, depression and new identity formation. When the individual proceeds through these four stages within a reasonable amount of time, the result is a normal grief reaction. Distorted grief reactions are evident in symptomatology that is often similar to that of a normal grief reaction, but which is exaggerated, prolonged, delayed, or emerges in a distorted form.[1]

Denial

The first stage of a grief reaction is that of denial and disbelief. Bowlby states that when confronted with loss, the individual is at first in a state of disbelief, sometimes continuing to act as if the lost object were still there.[2] Parkes also refers to the initial reaction of numbness and of denying the loss.[3] Kubler-Ross notes that most individuals react to the initial awareness of terminal illness with denial.[4]

Denial is considered normal when the individual is

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[1]Collin M. Parkes, Bereavement, Studies of Grief in Adult Life (New York: International Universities Press, 1972), p. 183.

[2]Bowlby, "Processes of Mourning," p. 333.

[3]Parkes, Bereavement, p. 183.

[4]Elizabeth Kubler-Ross, On Death and Dying (New York: MacMillan Co., 1969), p. 39.

able to progress to the next stage of grief. Sometimes, however, the individual remains in the denial phase, constituting a maladaptive response to grief. Lindeman refers to the avoidance of expressing grief or emotions related to loss as relevant to morbid grief reactions.[1] Parkes concludes that one reaction common to atypical, disturbed grief is that of strong attempts to avoid grieving.[2] Bowlby refers to the fact that the starting point of depressive illness often occurs when the individual remains oriented to the lost object and continues to live as if it were present or retrievable.[3] Thus, denial can cease to be a healthy adaptive response to stress or loss, and become pathological, aggravating the very problem it is directed against.

Denial, the first phase of grief, is seen in the aged in response to health losses. Butler and Lewis refer to denial as a common adaptive technique or defense mechanism in the aged.[4] Clark notes the positive cultural values associated with mastery and competence in American society,

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[1]Erich Lindeman, "Symptomatology and Management of Acute Grief," in Crisis Intervention: Selected Readings, ed. Howard J. Parad (New York: Family Service Association of America, 1965), p. 143.

[2]Collin Murray Parkes, "Bereavement and Mental Illness, A Clinical Study of the Grief of Bereaved Psychiatric Patients." British Journal of Medical Psychology 38 (January 1965): 12.

[3]Bowlby, "Processes of Mourning," p. 336.

[4]Butler and Lewis, Aging and Mental Health, p. 40.

stating that "Only by being independent can an American be truly a person, self-respecting and worthy of concern and the esteem of others."[1] As a result, dependency, particularly threatening to the aged, is often reacted to with denial or self-recrimination.[2] The researcher speculates that health losses, since they frequently threaten the individual's independence, would be especially likely to be reacted to with denial.

Denial by the aged person of the psychological losses of aging would occur when he confabulates in an effort to hide memory lapses. Similarly, the refusal of the aged person to use accommodating techniques, such as leaving notes to himself of appointment dates, is a form of denial of the psychological losses. Carp refers to individuals who react to these losses by denying them.[3] In relation to denial as a response to the physical losses, Butler and Lewis cite the elderly individual who denies he is ill and refuses to see a doctor or take medication.[4] Verwoerdt refers to the denial by the cardiac patient of the seriousness of his condition

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[1]Margaret Clark, "Cultural Values and Dependency in Later Life," in Aging and Modernization, eds. Donald O. Cowgill and Lowell D. Holmes (New York: Meredith Corp., 1972), p. 263.

[2]Ibid.

[3]Carp, "Psychology of Aging," p. 110.

[4]Butler and Lewis, Aging and Mental Health, p. 40.

and consequent failure to limit his activities.[1] The failure of the older person to make accommodations in lifestyle to these physical losses is another instance of denial. Forms of denial by the aged person of mental disorders were not noted in the literature. The researcher speculates that an example could be the use of "busyness" to ward off depression and to deny depressed feelings. Perlin and Butler noted this use of activity in response to changes accompanying aging.[2]

One feature characteristic of the initial stages of grief is that of helplessness and dependency. Lindeman refers to loss of a significant object causing the bereaved to feel aimless and disorganized as he realizes the impact on his life. As a result, there is a strong dependency on anyone who stimulates the bereaved to activity.[3] Parkes similarly refers to the bereaved adopting a submissive, defeated attitude, relying on others for help.[4]

This helplessness as characteristic of the initial stages of grief is relevant to health losses in the elderly. For example, Verwoerdt refers to the phenomenon of reacting to loss by becoming overly helpless and dependent.[5] In

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[1]Verwoerdt, "Psychiatric Aspects," p. 131.

[2]Infra, pp. 124-125.

[3]Lindeman, "Symptomatology," p. 143.

[4]Parkes, Bereavement, p. 86.

[5]Verwoerdt, "Psychiatric Aspects," p. 131.

relation to the psychological losses of aging, the researcher speculates that some are not, in fact, irreversible losses, but symptoms of the individual's grief reaction to other losses. For example, lapses in memory might be an indication of the need for dependency characteristic of the initial stages of grief. It is more acceptable socially to satisfy dependency needs through the sick role than by directly asking for help. The researcher similarly conjectures that some of the physical losses are indicative of dependency needs related to grief. Estes refers to the longer hospital stays of the older patient, in comparison to the younger one.[1] It is feasible that this pattern is not based entirely on physical needs, but is an expression of dependency needs. In relation to mental disorders in the aged, Goldfarb notes a subjective sense of helplessness, accompanied by anxiety and a propensity to search out and delegate special powers to a parent surrogate, as common to all the mental disorders of the aged.[2] Thus, there is indication of this characteristic common to the early stages of grief in the mental disorders of the aged.

Theories of aging. The researcher has hypothesized that disengagement, activity and developmental theorists might all regard denial of the health losses of aging as

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[1]Estes, "Health Experience," p. 115.

[2]Alvin I. Goldfarb, "The Psychotherapy of Elderly Patients," in Medical and Clinical Aspects of Aging, ed. Herman J. Blumenthal (New York: Columbia University Press, 1962), p. 106.

dysfunctional to optimal aging. Implicit in the individual's readiness to disengage from society is his acceptance of ego changes and of reduced capacities that make disengagement functional for both the individual and society. Activity theorists might see denial of health losses in aging as an obstacle to finding substitutes for these losses. Similarly, developmental theorists might view denial of the physical losses as blocking the individual's developmental task of forming a modified self-conception based on the integration of the physical changes of aging.

Anger

The second stage of a grief reaction is that of anger. Bowlby and Parkes refer to anger as characteristic of the "protest" and "pining" periods of grief, respectively.[1] Kubler-Ross states that the second stage of grief is that of anger.[2] Parkes, Lindeman and Kubler-Ross refer to this anger often being associated with general irritability and bitterness to others.[3]

Generally, there is little reference in the literature to the expression of anger by the aged in response to health

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[1]Bowlby, "Processes of Mourning," p. 333; Parkes, Bereavement, p. 79.

[2]Kubler-Ross, On Death and Dying, p. 51.

[3]Parkes, Bereavement, p. 80; Lindeman, "Symptomatology," p. 142; Kubler-Ross, On Death and Dying, p. 51.

losses. Butler and Lewis refer to some old people who are described as "cantankerous, ornery, irritable" and relate this to outrage felt by the individual at his situation.[1] Pincus refers to the "angry men," an unsuccessful pattern of adaptation to aging conceptualized by Reichard.[2]

Cath offers explanation for this lack of evidence of anger by the aged in reaction to health losses. He refers to aggression being turned inward in the elderly, as turning it outward might precipitate desertion and helplessness.[3] Thus, the aged appear to commonly express their anger in depression, which is the next stage of a grief reaction.

Depression

The third stage of a grief reaction is that of depression. Parkes refers to despair and depression being characteristic of the later phases of grief. Closely associated is apathy, aimlessness, withdrawal and loss of aggressiveness.[4] Freud notes feelings of painful dejection and loss of interest in the outside world during mourning.[5]

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[1]Butler and Lewis, Aging and Mental Health, p. 39.

[2]Allen Pincus, "Toward a Developmental View of Aging for Social Work." Social Work 24 (July 1967): 40.

[3]Cath, "Dynamics of the Middle and Later Years," p. 189.

[4]Parkes, Bereavement, p. 79.

[5]Freud, "Mourning and Melancholia," p. 153.

Bowlby's second phase of mourning, "Despair," is similarly associated with depression. He states depression results from hopes of retrieving the lost object fading. As a result, despair sets in, while behavior becomes disorganized since the individual lacks a love-object to whom to relate.[1] Kubler-Ross also refers to depression as characteristic of the fourth stage of grief.[2]

In the depressed stage, the grieving individual tends to withdraw socially. Most theorists relate this behavior to the individual being absorbed with the tasks of "grief work." For example, Parkes states that two important components of grief work are the painful repetitious recollection of the loss experience and the attempt to make sense of the loss, fitting it into one's set of assumptions of the world.[3] Freud refers to the task of withdrawal of the libido from attachment to the lost object. Each of the memories and hopes which bound the libido to the object is brought up and hyper-cathected, before detachment of the libido can occur.[4]

The high incidence of depression in the aged has been noted.[5] The researcher speculates that some of this

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[1]Bowlby, "Processes of Mourning," pp. 334-335.

[2]Kubler-Ross, On Death and Dying, p. 86.

[3]Parkes, Bereavement, p. 77.

[4]Freud, "Mourning and Melancholia," p. 154.

[5]Supra, p. 33.

depression is symptomatic of the third phase of the aged individual's grief reaction to health losses. Busse found that a large percentage of the aged individuals in his study could relate the advent of depression to a specific stimulus.[1] Other theorists agree with this view of depression in the aged being primarily reactive.[2] Although physical losses may not be the stimulus precipitating all reactive depressions in the aged, at least some of these depressions might be reactions to the physical losses of aging.

As noted, social withdrawal is often associated with the depressive stage of loss. This can be adaptive, freeing energy for grief work. At other times, withdrawal can become maladaptive. The researcher speculates that health losses may be particularly likely to result in maladaptive withdrawal because the nature of these losses makes social reintegration hard. For example, in relation to psychological losses, the individual who suffers memory deficits will find it increasingly difficult to re-engage himself in social interaction with others and may tend to withdraw further, thereby attenuating his grief reaction. In relation to physical losses, instances of withdrawal can also be seen. Carp refers to the person who, as a result of perceptual decrement,

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[1]Busse, "Research of Aging," p. 81.

[2]Supra, pp. 32, 34.

becomes hesitant, loses confidence and withdraws from others.[1] The relationship between deafness and schizophrenia has been noted.[2] This instance is a severe form of withdrawal.

Thus, it would appear that there is some evidence that the third stage of grief, depression, and the accompanying social withdrawal are seen in the individual's response to health losses. Guilt is a factor that can complicate the normal depressive stage of grief, leading to morbid grief reactions. Lindeman and Parkes both note the association of guilt and self-blame with chronic grief.[3] Freud refers to ambivalence in the object relationship making pathological grief more likely. In these cases, the mourner may blame himself for the object-loss, resulting in a state of depression.[4]

Grinberg differentiates between persecutory and depressive guilt. The latter, characterized by sorrow and concern for the object-loss and for self, is seen in normal mourning; the former, exemplified by resentment, despair and self-reproaches, is considered pathological. In persecutory guilt, resentment is felt against the lost object, which the

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[1] Carp, "Psychology of Aging," p. 110.

[2] Supra, p. 24.

[3] Lindeman, "Symptomatology," p. 145; Parkes, "Bereavement and Mental Illness," p. 25.

[4] Freud, "Mourning and Melancholia," p. 161.

individual thinks to be responsible for the loss and to have taken certain parts of the self. The greater the resentment, the greater is the guilt and persecution, and the more mourning is disturbed. As well as being directed against the lost object, resentment can be directed against the ego itself. Grinberg feels that the hypochondriacal reactions or psychosomatic disorders so often seen in pathological mourning are due to this persecutory guilt being internalized.[1]

The researcher speculates that the persecutory guilt formulated by Grinberg could complicate some reactions to health losses, leading to pathological grief. For example, the individual could feel very resentful about physical and psychological losses he has suffered, particularly since these losses have literally taken a part of himself. Since the loss in this case is not that of an external object, but of part of the individual, it seems likely that resentment felt at the loss would be directed against the ego itself, as Grinberg states occurs at times. Thus, one can see indications for the presence of persecutory guilt in the aged, in reaction to health losses. Some of the hypochondriacal reactions and psychosomatic disorders noted in the aged could be attributed to this persecutory guilt.[2]

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[1]Leon Grinberg, "Two Kinds of Guilt -- Their Relations with Normal and Pathological Aspects of Mourning." International Journal of Psycho-analysis 45 (1964): 367-368.

[2]Supra, p. 35.

Theories of aging. The researcher speculates that disengagement theorists might view depression in response to health losses differently than activity and developmental theorists. Disengagement theorists might view depression as a transient response indicating the individual is not yet ready to disengage. For example, Cumming and Henry found morale to be highest at the beginning and end stages of disengagements, with lowered morale characteristic of the middle phase.[1] Thus, depression might be viewed as incomplete or poorly executed grief by these theorists.

Both activity and developmental theorists might regard depression as reactive to the losses suffered. Thus, the former would view depression as a normal phase the individual must go through before substituting for these losses; the latter would see it as a preparatory step, preceding the developmental task of accepting the loss and attaining growth. Thus, these two aging theories would view depression as having a function similar to that postulated by the grief theorists.

New Identity

The last stage of grief is that of establishing a new identity. An important part of ego-identity is the relationships with objects of both the inner and outer world, so that

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[1]Cumming and Henry, Growing Old, p. 136.

loss of a significant object threatens the cohesion of the ego and identity.[1] As a result, one task of the last stage of grief becomes that of establishing a new or modified identity.

Freud refers to withdrawal of the libido from the lost object serving to free it to become redirected to another object.[2] Parkes speaks of the necessity of establishing a new identity in the final stage of grief, since old roles and functions now become obsolete.[3] Bowlby notes the similar function of the last phase of grief, "Reorganization," in which the individual detaches himself from the lost object.[4]

Butler has formulated the life review to explain reminiscence in the elderly. His life review is similar to this last phase of grief which is characterized by withdrawal from the lost object and formation of a new identity. Butler's conceptualization of the function of reminiscence in the elderly is that of examining the past in order to survey and reintegrate past experiences and conflicts.[5] This is comparable to Freud's postulation of the withdrawal of the

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[1]Grinberg, "Two Kinds of Guilt," p. 369.

[2]Freud, "Mourning and Melancholia," p. 159.

[3]Parkes, Bereavement, p. 93.

[4]Bowlby, "Processes of Mourning," p. 333.

[5]Robert N. Butler, "The Life Review: An Interpretation of Reminiscence in the Aged." Psychiatry 26 (February 1963): 66.

libido from the lost object by activating, in a slow and gradual way, memories and then giving them up, before attachment to new objects is possible.[1] After this harmonious integration of past life by means of the life review, the individual benefits from a revised understanding of the past and has a perspective on the future.[2]

Thus, the individual who successfully grieves the health losses of aging would complete the fourth stage of grief, in which he mourns these losses and is then able to form a new identity of himself in which he integrates the losses. To exemplify by reference to the psychological losses, the individual would review gradually how he has changed in his later years, in learning and memory capacities. This would assist him to detach himself from his former self-concept as a youthful person and to form a revised one. A similar process would occur with the physical and mental health losses, in which the aged individual would review his losses, mourn and then accept them, forming a new self-concept.

However, the researcher speculates that difficulties could easily occur at this final stage of grief, that of formation of a new identity. Kuhlen refers to the fact that

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[1]Freud, "Mourning and Melancholia," p. 166.

[2]Butler, "The Life Review," p. 68.

American society is geared to and idealizes youth.[1] It thus becomes difficult for the older person to form a new identity of himself as an aging individual with health losses, when the cultural norm is to negatively regard wrinkles, grey hair and lack of agility, and to positively regard beauty and speed. To illustrate through the physical losses of aging, Butler and Lewis refer to aging and disease threatening a person's sense of who they are. People report feelings of shock and disbelief looking at themselves in the mirror.[2] These feelings are probably rooted, not only in the individual's fear of losing part of himself, but in his realization of the lack of cultural identity alternatives. In other words, it becomes difficult for the individual to form a new conception of himself as a physically aged individual when the cultural milieu applauds youth. The individual is thus faced with the alternatives of accepting his physical aging and forming an identity based on negative cultural values, which in turn would lead to low self-esteem, or of denying his aging and seeking to retain the culturally valued youth.

This speculated difficulty in completing the final stage of grief is particularly detrimental since the

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[1] Raymond G. Kuhlen, "Developmental Changes in Motivation During the Adult Years," in Middle Age and Aging, ed. Bernice Neugarten (Chicago: University of Chicago Press, 1968), p. 117.

[2] Butler and Lewis, Aging and Mental Health, p. 34.

individual's acceptance of health losses can be attained only when he has terminated the four stages of grief. Only when he has formed a new self-identity which integrates these losses, is the individual able to use various accommodating techniques to adjust to them. Unless grief is complete, the individual will probably continue to intermittently deny health losses and fail to adjust his lifestyle to compensate for them. He may remain at the prior stage of grief, that of depression. The high incidence of depression in the aged would support this hypothesis.[1]

Theories of aging. The researcher speculates that disengagement, activity, and developmental theorists might see the last stage of grief from differing perspectives. Disengagement theorists might not view emotional detachment from the lost object as an active process the individual works through. Rather, this emotional detachment might be seen as intrinsic to the aging process. Damianopoulos refers to disengagement as an "inevitable ego change programmed into the development of the organism."[2] Since disengagement theorists view this emotional detachment as intrinsic to aging, it would follow that new identity formation might be axiomatic to aging. For example, the individual would, as an intrinsic process of aging, be sufficiently disengaged

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[1]Supra, p. 33.

[2]Damianopoulos, "Formal Statement of Disengagement Theory," p. 213.

from social interaction that losses in health which cause decreased interaction would not cause the individual to grieve.[1]

Activity theorists might not advocate the individual working through this stage of attaining new identity. Rather, since maintenance of relatively consistent levels of activity throughout life is advised, an element of denial would seem to be required in this stage of new identity formation. In other words, the goal of retaining a fairly consistent level of functioning would seem to necessitate some denial of the physical losses.

The researcher speculates that developmental theorists might advocate an approach which would correlate most closely to that of the last stage of grief. The developmental task might be for the individual to actively work through the stages of accepting his losses and forming a new self-identity into which the health losses are integrated. The aspect of opportunity for growth would be stressed. For example, physical aging might precipitate the individual's reassessment of his traditional emphasis on physical attractiveness. He might begin to realize the importance of emotional or spiritual attributes.

Distorted Grief Reactions

Sometimes the individual does not adequately handle

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[1]Supra, p. 28.

his grief and distorted reactions result. As stated earlier, distorted reactions to loss are similar in nature to adaptive ones, but differ in intensity or length.[1] Distorted grief reactions of denial, depression, social withdrawal and anger have already been discussed. Another distorted grief reaction is conversion into physical or mental illness.

Parkes comments on the increased incidence of widows in his study seeing a physician in the month following bereavement with complaints of somatic anxiety symptoms, headaches, digestive upsets, and rheumatism. He comments that some potentially fatal conditions such as coronary thrombosis seem to be precipitated or aggravated by major losses.[2] Fredrick similarly refers to various studies showing the increased mortality rate and incidence of malignancies in the bereaved.[3]

Already discussed is the relevance of psychological factors to the etiology of illness in the aged.[4] The frequency of psychosomatic and hypochondriacal reactions was

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[1]Supra, p. 39.

[2]Parkes, Bereavement, p. 22; Parkes, "Bereavement and Mental Illness," p. 25.

[3]Jerome F. Fredrick, "Physiological Reactions Induced by Grief." Omega 2 (1971): 71-72.

[4]Supra, pp. 29, 30.

noted.[1] The researcher speculates that the increased incidence of such disorders in the elderly could be indicative of a distorted grief reaction. Stern's study has been noted, which tends to support this hypothesis.[2]

Psychiatric illness has also been related to distorted grief reactions. Freud states that the individual may find it so difficult to withdraw from object attachments that a turning away from reality results, with the object being clung to through psychosis.[3] Parkes, in his study of psychiatric patients whose illness had come within six months of bereavement, found atypical grief, in the form of "difficulty in accepting the fact of the loss" and "ideas of self-blame", more common in the psychiatric group.[4] Other studies support this pattern of increased incidence of mental illness in the bereaved.[5]

The increased incidence of psychiatric disorders in old age has already been noted.[6] Also mentioned was the apparent diminished importance of intrinsic, and increased

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[1]Supra, p. 35.

[2]Supra, p. 35.

[3]Freud, "Mourning and Melancholia," p. 154.

[4]Parkes, "Bereavement and Mental Illness," p. 12.

[5]Parkes, Bereavement, p. 26.

[6]Supra, p. 30.

importance of exogenic, factors in the etiology of "organic" as well as of functional disorders.[1] Thus, it would seem feasible that the increased incidence of psychiatric illness in old age is symptomatic of distorted grief reactions to the losses suffered. Various theorists support this hypothesis. Cath speculates that the accentuation of neurotic traits in old age is a defense against anxiety about further "depletion" or loss.[2] Butler hypothesizes that the increased incidence of mental disorders in old age may be related to difficulties in the life review. In other words, some individuals find a review of past experiences particularly painful or anxiety-provoking. Guilt, despair, and even suicidal wishes occur as the individual is unable to successfully integrate his life experiences.[3] Verwoerdt refers to senility as a complete withdrawal into fantasy and past life, often precipitated by the experience of significant losses.[4] Thus, theorists support this conceptualization of depression and suicide in the elderly as attributable to a form of distorted grief.

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[1]Supra, pp. 31-32.

[2]Cath, "Dynamics of Middle and Later Years," p. 188.

[3]Butler, "The Life Review," p. 73.

[4]Verwoerdt, "Psychiatric Aspects," p. 129.

Conclusion

According to the major grief theories, the individual who has successfully dealt with his physical losses would have gone through the four stages of grief: denying the losses, being angry at suffering them; becoming depressed and socially withdrawn while psychic energy was focussed on working through the losses; and finally, accepting the losses, accommodating to them and forming a new conceptualization of self. With reference to the normal stages of grief, few data were found in the literature to directly substantiate the hypothesis that the aged react to health losses in stages similar to those of a grief reaction. However, this does not necessarily imply that such a relationship does not exist. Rather, it could be attributed to the fact that there is little mention in the literature of any type of normal reaction to the physical losses of aging. Butler and Lewis refer to the traditional focus on the sick or institutionalized aged in research studies until recent years.[1] Various distorted or pathological reactions to loss have been related to reactions to health loss in the aged. Some similarities of response have been found, such as denial, social withdrawal, depression, helplessness and impairment of physical and mental health. As a result, there is some indication that the aged individual's response to health losses in old age is a grief reaction.

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[1]Butler and Lewis, Aging and Mental Health, p. 18.

CHAPTER III

WORK AND LEISURE

Introduction

Loss of work is often cited as one of the major losses of aging. While health losses in aging could be regarded as fairly universal to all cultures throughout time, the loss of work, or retirement, is recent in development and particular to industrial societies. Orbach refers to retirement developing from a complex series of interrelated changes in the technical, social, political and demographic characteristics of society.[1] Retirement initially arose out of concern for the protection of the earner and his family when advanced age or declining health made work impossible. As retirement became institutionalized, this focus shifted to become that of leaving room for the advancement of the younger worker, with management and unions pressuring senior workers to retire.[2] Thus, the age at which the older worker might retire gradually became that at which he was expected to

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[1]Harold L. Orbach, "Normative Aspects of Retirement," in Social and Psychological Aspects of Aging, eds. Clark Tibbitts and Wilma Donahue (New York: Columbia University Press, 1962), p. 54.

[2]Ibid., p. 56.

retire.[1] In fact, retirement was often viewed negatively, being considered the ". . . negation of traditional values surrounding the place of work in Western society; men are loath of surrender the identifying position in society which a job bestows."[2]

Thus, a discussion of the losses of aging must include retirement. Work is invested with various meanings for individuals, and it is from this perspective that loss of work has been analysed. Since leisure is often considered to replace work as the primary use of time in the latter period of life, discussion has been focussed on whether leisure can or does replace work in Western industrialized society. Also analysed are the differing perspectives from which disengagement, activity and developmental theorists view retirement. Finally, reference has been made to the similarities between reactions to retirement, as noted in the literature, and the four stages of a grief reaction -- denial, anger, depression and new identity.

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[1]Juanita M. Kreps, "Economics of Retirement," in Behavior and Adaptation in Late Life, eds. Ewald Busse and Eric Pfeiffer (Boston: Little, Brown and Co., 1969), p. 81.

[2]Orbach, "Normative Aspects," p. 55.

Loss of Work

Friedmann and Havighurst have formulated five functions of work which they consider universal to all jobs, although these functions may have different meanings for various individuals. These include sources of income, identity and status, association patterns and meaningful experience, and regulation of the worker's pattern of life-activity.[1] The loss of work has been analysed from the perspective of these functions, since it is not the loss of work itself, but the loss of those functions and meanings attached to work which is relevant to the individual. Leisure has been included in the discussion in relation to whether it replaces work and its functions.

Income

One function of work is that of providing a source of income to the worker, enabling him to maintain at least a minimal level of existence.[2] Various authors indicate that retirement often signals an emphatic loss of income. For example, Streib and Schneider report a 50 per cent drop in income from pre-retirement levels in their study sample; Clark and Anderson note that 17 per cent of their sample of

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[1] Eugene A. Friedmann and Robert J. Havighurst, The Meaning of Work and Retirement (Chicago: University of Chicago Press, 1954), p. 7.

[2] Ibid.

older people missed the salary from work; Shanas et al. remark on a similar trend in their American sample.[1]

Personal savings and public and private pension benefits are the main sources of income in retirement. However, these do not presently compensate for the loss of salary resulting from retirement. Kreps refers to the difficulties in saving for retirement, due to factors such as the erosion of purchasing power through price increases and the shortening of the worklife relative to the total life span. As a result of these obstacles to personal saving, the major source of retirement income will continue to be pension benefits. However, this public responsibility to provide for the retired is not yet adequately recognized.[2] For example, despite higher per capita incomes and wage rates in the United States today than previously, the proportion of earned income retained for the retired is relatively low, so that the income gap between worker and retired individual remains large.[3]

When adequate income is assured, workers generally do

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[1]Gordon F. Streib and Clement J. Schneider, Retirement in American Society (Ithaca, New York: Cornell University Press, 1971), p. 160; Margaret Clark and Barbara Anderson, Culture and Aging (Springfield, Illinois: Charles C. Thomas, 1967), p. 321; Ethel Shanas et al., Old People in Three Industrial Societies (New York: Atherton Press, 1968), p. 345.

[2]Juanita Kreps, "Aging and Financial Management," in Aging and Society, Vol. 2: Aging and the Professions, eds. Matilda W. Riley, John W. Riley and Marilyn Johnson (New York: Russell Sage Foundation, 1969), pp. 223-225.

[3]Kreps, "Economics of Retirement," p. 77.

not regard retirement negatively. Reno found that the presence of second pensions had an important influence on the willingness of workers to accept or initiate early retirement. For example, only 15 per cent of those with reduced benefits under $1,000, while 75 per cent of those with an income of $5,000 or over, willingly retired when given the opportunity.[1] Orbach refers to a similar trend with regard to workers in the automotive industry. As pension plans have improved through union bargaining, there has been a gradual decline in the proportion of workers who wait for compulsory retirement. He adds that health reasons do not account for all such early retirements.[2]

Thus, it appears that retirement is not regarded as a loss of devastating proportions when the income function of work is substituted for by adequate pension plans. Furthermore, some speculate that this economic meaning of work has increased with time, in comparison to the other meanings of work. Mills refers to forms of Protestantism as being the basic philosophy of work until recently. Thus, gratifications derived from work included gains of religious status and the assurance of being among the elect which resulted from work, and were not intrinsic to the job itself.

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[1] V. Reno, "Why Men Stop Working At or Before Age Sixty-Five: Findings from the Survey of New Beneficiaries." Social Security Bulletin 34 (June 1971): 14.

[2] Orbach, "Normative Aspects," p. 60.

However, he states that today work is being undertaken mainly as a means of subsistence, so that holding a job is not a challenge but a necessary evil.[1] Havighurst and Friedmann's study results indicated that this pattern was particularly evident for those workers of lower skill and socioeconomic status.[2]

Thus, retirement at present is a severe loss for the individual in that it deprives him of an important source of income. Evidence indicates the increasing attribution to work of a primarily economic function, particularly for the lower occupational groups. The researcher speculates that compensation for the loss of the economic function of work through measures such as improved pension plans would result in retirement being viewed more optimistically by many.

Regulation of Life Activity

The second function of work is that of regulation of the worker's pattern of life-activity. To the individual, this means he has something to do, a way of filling his day and of passing time.[3] It appears uncertain whether the

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[1] C. Wright Mills, "The Meanings of Work Throughout History," in The Future of Work, ed. Fred Best (Englewood Cliffs, New Jersey: Prentice-Hall, 1973), p. 9.

[2] Friedmann and Havighurst, Meaning of Work and Retirement, p. 173.

[3] Ibid., p. 7.

retired consider the loss of the regulatory function of work as significant. Some retired do seem to feel this way, as indicated in Clark and Anderson's study. They found that 23 per cent of the retired gave routinism or keeping busy as a reason for missing work.[1] Friedmann and Havighurst found that the differing occupational groups in their study valued work equally as a routine to pass time.[2] They speculate that this function of work can be met through leisure.[3]

Gubrium qualifies this assessment, stating that whether leisure can replace the time-filling function of work is dependent on retirement income. He states that if retirement is accompanied by a relatively severe drop in income, then activity similarly decreases. On the other hand, if retirement is not accompanied by drastic changes in income, activity in previously neglected areas may increase.[4] Thus, it could be that those with sufficient income are able to keep themselves busy with various leisure activities to replace the time-filling aspect of work, while those retired

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[1]Clark and Anderson, Culture and Aging, p. 321.

[2]Friedmann and Havighurst, Meaning of Work and Retirement, p. 173.

[3]Robert J. Havighurst, "The Nature and Values of Meaningful Free-Time Activity," in Social and Psychological Aspects of Aging, eds. Clark Tibbitts and Wilma Donahue (New York: Columbia University Press, 1962), p. 903.

[4]Jaber F. Gubrium, The Myth of the Golden Years, with a Foreword by David O. Moberg (Springfield, Illinois: Charles C. Thomas, 1973), p. 115.

with inadequate income miss the routine of work because they are unable to replace it through leisure activities.

Identity and Status

The third function of work is that of establishing identity and status. In other words, it provides the individual with a source of self-respect, a way of achieving the recognition and respect of others, and a means of role definition.[1] Friedmann and Havighurst found no differences among occupational groups in their study in the amount of self-respect and respect from others derived from work.[2] However, there appears to be disagreement among various authors regarding the question whether work does in fact function as a source of identity and status, and whether leisure can replace work to serve this function.

Orbach refers to the basic problem of retirement being the transition from one social role to another and the consequent changes in status accompanying this role change. He notes the influence that significant others and reference groups play in determining the nature of what one's social role is and ought to be.[3] Thus, the establishment of new

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[1] Friedmann and Havighurst, Meaning of Work and Retirement, p. 7.

[2] Ibid., p. 174.

[3] Orbach, "Normative Aspects," p. 53.

roles, identity and status becomes difficult in retirement, since leisure as a full-time occupation does not provide a socially approved status-giving role.[1] Cavan refers to a similar problem, noting that work provides an important social role that cannot be replaced by leisure. She states that for a new self-image to be satisfactory, it must be equivalent to the lost one. She, like Orbach, feels that leisure is not equivalent in social evaluation or status to occupation.[2]

Atchley, on the other hand, disagrees with the view that work and occupational identity are central to life and that retirement consequently is a form of identity loss, removing the individual's former claims to status. He states that many individuals are never very work-oriented and thus do not have problems adjusting to a life in which leisure plays a major role. He adds that workers tend to select friends at work from their own age group, creating "retirement cohorts" of friends. This provides for a continuity of identity when the worker retires and continues to associate with these friends. Self-respect can be gained from leisure

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[1]Wilma Donahue, Harold Orbach, and Otto Pollak, "Retirement: The Emerging Social Pattern," in Handbook of Social Gerontology, ed. Clark Tibbitts (Chicago: University of Chicago Press, 1961), p. 336.

[2]Ruth S. Cavan, ed., "The Couple in Old Age," in Marriage and Family in the Modern World (New York: Thomas Y. Crowell Co., 1969), p. 384.

in retirement if the individual has sufficient income to use his free time creatively and if he has a cohort of friends who will accept full-time leisure as a legitimate occupation. Atchley speculates that as retirement becomes an increasingly expected part of the life-cycle, social sanctions will develop to give status to the retired person.[1]

Association

The fourth function of work is that of providing association patterns, such as friendship and superordinate-subordinate relations.[2] As with the other functions of work, there exists controversy regarding whether work provides association patterns and whether loss of work results in loss of association patterns. Donahue states that occupational and family relations constitute the two major foci around which many of the other subsidiary roles revolve.[3] Clark and Anderson found that 28 per cent of their retired subjects missed the companionship of work.[4] Ellison refers to

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[1]Robert C. Atchley, "Retirement and Leisure Participation: Continuity or Crisis?" The Gerontologist 11 (Spring 1971), p. 16.

[2]Friedmann and Havighurst, Meaning of Work and Retirement, p. 7.

[3]Donahue, Orbach and Pollack, "Retirement: Emerging Pattern," p. 333.

[4]Clark and Anderson, Culture and Aging, p. 321.

retirement as isolating the individual from meaningful social relationships, while Orbach and Cavan point to the lack of reference or peer group to replace work contacts.[1]

Streib, on the other hand, states that work is not always a source of social contact.[2] Others note that retirement does not necessarily reduce social relationships. For example, Rosenberg's study in 1970 showed that retirement had no bearing on reducing contact with kin and sometimes increased it. Streib similarly found that retirement, as compared to continued employment, did not result in decreased participation in friendship roles and community activity.[3] Gubrium speculates that the reason for these conflicting findings may lie in income differences. For example, reduced income will lead to reduced activity.[4] Thus, it would appear that for some, retirement marks the end of a period of social relationships with work associates, constituting a significant loss. For others, who never derived satisfaction from work associations or who are able to develop a new reference group or maintain contact with their retired cohorts, retirement

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[1] David L. Ellison, "Work, Retirement, and the Sick Role." The Gerontologist 8 (Autumn 1968), p. 190; Orbach, "Normative Aspects," p. 55; Cavan, "The Couple in Old Age," p. 385.

[2] Streib and Schneider, Retirement, p. 181.

[3] Gubrium, Myth, pp. 110, 114.

[4] Ibid., p. 115.

does not signal a loss of association patterns.

Meaningful Experience

The last function of work is that of providing a meaningful life experience which gives purpose to life and offers the opportunity for creativity, self-expression, new experience or service to others.[1] Once again, various theorists disagree on the relative importance of this function of work. In Clark and Anderson's study, 16 per cent of the retired missed work because of interest in the content of work itself. This, however, was the least reported reason for missing work.[2] Streib and Schneider state that while feelings of usefulness were more likely to be held by the working old than the retired, only one-quarter of the retired felt useless.[3] Friedmann and Havighurst found that work was important as a source of intrinsic enjoyment for the various occupational groups. However, the higher socioeconomic groups stressed this, and the other, extrafinancial meanings of work more.[4] Stokes and Maddox, and Shanas et al., similarly found in their respective studies that the white collar workers were more

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[1] Friedmann and Havighurst, Meaning of Work and Retirement, p. 170.

[2] Clark and Anderson, Culture and Aging, p. 332.

[3] Streib and Schneider, Retirement, p. 161.

[4] Friedmann and Havighurst, Meaning of Work and Retirement, p. 174.

likely to attribute intrinsic rewards to their jobs.[1] Friedmann and Havighurst speculate that this function of work can be met through leisure activities, although they admit that there may remain a small group of workers, particularly in the higher occupational groups, for whom there is no adequate substitute for a job.[2] Thus, the loss of the intrinsic meaning of work appears to be a problem mainly for the higher occupational groups.

To summarize, it would seem that the five functions of work formulated by Friedmann and Havighurst are of differing relevance to the various occupational groups. Generally, the economic meanings of work are most important to the lower occupational groups, while the extra-financial meanings of work -- regulation of life-activity and source of identity and status, association patterns and meaningful experience, are most relevant to the higher occupational groups. As a result, retirement would constitute a loss to the various occupational groups, but this loss would be somewhat different in nature, according to the occupational group of the retiring individual.

Best comments on the changing expectations of work.

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[1]Randall G. Stokes and George L. Maddox, "Some Social Factors on Retirement Adaptation." Journal of Gerontology 22 (July 1967): 331; Shanas et al., Old People in Three Industrial Societies, p. 345.

[2]Friedmann and Havighurst, Meaning of Work and Retirement, p. 186.

He states that:

> As human beings, we have important needs that extend far beyond the mere satisfaction of our material wants, and truly humane work must integrate these needs in a way which gives our lives balance, completeness, and purpose. In sum, it is the totality of our human needs which will guide and shape the evolving goals and conditions of work in the future.[1]

Such a shift in the expectations of work might result in the increased relevance of all five functions to the various occupational groups and to consequent changes in the implications of the loss of work.

Theories of aging and work loss

Disengagement, activity and developmental theorists view the loss of work through retirement from differing perspectives. Disengagement theorists see retirement for men as signalling the beginning of the disengagement process. For males, retirement may sometimes constitute a loss. Retirement is not viewed as a problem for women, since their central function is seen as affective. Thus, women work mainly to fill time or supplement income and the loss of the instrumental function of work is not seen as particularly critical.[2]

Disengagement theory is functionalist in approach. In other words, the efficient functioning of society is of

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[1]Fred Best, ed., The Future of Work (Englewood Cliffs, New Jersey: Prentice-Hall Inc., 1973), p. 17.

[2]Cumming and Henry, Growing Old, pp. 143-145.

primary importance. Thus, retirement is considered necessary to prevent disruption of the productive functioning of society by the death or disease of the older worker.[1] If both the individual and society are ready to disengage, the process of disengagement is completed without difficulty. Sometimes society is ready to disengage and the individual is not. Because of the functionalist aspect of disengagement theory, disengagement usually occurs nonetheless in these cases. Damianopoulos states that the latter is not uncommon in American society, when the individual has not yet experienced sufficient ego change to make him willing to disengage.[2] Cumming and Henry agree that retirement represents the loss of work functions mentioned earlier, and as such, may lead to temporary lowering of morale, when the individual is not yet ready to disengage.[3] Often, short-term re-engagement by returning to work or substituting "work-like" activities for work, will aid the individual until he is ready to disengage.[4] Loss of status and identity derived from work is also a problem for some individuals.[5] However, this resolves itself as

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[1] M. Elaine Cumming, "New Thoughts on the Theory of Disengagement," in New Thoughts on Old Age, ed. Robert Kastenbaum (New York: Springer Publishing Co., 1964), p. 9.

[2] Damianopoulos, "Statement of Disengagement Theory," p. 214.

[3] Cumming and Henry, Growing Old, p. 149.

[4] Ibid., p. 151.

[5] Ibid., p. 147.

individuals continue to disengage, turning inward and identifying with past accomplishments.[1] The loss of peer group associations is also problematic.[2] This loss, too, will eventually be resolved, for as disengagement continues through time, the individual does not desire or require this type of peer group interaction.[3] Thus, disengagement theorists acknowledge that retirement may initially constitute real losses for those individuals who are not yet ready to disengage. In such instances, temporary substitution of work-like or leisure activities for work may become necessary. Ultimately, however, retirement is not a loss, because ego changes result in a reorientation making retirement from work compatible with the disengagement process.

Activity theorists would regard retirement as a stressful time because of the central importance they attribute to work. Although the focus of the sense of loss might differ from person to person, most retiring individuals will keenly feel retirement as a loss.[4] Substitution of leisure activities for work will enable the individual to deal with the loss. For example, Friedmann and Havighurst emphasize the importance of learning the leisure arts,

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[1]Ibid., p. 150.

[2]Ibid., p. 148.

[3]Ibid., p. 153.

[4]Shanas, "Adjustment to Retirement," p. 223.

stating that retirement will become a signal to increase and adapt one's play or leisure activities to derive satisfactions from play that were formerly obtained from work.[1] Support for this view of replacing work with leisure would be obtained from studies such as Havighurst, Neugarten and Tobin's, in which they found that level of activity was often correlated positively to the individual's feeling of contentment with current activities. Furthermore, this relationship was even stronger in those seventy years old and over, than in the fifty to seventy age range.[2] Havighurst and Feigenbaum similarly found that those with the most successful life-styles had high leisure scores.[3]

Activity theorists would therefore not agree with disengagement theorists that optimal retirement is characterized by a lowered level of activity. The researcher speculates that the former might explain much of the "disengagement" in retirement as a result of factors such as reduced income or physical limitations, rather than of intrinsic ego changes. Thus, retirement would be viewed by activity

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[1]Friedmann and Havighurst, Meaning of Work and Retirement, p. 192.

[2]Robert J. Havighurst, Bernice L. Neugarten, and Sheldon S. Tobin, "Disengagement and Patterns of Aging," in Middle Age and Aging, ed. Bernice Neugarten (Chicago: University of Chicago Press, 1968), p. 171.

[3]Robert J. Havighurst and Kenneth Feigenbaum, "Leisure and Life-Style," in Middle Age and Aging, ed. Bernice L. Neugarten (Chicago: University of Chicago Press, 1968), p. 350.

theorists as a significant loss to the individual. However, they believe this loss can be compensated for by substitution of leisure activities to replace the work role and to maintain a comparable level of activity.

Developmental theorists would view retirement from yet another perspective. Unlike disengagement and activity theories, this approach does not specifically advocate more or less activity. Rather, the theorists state that the optimal response to loss of work depends on a number of interacting factors, such as personality functioning and social environment. Thurnher summarizes the stance of the developmental theorists in saying that the degree of isolation resulting from retirement will depend on the individual's previous life style, while his success in coping with it will be influenced by variables such as economic resources, health status, social supports, personality characteristics, and by the values and goals he had strived to attain in life.[1] For example, already referred to is the importance of economic resources to retirement satisfaction.[2] Clark speaks of social supports when she refers to the negative evaluation of any type of dependency within the American culture and to the

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[1]Majda Thurnher, "Goals, Values, and Life Evaluations at the Preretirement Stage." Journal of Gerontology 29 (January 1974): 85.

[2]Supra, p. 64.

consequent negative evaluation of the aged by society.[1] Neugarten, Havighurst and Tobin's study found personality to be "pivotal" in describing patterns of aging and in predicting the relationships between level of social role activity and life satisfaction.[2] Kastenbaum refers to psychological development in later life as dependent to a great extent on personality integration created early in life.[3] Buhler speaks of the importance of cultural, health and personality factors, and of previously set values and goals, to meaningful living in the later years.[4]

Developmental theorists view retirement as a developmental phase or critical period which may cause anxiety and unhappiness, but may also be a strong motivating force for self-appraisal and change.[5] The developmental task of retirement is not specifically delineated, but the researcher

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[1]Clark, "Cultural Values and Dependency in Later Life," pp. 263, 273.

[2]Robert J. Havighurst, Bernice L. Neugarten, and Sheldon S. Tobin, "Personality and Patterns of Aging," in Middle Age and Aging, ed. Bernice Neugarten (Chicago: University of Chicago Press, 1968), p. 177.

[3]Robert Kastenbaum, ed., "Is Old Age the End of Development?", in New Thoughts on Old Age (New York: Springer Publishing Co., 1964), p. 69.

[4]Charlotte Buhler, "Meaningful Living in the Mature Years," in Aging and Leisure, ed. Robert W. Kleemeir (New York: Oxford University Press, 1961), pp. 348-349.

[5]Kuhlen, "Developmental Changes," p. 118.

speculates it might include the transition from the value orientation of ambition and competitiveness to that of relaxation and cooperation, which is cited by Clark as an adaptive value orientation to significant goals in later life.[1] In line with their emphasis on psychosocial factors, developmental theorists attribute evidence of disengagement to factors such as poor health, inadequate income, previous personality functioning, or negative social attitudes.[2] Developmental theorists would not agree with activity theorists that substitution is a way of adjusting to the losses of retirement. Rather, because of the potential of the personality to develop throughout life, retirement is seen as a possibility for growth.[3] Thus, developmental theorists view retirement as a loss, but emphasize that the loss of work will have differing significance for individuals, depending on interrelated psychosocial factors. Furthermore, the loss can have positive results, precipitating further growth and development.

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[1]Clark and Anderson, Culture and Aging, p. 287.

[2]Kuhlen, "Developmental Changes in Motivation," p. 121.

[3]Charles Taylor, "Developmental Conceptions and the Retirement Process," in Retirement, ed. Frances Carp (New York: Behavioral Publications, 1972), p. 112.

Response to Retirement as a Grief Reaction

Retirement signals the loss of work and of the various meanings it has for different individuals. The researcher has speculated that the response to retirement, or loss of work, might follow the stages of a grief reaction. Analysis of the four phases of grief and of the accompanying characteristics has clarified the relationship.

Denial

Denial and disbelief are characteristic of the first stage of grief.[1] Frequently accompanying the denial stage are feelings of helplessness and dependency.[2] These features of early grief seem evident both in the reactions of many workers to the prospect of retirement and in some patterns of adjustment to retirement.

Field states that many react negatively to the prospect of retirement, denying its inevitability until it is upon them, even though they consciously realize retirement is imminent.[3] The author speculates that this denial might explain the failure of most workers to plan for retirement. For example, Morgan's study indicated that of the older men

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[1] Supra, p. 39.

[2] Supra, p. 42.

[3] Field, The Aged, the Family, and the Community, p. 45.

who planned to retire, 49 per cent stated they were doing little or no planning.[1] Fillenbaum found that 97 per cent thought retirement planning should be engaged in, but only 66 per cent reported thinking of retirement, while only 28 per cent had actually made plans.[2] Thurnher noted that men lightly dismissed the fact that they had been forced to abandon goals in the preretirement period when the prospect of retirement made it clear they would be unable to attain these goals. She interprets this light dismissal of formerly meaningful goals as evidence of the need for denial.[3] Thus, some evidence exists to indicate that denial occurs in response to loss of work. Examples include the failure to plan for retirement and denial of the meaning of retirement to values and goals.

Denial can be adaptive or maladaptive in response to loss.[4] The researcher speculates that the reaction of denial can become maladaptive if it persists into the retirement period, becoming a pattern of functioning, rather than a transient response to actual or potential loss. Data

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[1]Riley and Foner, Aging and Society, Vol. 1, p. 446.

[2]Gerda Fillenbaum, "Retirement Planning Programs -- At What Age, and For Whom?" The Gerontologist 11 (Spring 1971): 35.

[3]Thurnher, "Goals, Values, and Life Evaluation," p. 95.

[4]Supra, p. 40.

indicate that this maladaptive response does sometimes occur.

Buhler delineates four groups of aging patterns. One group, the "active participants," includes those who feel their active life is never finished and continue striving to the end.[1] Neugarten describes various types of response to aging. The "armored-defended" are striving, ambitious and achievement-oriented, with high defenses against anxiety. One pattern of this type seems to use denial. The "holding-on" group consider aging a threat and respond by holding on as long as possible to their middle-age patterns. These individuals are quite successful in their attempts, resulting in a pattern of high satisfaction and medium-high activity.[2] The researcher speculates that denial is central to the functioning of the "holding-on" group, and that should an external factor such as loss of health or part-time job demolish their "pseudo" middle-age patterns, problems would ensue. Verwoerdt, the only theorist known to equate response to retirement to a grief reaction, states that aggressive, highly dependent individuals often react to retirement with overcompensatory denial. Since these individuals' self-esteem depends on activity and independence, retirement poses a serious loss and is often reacted to by denial. Once this overcompensatory denial breaks

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[1]Kuhlen, "Developmental Changes," p. 135.

[2]Havighurst, Neugarten, and Tobin, "Personality and Patterns of Aging," p. 176.

down, the individual may move in the opposite direction and become very dependent.[1]

The prevalence of feelings of helplessness and dependency in the early stages of grief has been noted. Forms of dependency can also be seen in two patterns of aging adaptation discerned by Reichard and by Havighurst, Neugarten, and Tobin. Reichard refers to the "rocking chairmen," who welcome the chance to be free of responsibility and to indulge in passive needs.[2] Havighurst notes the "passive-dependent" group, comprising the "succorance-seeking" and "apathetic" types.[3] The former strive to satisfy strong dependency needs through significant others, and are able to maintain a fairly satisfied and active lifestyle if there are people present who meet these needs; the latter are characterized by low activity and satisfaction. However, these theorists refer to the above dependent styles as a continuation of long-standing patterns of functioning, or as the emergence of dependency needs in old age, due to social sanctions which allow a degree of dependency in the later years. As a result, the researcher concludes that these dependency patterns cannot be interpreted as supportive of the expression of the initial

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[1]Adriaan Verwoerdt, "The Physician's Role in Retirement Counseling." The Gerontologist 10 (Spring 1970): 23.

[2]Pincus, "Developmental View of Aging," p. 40.

[3]Havighurst, Neugarten, and Tobin, "Disengagement and Patterns of Aging," p. 176.

stages of grief.

Theories of aging. The researcher speculates that disengagement theorists might regard denial of the impact of the loss of work as dysfunctional to optimal retirement. For example, the individual's readiness to retire is essential to the functionalist aspect of disengagement theory. His denial of the loss of work by returning to work on a part-time basis or by participating in "work-like" leisure activities would be acceptable only as a temporary measure, until the individual were ready to truly disengage.[1] Denial might be considered dysfunctional by the activity theorists in that it would hinder the individual from substituting leisure activities to replace the lost functions of work. Developmental theorists might view denial as a block to the developmental task of modification of existing goals and value orientations.

Anger

Anger has been referred to as the second stage of a grief reaction.[2] No literature was noted which indicated anger as a response to loss of work. Verwoerdt states that some individuals with very aggressive and competitive

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[1] Supra, p. 74.

[2] Supra, p. 44.

feelings, who have difficulty in differentiating between the two, consequently often have problems in their careers. The final failure of loss of work may provoke anger and guilt in these persons. Verwoerdt suggests an explanation of how this anger is expressed, which is similar to that offered by Cath.[1] Verwoerdt states that anger is seldom expressed directly, but is instead introjected in the form of depression, or externalized through paranoia.[2] The frequency of depression and paranoia in the aged, already noted, would seem to support this view.[3]

Rose refers to the beginnings of a social movement of the aged to raise their status and prestige.[4] The researcher speculates that the fairly recent emergence of these age-conscious groups might result in the retired being able to express their anger at the losses of retirement in a more adaptive way than through depression or paranoia. Thus, they might voice anger at the sudden drop in income with retirement and demand improved pensions.

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[1] Supra, p. 45.

[2] Verwoerdt, "The Physician's Role," p. 23.

[3] Supra, p. 33.

[4] Arnold Rose, "A Current Theoretical Issue in Social Gerontology," in Middle Age and Aging, ed. Bernice Neugarten (Chicago: University of Chicago Press, 1968), p. 187.

Depression

Depression has been referred to as the third stage of a grief reaction. Feelings often accompanying this stage are those of apathy, aimlessness, and social withdrawal.[1] There is some evidence in the literature to support the view of depression in reaction to the loss of work. Havighurst describes three phases of adjustment to retirement. His first two phases would seem similar to the depressive stage of a grief reaction. For example, immediately following retirement, the individual often takes a trip or dissolves his household. Following this initial phase, the individual then goes through a period of restlessness in which he seeks to establish new roles and to set new levels of aspiration for himself which are compatible with the status and roles assigned to retirement in our society.[2] This transitory reaction of aimlessness resulting from the individual's recent loss of work having left an emptiness or vacuum in his life, appears very similar to the depressive stage of a grief reaction.

Sometimes, however, the depressive stage is attenuated in length or intensity, becoming pathological. The presence of guilt and ambivalence is generally considered to

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[1] Supra, p. 45.

[2] Donahue, Orbach, and Pollak, "Retirement: the Emerging Pattern," p. 380.

be responsible for this morbid depression.[1] Pathological depression appears to result sometimes in response to retirement. For example, Verwoerdt notes that the individual's successful resolution of his grief reaction to retirement can be blocked by marked ambivalence to his job. He refers to various clinical prototypes of those with ambivalence to work and notes the frequency of attendant depression. In addition, those who used work to achieve a "lost paradise" realize with retirement that they will never attain this paradise. This often results in "nostalgic depression." The aggressive, highly dependent person previously referred to, whose initial reaction to retirement is that of denial, often becomes depressed when this overcompensatory denial breaks down.[2]

Two types of aging patterns discerned by Buhler also appear to indicate morbid depressive reactions. She cites those who are dissatisfied with their lives and accomplishments, but, because they lack the strength, ability or willpower to continue struggling, find an unhappy sort of resignation. The other type, feeling that they have had thoughtless and meaningless lives, react to the aged years with feelings of frustration, guilt, and regrets.[3] Buhler does

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[1]Supra, p. 48.

[2]Verwoerdt, "The Physician's Role," p. 23; Supra, p. 82.

[3]Kuhlen, "Developmental Changes in Motivation," p. 135.

not refer to these feelings of regret and guilt as being related specifically to work. However, the researcher speculates that, given the importance of work to many, it can be concluded that at least some of these depressed feelings result from work loss.

Theories of aging. The respective theorists might see depression somewhat differently. Disengagement theorists view depression in response to loss of work as particularly characteristic of those who had high prestige or power in their employment.[1] In the case of individuals such as these, for whom work was the central task and source of prestige, retirement can be troublesome and may lead to temporary lowering of morale, which resolves itself with time.[2] Thus, disengagement theorists regard depression in response to retirement as most common in the higher occupational groups and as of transitory duration.

Activity theorists were not noted to refer to depression resulting from retirement. However, the researcher speculates that these theorists might view a period of depression as a normal reaction to the loss of work. Prolonged depression might be regarded as indicative of the individual's failure to give up work, which interferes with

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[1] Damianopoulos, "Formal Statement of Disengagement Theory," p. 218.

[2] Cumming and Henry, Growing Old, p. 149; Supra, pp. 74-75.

the process of engaging in new leisure activities and substituting for the loss of work.

The researcher speculates that developmental theorists might view depression in response to retirement as a normal reaction to loss. Kuhlen, speaking of developmental changes in motivation through the years, states that while growth-expansion motives seem to dominate the first half of adult years, needs stemming from insecurity and threat become important in the later years.[1] If anxiety becomes too great, constructive efforts to reduce anxiety will no longer be generated, and defensive and handicapping behavior patterns may result. Social losses are noted as a possible source of increased anxiety. Kuhlen states that one way in which anxiety and maladjustment may be shown is through changes in subjective happiness.[2] Thus, the researcher speculates that developmental theorists might view depression as a response to heightened anxiety about the social loss of work.

Whether the individual were able to overcome this anxiety evidenced in depression and proceed to the next stage of grief, or whether he remained in the depressed stage, might be considered by these theorists as dependent on factors such as the individual's previous pattern of

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[1]Kuhlen, "Developmental Changes in Motivation", p. 115.

[2]Ibid., pp. 124-125.

functioning and on social supports. For example, Buhler refers to the importance of maintaining alternate rhythms of work, recreation and rest throughout life. In this way, a pattern is formed which facilitates the transition to meaningful use of free time in the later years. She notes the failure of Western culture to educate the individual to this sense of direction and the cultural devaluation of passive types of activity, such as contemplation. This results in the emptiness and depression so common in the aged.[1] Thus, developmental theorists might view temporary depression in response to loss of work as a normal reaction. Prolonged depression might be attributed to deficits in lifestyle, personality functioning, or lack of cultural supports.

New Identity

The establishment of a new identity has been cited as the last stage of a grief reaction, signalling successful completion of the processes of mourning.[2] Data on adaptation styles of successfully retired individuals seem to indicate that some similarities between adaptation to loss and to retirement exist. For example, Havighurst, Neugarten and Tobin found that the personality type judged to have the highest life satisfaction was the "integrated"

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[1] Supra, p. 33.

[2] Supra, p. 50.

type, characterized by well-functioning, intact cognitive abilities and a functional balance between control and flexibility. Within the "integrated" category, the "focussed" and the "disengaged" appear to have attained the last stage of grief. To illustrate, the "focussed" participated selectively in activities, resulting in a medium level of activity, while the "disengaged" had voluntarily given up role commitments and were characterized by low activity.[1] These functional patterns, the researcher speculates, seem to indicate that the individual has successfully detached himself from work and the meanings it had for him. He has then been able to forge a new identity, based on various levels of activity compatible with the individual's particular desires and interests.

Reichard describes the "mature" type of adaptation to aging. These individuals, relatively free from neurotic conflict, have accepted themselves realistically and felt life to have been rewarding, so that they are able to grow old without regret for the past.[2] The researcher speculates that these individuals have, in order to accept themselves and grow old without regrets, been able to resolve their losses of aging, of which one loss might have been that of work. Shanas reported that the longer an individual had been retired, the

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[1]Havighurst, Neugarten, and Tobin, "Personality and Patterns of Aging," p. 175.

[2]Pincus, "Toward a Developmental View for Aging," p. 40.

less likely he was to want to return to work. She concluded that this trend was due not only to advanced age, but to the existence of a critical turning point at which the individual ceased to think of himself as a potential worker and accepted the role of a retired individual.[1] Shanas does not note whether the individual accepts the role of retiree with equanimity or resignation. The researcher speculates that, if the former were the case, the "critical turning point" might be equated with successful completion of the last phase of grief, in which the worker had successfully detached himself from his old identity and established a new one. If the latter were the case, the retired individual might be considered to have remained in the depressed stage of grief.

The Kansas City study, in summarizing its findings, notes that the majority of the aged regretted the drop in role activity that occurred. Some were able to accept this decrease as inevitable to aging and maintained a sense of self-worth and satisfaction, while others could not accept the loss, continuing to regret it and to be dissatisfied with their past and present lives.[2] The researcher speculates that the former group consisted of those who had resolved their losses and formed a new identity, while the latter were unable to do so, remaining in the depressive

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[1]Shanas et al., Old People in Three Industrial Societies, p. 345.

[2]Havighurst, Neugarten, and Tobin, "Personality and Patterns of Aging," p. 171.

stage of grief. Although the Kansas City statement does not specifically refer to work role decrease, it seems logical that since work constitutes a significant source of roles for most individuals, then some of the role decrease referred to could be attributed to retirement.

The researcher speculates that many retired persons might have difficulty in achieving the last stage of grief, that of establishing a new identity, due to the lack of social supports to assist them in this task. For example, Cavan, Donahue, Streib and others note the "rolelessness" of the retired individual.[1] In Western society, work and family are the two main sources of roles.[2] As a result, the individual, when retired, finds himself deprived of a part of his self-identity. Furthermore, leisure does not provide a socially approved status-giving role, enabling it to replace work as a satisfactory source of self-identity.[3] Cavan adds that necessary for a satisfying adjustment to retirement are a culturally approved set of values for old age, the acceptance of these values by society and the individual's reference group, and roles through which the retired individual

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[1]Cavan, "The Couple in Old Age," p. 383; Donahue, Orbach and Pollak, "Retirement: Emerging Social Pattern," p. 334; Streib and Schneider, Retirement in American Society, p. 169.

[2]Donahue, Orbach and Pollak, "Retirement: Emerging Social Pattern," p. 336.

[3]Ibid., p. 333.

can express his new self image.[1]

Thus, it is speculated that many individuals, looking back over their work life in a manner similar to Butler's life review, might have problems detaching themselves from the work role and assuming the new identity of a retired individual.[2] As a result, they might remain in the depressed stage of grief. Clark and Anderson's findings on the process of aging adaptation in American culture would seem to support this hypothesis of lack of social supports and alternatives causing problems in the stage of formation of a new identity. They found that of the five main tasks of adaptation, the greatest proportion of individuals had problems with substitution of alternative sources of need satisfaction. In other words, individuals could not find replacements for old interests, activities, and relationships.[3]

Other theorists indicate that this problem of lack of roles is becoming less acute. As more and more people retire, there is a larger reference group to which the retiree can look to for norms, values and peer-group relationships. They also point to an increasingly positive evaluation of leisure activities and to the fact that many

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[1]Cavan, "Couple in Old Age," p. 384.

[2]Supra, p. 50.

[3]Clark and Anderson, Culture and Aging, pp. 407, 412.

individuals are never very work-oriented.[1] Thus, it appears that the stage of new identity formation may be less difficult, because of decreased attachment to the lost object and available alternatives to replace the lost object.

Theories of aging. The researcher speculates that the various theorists would view detachment from the lost object -- work, and formation of a new identity to be necessary for optimal retirement satisfaction. However, disengagement theorists might not see adjustment to retirement as a grieving process which the individual must work through rather actively. The loss of work might be seen as compatible with the disengagement process in most cases, so that a new identity as a retired individual would ensue naturally from ego changes intrinsic to old age. Activity theorists might similarly view the completion of grief and formation of a new identity as a retired individual necessary. The individual could then embark on his new life in which leisure activities are substituted for work. Developmental theorists do not specifically elucidate what they consider to be the optimal response to retirement. The researcher speculates that they would not see successful adaptation to the loss of work as comparable to that of the last stage of grief. For example, Buhler speaks of the importance of the individual maintaining a balance between work, recreation and rest

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[1] Supra, pp. 68-69.

throughout his life.[1] Thus, retirement would not necessitate formation of a new identity, but rather, a modification of the existing balance.

Distorted Grief Reactions

Distorted grief reactions sometimes occur in response to loss.[2] Already referred to are various patterns of aging which the researcher speculates might be indicative of distorted grief reactions. For example, the "holding on" type may be indicative of pathological denial, while the two patterns of aging cited by Buhler might be illustrative of pathological depression.[3] Another distorted reaction is conversion into physical or mental illness.[4] There is limited evidence that the loss of work is reacted to by conversion into physical illness. Verwoerdt and Cameron refer to hypochondriasis being common in the recently retired, in response to the sudden loss of work.[5] Others, however,

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[1]Buhler, "Meaningful Living in the Later Years," p. 370.

[2]Supra, p. 82.

[3]Supra, p. 87.

[4]Supra, p. 56.

[5]Verwoerdt, "Physician's Role," p. 26; Norman Cameron, "Neuroses of Later Maturity," in Mental Disorders in Late Life, ed. Oscar J. Kaplan (Stanford, California: Stanford University Press, 1956), p. 219.

indicate little decline in health. For example, Streib and Schneider note a moderate decline in subjectively rated health in the years from sixty-five to seventy, but conclude that this decline cannot be related to retirement itself.[1] Eisdorfer notes the different findings of studies on the relationship between health and retirement, adding that some studies have found health improved with retirement.[2]

In relation to retirement as resulting in mental illness, Clark and Anderson state that retirement posed a serious threat to the personality organization of some of their retired subjects.[3] Depression and suicide are often related, particularly in advanced age.[4] Kuhlen refers to the differing incidence of suicide with age. It increases steadily for white males with age, but decreases for females in the advanced years. He hypothesizes this difference is attributable to problems encountered by males in divesting themselves of their former career and work focus.[5] Cameron states that:

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[1]Streib and Schneider, Retirement in American Society, p. 159.

[2]Eisdorfer, "Adaptation to Loss of Work," p. 247.

[3]Clark and Anderson, Culture and Aging, p. 324.

[4]Supra, pp. 34-35.

[5]Kuhlen, "Developmental Changes in Motivation," p. 133.

> The abrupt termination of one's active interests and occupation, unless carefully handled, can have disastrous personal effects. Unemployment aggravates existing neuroses and tends to reactivate normal ones . . . The experience . . . may precipitate restlessness, weariness, and dejection that lead over into hypochondria, chronic fatigue states, or neurotic depression with resentment and self-depreciation.[1]

Thus, there is limited evidence for the presence of distorted grief reactions in response to the loss of work.

Conclusion

An analysis of work and leisure in the framework of grief theory leads to inconclusive results, which tend to support the hypothesis that loss of work is reacted to in a pattern predicted by grief theorists. Evidence has been presented which supports the similarities of response to retirement and the four stages of a grief reaction.

Reference in the literature to retirement is often sociological in orientation, so that there was difficulty in locating data on the individual's subjective response to retirement. As a result, it is not known whether the paucity of data found to support the hypothesis is attributable to the lack of relevance of the hypothesis or to the sparsity of available information.

It has been established that retirement constitutes a loss, although the nature and intensity of this loss seem to

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[1]Cameron, "Neuroses of Later Maturity," p. 219.

vary according to factors such as personality characteristics and occupational group. Furthermore, it is speculated that retirement may be different not only within each generation, but from generation to generation, of retired individuals. This would have implications for retirement as a loss. For example, indications are that today's retiree suffers a less substantial loss than the retiree of former years, due to the increasing reference group of retired individuals. If work continues to decrease in meaning and leisure assumes an increasingly important role, as speculated by some theorists, it is hypothesized that tomorrow's generation of retirees will see retirement more as an opportunity than as a loss. On the other hand, if work is modified to satisfy an increased range of human needs, as speculated by other theorists, then retirement in the future may constitute a more significant loss than retirement today.

CHAPTER IV

FAMILY AND FRIENDS

Introduction

Social relationships are of primary importance in the life spaces of most individuals. From family and friends, the individual derives gratification of such diverse needs as those of status, identity, love, companionship and support. It is frequently contended that with old age, the individual is deprived of family and friends, and consequently, of the need-gratifying and supportive functions which they perform. Some theorists, however, do not agree with this viewpoint. Perlin and Butler found that psychosocial changes, such as loss of friends or spouse, or modifications in social and familial roles, were frequently seen by the aged to have some positive effects.[1]

The researcher has in Chapter IV pursued the area of social relationships, seeking to establish if the aged suffer extensive losses in this life space. The perspectives from

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[1]Seymour Perlin and Robert N. Butler, "Psychiatric Aspects of Adaptation to the Aging Experience," in Human Aging: A Biological and Behavioral Study, eds. James E. Birren et al. (Bethesda, Maryland: National Institute of Mental Health, U. S. Department of Health, Education and Welfare, 1971), p. 162.

which disengagement, activity and developmental theorists view the role of family and friends in old age has been discussed. The older person's reactions to the loss of social relationships have been noted as illustrative of normal and distorted grief reactions. The role of family and friends as social supports to help the individual cope with his various losses in the lifespaces of health, work and social relationships has been clarified.

Losses in Social Relationships

Marital Relationship

Loss as it affects the marital relationship has been discussed from two perspectives -- quality and quantity. Some state that the quality of the marital relationship declines in the later years, so that these marriages are characterized by bickering and tension or resignation to an ungratifying existence. The researcher has reviewed the literature on the marital relationship of the later years to establish if there is such a loss in quality of interaction. In addition, the relevance of loss in a more concrete sense, that of death of the spouse, has been studied.

Marriage is a status occupied by many older individuals. Shanas et al. found that married couples constituted 35 to 45 per cent of the households they studied.[1] United

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[1]Shanas et al., Old People in Three Industrial Societies, p. 218.

States statistics reveal that in 1966, two-thirds of the men over sixty-five were living with wives, while only one-third of the same age group of women were married and living with their husbands.[1] This trend has been attributed to such factors as the longer life span of women, the fact that women marry at a younger age than men, and the increased possibility of men remarrying.[2] Due to factors such as the longer life span of the aged parent and earlier marriage ages for children, there has been an increase of about fifteen years in the length of time the marriage is characterized by no children living at home.[3] Thus, the "quality" of the marital relationship has become increasingly important for many.

Numerous researchers have concluded that marital happiness in the later years is related to the pattern of interaction in the earlier ones. For example, some found marital dissatisfaction to be more common when there had been little shared companionship or satisfaction in the

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[1]Donald O. Cowgill, "Aging in American Society," in Aging and Modernization, eds. Donald O. Cowgill and Lowell D. Holmes (New York: Meredith Corp., 1972), p. 246.

[2]Butler and Lewis, Aging and Mental Health, p. 7.

[3]M. F. Nimkoff, "Changing Family Relationships of Older People in the United States during the Last Fifty Years," in Social and Psychological Aspects of Aging, eds. Clark Tibbitts and Wilma Donahue (New York: Columbia University Press, 1962), p. 406.

earlier years.[1] Others noted a decline in marital happiness when the rearing of children had been the primary focus in the marriage. In the latter cases, the departure of children signalled a decrease in marital satisfaction.[2]

Lipman and Cavan note that, with retirement, couples face a major transitional period in their marriages. The recently retired husband may seek to fill his role loss through participation in some of the wife's activities or functions, while the wife may resent this intrusion into a domain which was formerly exclusively her own.[3] Tuckman and Lorge, and Townsend, found in their respective studies that a significant number of women were not anxious for their husbands to retire because they did not want them home all day.[4] Neugarten and Heyman both noted instances of role reversal, in which one spouse was resentfully demoted to a

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[1]Nick Stinnett, Linda M. Carter, and James E. Montgomery, "Older Persons' Perceptions of their Marriages." Journal of Marriage and the Family 34 (November 1972): 665; Gordon F. Streib and Wayne E. Thompson, "The Older Person in a Family Context," in Handbook of Social Gerontology, ed. Clark Tibbitts (Chicago: University of Chicago Press, 1960), p. 472.

[2]Nimkoff, "Changing Family Relationships," p. 412.

[3]Aaron Lipman, "Role Conceptions of Couples in Retirement," in Social and Psychological Aspects of Aging, eds. Clark Tibbitts and Wilma Donahue (New York: Columbia University Press, 1962), p. 484; Cavan, "The Couple in Old Age," pp. 385-386.

[4]Donahue, Orbach, and Pollak, "Retirement: Emerging Social Pattern," p. 371.

less active position. For example, the former noted instances in which wives were not willing to involve husbands in household activities, so that the husband's post-retirement roles and functions were minimal.[1] The latter found examples of the husband taking over the wife's homemaker role, supervising the buying of food and other administrative tasks, while the wife was relegated to more menial tasks such as washing dishes.[2]

The key element to satisfaction in the later years of marriage appears to be the ability of both partners to be flexible, adapting and accommodating to the various changes which aging often brings in the social, economic and physical spheres.[3] Lipman states that successful transition to the retirement marriage necessitates changes by both husband and wife. He found that the husband who was able to alter his perception of himself, achieving feelings of usefulness through helping with household activities and emphasizing expressive qualities such as love and companionship, was better adjusted to retirement and marriage. He notes that this change in the husband's self-perception demands a simultaneous change in that of the wife. She must be able

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[1] Ibid.

[2] Dorothy K. Heyman, "Does a Wife Retire?" The Gerontologist 10 (Spring 1970): 54.

[3] The researcher suggests that adaptability and flexibility are central to marital satisfaction for any age group.

to adapt, relinquishing some instrumental roles in order to enable her husband's participation in household activities.[1] Ballweg found that the problem of the greater participation by the retired husband in household tasks was resolved by the husband assuming more traditional male tasks such as repairing faucets, so that the wife was able to retain many of her former roles.[2] Cavan notes a similar process of adaptation and accommodation by both spouses preceding a satisfactory retirement marriage.[3] Kerkhoff refers to lack of flexibility resulting in marital unhappiness. He found that in some marriages, both husband and wife rejected the idea of the participation of the husband in household tasks. Sometimes the husband participated nonetheless in these activities, despite his professed disapproval, resulting in the wife feeling resentful and dissatisfied.[4]

Somerville, speculating on the future of family relationships, states that the women's liberation movement, with its emphasis on the development of the woman as an individual with her own needs and interests, coupled with

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[1] Lipman, "Role Conceptions of Couples," p. 484.

[2] John A. Ballweg, "Resolution of Conjugal Role Adjustment After Retirement," Journal of Marriage and the Family 29 (May 1967): 278.

[3] Cavan, "Couple in Old Age," p. 386.

[4] Nye and Berardo, The Family, Its Structure and Interaction (New York: MacMillan Co., 1973), p. 567.

the lowered birth rate, may have positive implications for the later years of marriage. For example, spousal interaction may become emphasized throughout the married years, so that there will be less likelihood of the couple finding, after the children have left home, that there is little gratification in the marital relationship.[1] The researcher speculates further that the growing trend toward the lack of differentiation of male and female roles, in which both husband and wife work and share in the domestic activities, will result in less conflict between husband and wife over the division of household tasks at retirement.

Death of spouse is a loss frequently suffered by the elderly. This loss is most common in women, so that while most elderly men are married, most elderly women are widows. Reasons for this differing incidence have been suggested.[2] Furthermore, the number of widows in comparison to the number of widowers is still increasing. Cowgill reports that according to 1966 United States statistics, there were 5.5 million widows as compared to 1.5 million widowers in the over sixty-five age group. These figures represent one half of the female population and one-fifth of the male population.[3]

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[1]Rose M. Somerville, "The Future of Family Relationships in the Middle and Older Years: Clues in Fiction." The Family Coordinator 21 (October 1972): 491.

[2]Supra, p. 102.

[3]Cowgill, "Aging in American Society," p. 246.

By 1972 the number of widows had increased to 9.6 million, while the number of widowers remained relatively constant at 1.8 million. Although the 1972 statistics apply to the total population, Kimmel notes that most of the figures apply specifically to those over sixty-five.[1] Thus, many elderly persons, particularly women, suffer the loss of spouse. The differing implications of this loss according to structural context have been discussed later.[2]

To summarize, research on the marital relationship of the aged couple seems to indicate that for most, marriage is a mutually satisfying relationship, once the initial role adjustments following retirement has been made. There exists a minority for whom marriage of the later years is characterized by decreased satisfaction. In such cases, there is often a lack of flexibility on the part of one or both partners preventing a satisfactory adjustment to the changes in their marriage which social, economic and physical factors have produced. Another loss which frequently occurs is that of loss of spouse, affecting women mainly.

Parent-Child Relationship

The relationship between parent and child is another

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[1] Douglas C. Kimmel, Adulthood and Aging: An Interdisciplinary, Developmental View (New York: John Wiley and Sons, 1972), p. 227.

[2] Infra, p. 117.

area in which it is commonly believed that the old suffer significant losses. It is frequently stated that industrialization has had many negative repercussions on family relationships, so that adult children tend to see parents little and existing ties are characterized by role reversal.[1] Some theorists disagree with this assessment, stating that industrialization has made it easier for affectional ties to be realized.[2] The removal of clearly demarcated authority lines in the family and the decreasing responsibility of children to provide and care for parents has enabled "intimacy through remoteness."[3]

Most studies have indicated little role-reversal in the interactions between parent and child. Rather, the relationship is often characterized by a pattern of mutual help, with some variations according to class, age and sex of the aged person. For example, Shanas found that most old persons had at least one child living nearby with whom they had contact. Generally, the pattern of help was mutual, although there were slight modifications with class. For

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[1]Role reversal refers to those parent-child relationships in which the child meets the social and emotional needs of the parent, rather than vice versa.

[2]Streib and Thompson, "Older Person in a Family Context," p. 454.

[3]Rudolf Tartler, "The Older Person in Family, Community and Society," in Processes of Aging, Vol. 2: Social and Psychological Perspectives, eds. Clark Tibbitts and Wilma Donahue (New York: Atherton Press, 1963), p. 70.

example, the older parent of white collar background in Britain and the United States was more likely to give help, while the older parent of working class background in Britain was more likely to receive help.[1] With advancing age, Shanas et al. found that more old reported recent contact with children, contact was more frequently initiated by children, and fewer old were able to help children.[2] They also found women to be slightly more integrated with families than men.[3] This is compatible with the primarily affective role of the female. Streib and Thompson's, and Albrecht's respective studies similarly revealed close social and affectional ties with children.[4]

Furthermore, parents and children appear to have congruent expectations of the parent-child relationship. Several studies note that both generations feel that independence and non-interference are important to successful intergenerational relationships. Clark and Anderson point to the high value placed on personal independence in the American culture, with the result that the elderly are encouraged to

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[1]Ethel Shanas, "Family Help Patterns and Social Class in Three Countries." Journal of Marriage and the Family 29 (May 1967): 265.

[2]Shanas et al., Old People in Three Industrial Societies, p. 220.

[3]Ibid., p. 439.

[4]Streib and Thompson, "Older Person in Family Context," p. 496.

keep separate households and maintain friendship ties.[1] Field states that the older usually understand that children have their own family expenses and therefore do not expect help.[2] Streib and Thompson found that parents did not resent their children achieving a higher status than they had in their careers, but instead shared their children's achievement-oriented values.[3] Albrecht discerned four types of aged parents. Of these, the "independent" type, constituting 85 per cent of the sample, seem to illustrate these points. For example, this parent type allowed his children to be mature and independent, while at the same time maintaining close social and affectional ties with them. Usually he lived in a separate household and led his own life, although he was able to accept advice and help from children without feeling threatened.[4]

Sometimes the parent does become dependent, the phenomenon previously referred to as "role reversal." Field states that some elderly become dependent on the younger for satisfaction of their social and emotional needs.[5] This

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[1]Clark and Anderson, Culture and Aging, pp. 275-276.

[2]Field, Aged, Family, and Community, pp. 50-52.

[3]Streib and Thompson, "Older Person in Family Context," p. 482.

[4]Nye and Berardo, Family, p. 584.

[5]Field, Aged, Family, and Community, pp. 52-53.

becomes a particular problem for children with unresolved dependency yearnings, or to those parent-child relationships characterized by ambivalence. In these cases, hostility and resentment often result.[1] Cameron refers to a similar phenomenon.[2] There are differing explanations of the causal dynamics of this dependency in the aged parent. Goldfarb interprets this pattern not as role-reversal, but as a lifelong dependent character emerging in clear form.[3] Albrecht's "dependent" type of parent, characterized by a high degree of "role reversal," represented 6 per cent of her sample.[4] However, she found this dependency usually occurred when the parent was physically disabled, senile, or had otherwise lost his capacity to maintain his independence.[5] The researcher speculates that both theorists have valid arguments. "Role reversal" is probably attributable to diverse causes, which may be either psychological, physical, or a combination of the two, depending on the individual.[6]

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[1]Donahue, Orbach and Pollak, "Retirement: Emerging Pattern," p. 374.

[2]Cameron, "Neuroses of Later Maturity," p. 215.

[3]Clark, "Cultural Values and Dependency," p. 271.

[4]Nye and Berardo, Family, p. 583.

[5]Ibid., p. 585.

[6]Infra, p. 125, for further discussion of dependency.

To summarize, it would appear that the majority of the aged do not suffer losses in the relationships with their children. Rather, the pattern is that of mutually satisfying affectional and social ties, and of frequent contacts. Sometimes parents become dependent and this may cause hostile reactions in the young.

Grandparent-Grandchild Relationships

Another area of social relationships particularly relevant to the aged is that with grandchildren. There has been little research on the role of grandparents in industrialized society. Much of what has been done is based on clinical data, which tend to over-represent dysfunctional modes of grandparenting. Tartler speaks of the grandparent role quite pessimistically. He states that the old, having lost because of industrialization economic and familial functions they formerly held, wish to assume new tasks within the family. This results in many grandparents consciously or unconsciously assuming an educational role with their grandchildren. This situation can become problematic, threatening parents and causing them to become fearful of having their authority undermined by the grandparent. They may feel that the grandparent's teachings are old-fashioned and will prevent children from adjusting satisfactorily to

contemporary society.[1] Other studies view the grandparent role similarly. For example, some say that grandparents compete with the parents for the child's love, seeking to win him over with indulgence and thereby undermining the parents.[2] These theorists would see the grandparent role as offering little gratification to the older person and as having potentially damaging effects on existing family relationships.

Others are more optimistic about the contemporary grandparent. Apple found that in those societies in which the grandparent retains much household authority, relationships with grandchildren are rather formal and authoritarian, whereas in those societies where the grandparent has little authority over the parental generation, interaction with grandchildren tends to be friendly, warm and indulgent.[3] This would seem to be another example of the "intimacy through remoteness" referred to earlier.[4] Nye, Nimkoff and others agree that this friendly and indulgent relationship is characteristic of the American grandparent.[5]

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[1]Tartler, "Older Person in Family, Community, Society," pp. 67-69; H. Warren Dunham, "Sociological Aspects of Mental Disorders in Later Life," in Mental Disorders in Later Life (Stanford, California: Stanford University Press, 1955), p. 169.

[2]Streib and Thompson, "Older Person in Family Context," p. 460.

[3]Nye and Berardo, Family, p. 586.

[4]Supra, p. 108.

[5]Nye and Berardo, Family, p. 586; Nimkoff, "Changing Family Relationships," p. 411.

Albrecht, and Neugarten and Weinstein found in their respective studies that grandparents usually have a "hands off" policy towards the rearing of grandchildren.[1] Albrecht noted that the roles of grandmothers were similar for the various socioeconomic classes, while the white-collar grandfather tended to have more interaction with grandchildren than the blue collar one.[2] Cavan, and Nye and Berardo all refer to the positive social evaluation of the grandparent role which enables both the older male and female to derive gratification from this role. A modification of self concept, from that of instrumentality to one which is emotional-affective, is necessary for males to enjoy the role. The existing positive evaluation of the grandparent role enables many grandfathers to achieve this transition.[3] Neugarten's study helps clarify the various types of relationships between grandparent and grandchild, and their frequency. She found five major styles of grandparenting. These were the "formal" style, the "fun seeker," the "distant figure," the "surrogate parent," and the "reservoir of family wisdom,"

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[1]Nye and Berardo, Family, p. 586.

[2]Ruth Albrecht, "The Family and Aging Seen Cross-Culturally," in Foundations of Practical Gerontology, 2d ed., rev., eds. Rosamonde R. Boyde and Charles G. Oakes (Columbia, South Carolina: University of South Carolina Press, 1973), p. 33.

[3]Cavan, "Couple in Old Age," pp. 388-389; Nye and Berardo, Family, pp. 589-590.

representing 32 per cent, 26 per cent, 24 per cent, 7 per cent and 4 per cent of the sample, respectively. The nature of each style is described concisely by the titles, which indicate that most grandparents are not closely attached emotionally to their grandchildren.[1]

To summarize, analysis of the grandparent role has been somewhat different than that of the other social relationships. The measurement of loss was not possible, since the grandparent role is initiated in the later years and thus constitutes a "gain". The researcher has therefore studied the nature of this gain, concluding that the incidence of the interfering grandparent is much exaggerated, while the trend may be in the opposite direction. Neugarten's study results indicate that many grandparents interact with their grandchildren in a peripheral manner and would not regard the grandparent-grandchild relationship as a major source of satisfying social relationships.

Friendship

Friends are another source of social relationships. Already discussed are conflicting opinions as to whether loss of friends and peer-group contact accompanies retirement.[2] Clark and Anderson found friendship to differ with variables

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[1] Ibid., p. 587.

[2] Supra, pp. 69-71.

of sex and psychiatric status. For example, females had more friends than males, and those subjects who lived in the community had more friends than those who had been in psychiatric hospital. The authors note that each person's definition of friendship was quite different, so that some relationships defined as friendship were essentially superficial social acquaintances, while others so defined were close, characterized by mutual understanding and concern.[1] Clark and Anderson found that most aged subjects explored little to find new friends, so that those lost through death were seldom replaced. Decreased energy, restricted mobility and limited finances were reasons given by the aged individual to account for this failure to replace lost friends.[2] Neither Clark and Anderson, nor Shanas et al. found that those without family were more likely to cultivate friends.[3]

Blau found that the effects of retirement and widowhood on friendship patterns were dependent on the structural context. In other words, a change in status placing the individual in a deviant position among his peers would have adverse effects on friendship. For example, if an individual retired when most of his age-sex-class peers were also retiring, there was no diminishing of friendship ties. On

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[1]Clark and Anderson, Culture and Aging, p. 304.

[2]Ibid., pp. 306-307.

[3]Ibid., p. 304; Shanas et al., Old People in Three Industrial Societies, p. 269.

the other hand, retirement had a negative effect on friendship when it was not common among the peer group of the retired individual. Retirement for women seldom had any effect on friendships, which Blau attributed to the secondary role of employment for women. Widowhood had a similar pattern of repercussions on friendship. For example, since the majority of women over seventy are widows, the loss of spouse would not place the bereaved wife in a deviant position among her peer group. Thus, widowed women had more friends than the married women. Blau found exception to this pattern in the case of lower class women, for whom widowhood had consistently adverse effects on friendship. She suggested that this was due to two main factors. Middle class women engaged in more social activities throughout their married lives, thereby developing friendship ties which were available when they became widowed, while the lower class wives developed fewer ties because of less social life independent of their husbands. Secondly, widowhood for the lower classes often meant a severe drop in economic position, limiting social activities.[1] It has been noted that Clark and Anderson's subjects also gave decreased finances as a cause of limited friendship ties.[2]

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[1] Zena Smith Blau, "Structural Constraints on Friendship in Old Age." American Sociological Review 26 (June 1961): 438-439.

[2] Supra, p. 116.

Thus, no firm conclusions can be given regarding the extent of friendship losses in aging. Inclusion of acquaintances in studies of friends has led to the speculation that these studies may have overestimated the prevalence of friendship ties. It appears fairly well established, however, that women tend to have more friends than men, that those with a history of psychiatric hospitalization have fewer, that friendship ties are no greater among those with or without family, and that friendship relationships decrease with age, due to various factors. Widowhood and retirement can have detrimental effects on friendship, depending on structural context and class. Thus, it is concluded that for some, aging is accompanied by a significant decline in friendship ties; for others, the decline is insignificant and cannot be considered a loss.

Theories of aging and losses in social relationships

Not all the theories of aging have explicitly referred to social relationships in old age, but the researcher speculates that friendship in the later years would be viewed as of differing importance. Cumming and Henry refer to the statuses of widow, parent, grandparent and friend as they relate to disengagement. They state that marriage becomes less functional with age, since the tasks of procreation and socialization of the young are complete. Children or siblings can replace the affective function of the marriage

partner, in the event of widowhood.[1] Widowhood is seen as fortifying disengagement, enabling the spouse to move from an intimate relationship to the less demanding, horizontal ties with friends.[2] Thus, the loss of spouse is not seen as totally disadvantageous to the aging process. Cumming and Henry found that in the earlier years, if children or siblings were lacking, siblings were more likely to be substituted for. However, one the individual was seventy or older, he was more likely to find substitutes for children he was missing, than for siblings.[3] Cumming and Henry attribute this change to the fact that the older individual is more disengaged and therefore seeks a less demanding and mutually reciprocating relationship.[4] In respect to grandchildren, Cumming and Henry found that few older people felt close to their grandchildren. They suggest this is because parents and children in American society maintain a fairly close relationship and do not need grandchildren to serve as mediators between the generations.[5] The researcher speculates that Cumming and Henry might agree that the lack of interest in grandchildren is due to the process of

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[1] Cumming and Henry, Growing Old, p. 155.

[2] Ibid., p. 157.

[3] Ibid., pp. 58-60.

[4] Ibid., p. 61.

[5] Ibid., pp. 60-61.

disengagement, which results in the individual desiring fewer social relationships. Friendship for its own sake did not seem sought in old age. For example, as mentioned earlier, siblings ceased to be substituted for, while children were increasingly substituted for. Friendship, when it existed, was often equated with a potentially helping relationship.[1]

Thus, Cumming and Henry appear to view loss of spouse and of friends, and the gain of the grandparent role, as of relatively minimal importance. They state that the disengaged individual will have fewer contacts and those remaining contacts will involve little responsibility or commitment on the part of the aged person. This is compatible with the individual's increased self-preoccupation and egocentricity. Thus, it is speculated by the researcher that Cumming and Henry would not view loss of social relationships with age as a loss per se, but rather as a change which is compatible with the disengagement process. The few remaining ties, which are frequently with children or child-substitutes, might be considered not so much as friendship, a mutually reciprocal relationship, but as a supportive-dependent relationship in which the older individual is helped by the other.

The researcher speculates that activity theorists would view a decline in social relationships as

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[1] Ibid., pp. 62-63.

dysfunctional to optimal aging. Studies which found that the most successful life-styles had high leisure scores would probably be cited to support this view.[1] Increased participation in leisure activities or organizations might be advocated to replace this loss.[2] Thus, loss of social relationships might be seen as having adverse effects on the individual, but would probably be considered replaceable through increased participation in other activities.

Developmental theorists, the researcher hypothesizes, would view decreased social relationships from numerous perspectives. As mentioned earlier, developmental theorists might regard changes in the aged as influenced by varied factors such as personality characteristics, economic resources, social supports and changing values.[3] Thus, it is speculated that changes in social relationships would be attributed to some of the above factors, and that whether the change is viewed as a loss or not would depend on the nature of the causal factor. For example, some studies have shown personality to be central in predicting patterns of aging, including level of role activity. Thus, an individual who has had few friends prior to old age would be predicted to continue a similar pattern of social relationships in old

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[1]Friedmann and Havighurst, Meaning of Work and Retirement, p. 190.

[2]Havighurst and Feigenbaum, "Leisure and Life Style," p. 350.

[3]Supra, pp. 77-78.

age. In such a case, lack of friendship ties would probably not be viewed as a loss. Reference was made earlier to decreased finances limiting sustainment or initiation of friendship patterns.[1] Developmental theorists would probably view declining social relationships if based on these factors as a loss, since the decrease in social interaction is not consonant with the individual's needs or desires. Kuhlen, referring to changing motivations and values through the years, notes a change in social interests and affiliation needs with age, so that there is less interest in extensive interaction and a shift to closer relationships with fewer people.[2] In such cases, a decrease in social relationships would probably not be regarded as a loss.

It is speculated that developmental theorists would not agree with disengagement theorists that decreased social interaction is characteristic of optimal aging. It is further hypothesized that they would not agree with activity theorists that leisure activities can replace lost social relationships. Weiss refers to the "fund of sociability" hypothesis, which states that individuals require a certain amount of interaction with others and that equal satisfaction may be derived from a few intense relationships or a large number of relationships of lesser intensity, as long as the

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[1]Supra, pp. 116, 117.

[2]Kuhlen, "Developmental Changes in Motivation," p. 119.

sum total of interaction is equal in both cases. Testing this hypothesis on "Parents without Partners" groups, Weiss found that the satisfactions derived from the former marital relationship could not be replaced by the substitute sociability of membership in the organization.[1] Developmental theorists might use this study to substantiate the argument that participation in leisure activities or organizations cannot replace the former, more intense involvements with spouse or friends.

Thus, while disengagement theorists regard diminishing and altered social relationships as characteristic of aging, activity theorists view sustained social relationships as representative of optimal aging. Developmental theorists appear to stand somewhere in between. They might view any level of social participation to be functional, as long as it were congruent with the individual's personality, needs or values.

Response to Loss of Social Relationships as a Grief Reaction

The four stages of denial, anger, depression and new identity formation have been presented as forming a grief reaction. Since grief theory is based on the individual's response to social loss, it seems logical that the aged will

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[1]Robert S. Weiss, "The Fund of Sociability." Transaction 47 (July-August 1969): 42.

react to losses in social relationships in these four steps. However, the relative importance of the lost relationship determines the intensity of the individual's reaction to the loss. Thus, the individual would probably not grieve all social losses equally.

Denial

Denial is the first stage of a grief reaction.[1] Little was found in the literature to indicate denial as a response by aged individuals to loss of social relationships. The researcher speculates that it is more difficult to deny a social loss, such as loss of spouse or friend, than it is to deny another type of loss, such as a physical one. For this reason, it is hypothesized that most older people would not deny the loss for any length of time but would progress to the next stage of grief.

Some indication of denial does exist, however. Lindeman refers to overactivity without a sense of loss sometimes occurring in distorted grief.[2] Perlin and Butler, who studied a group of nonpsychotic and medically healthy individuals who were community residents to ascertain the psychiatric aspects of adaptation to aging, found that the use of activity was a common adaptive pattern utilized in

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[1]Supra, p. 39.

[2]Lindeman, "Symptomatology and Management of Acute Grief," p. 144.

response to changes accompanying aging.[1] The researcher speculates that the dynamics of this activity are similar to those of denial, in that the individual seems to be seeking in both instances to forget or deny his loss by busyness. It is also hypothesized that, if one views this over-use of activity as a defense mechanism to deny the social losses of aging, then the activity theorists would seem to be perpetuating or supporting the use of this mechanism.

Dependency and helplessness have been noted to often accompany the first stage of grief.[2] Cavan refers to the phenomenon of children offering their recently bereaved parents a home with them.[3] It is speculated by the researcher that the older person may often accept such an offer if it is extended at this early stage of grief. However, problems may ensue later when the widowed, having culminated the dependent stage, regret having moved into the adult child's home, finding it limits their independence. In other cases, moving in with an adult child might elicit the manifestation of previously unexpressed dependency needs, so that the widowed become blocked at the dependent stage of grief. It is hypothesized that some instances of dependency noted earlier in the parent-child relationship could also be

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[1]Perlin and Butler, "Psychiatric Aspects," pp. 161, 175.

[2]Supra, p. 42.

[3]Cavan, "Couple in Old Age," p. 387.

attributed to this stage of the grief reaction.[1]

Theories of aging. The respective theorists do not refer to denial as a reaction to social losses in aging. The researcher speculates that according to the three theories, denial would be dysfunctional to optimal aging. Disengagement theorists might view denial of these losses by the individual, in the form of reluctance to decrease the number and intensity of social interactions, as a sign that he is not willing or ready to disengage. Activity theorists might see it as hindering the substitution of new relationships or activities for those lost, while developmental theorists might view denial of the social losses as an indication that the individual has been subjected to a higher level of anxiety than he can tolerate. Clark and Anderson refer to the ability to cope with extended losses or threats as an adaptive goal of aging.[2] Thus, denial might be interpreted by developmental theorists as a maladaptive response to increased anxiety, resulting from failure to attain a developmental goal.

Anger

Anger is the second stage of a grief reaction.[3]

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[1] Supra, pp. 110-111.

[2] Clark and Anderson, Culture and Aging, p. 287.

[3] Supra, p. 44.

Perlin and Butler found that the reactively depressed subjects had frequently sustained major losses, particularly the death of a wife or retirement.[1] Yarrow et al., using a male subgroup of Perlin and Butler's sample, found that those men who had suffered the most extensive losses were much more likely to be less organized, have no goals and feel unhappy and useless. Furthermore, they often differed from the other men in being much less sociable.[2] These findings illustrate clearly the feelings of depression, aimlessness and social withdrawal, characterizing the third stage of a grief reaction.

Guilt and ambivalence can result in the prolongation of depression.[3] For example, the widow who had a poor marital relationship throughout her married years, or who had not made role accommodations to enable her husband to adjust to retirement with more facility and satisfaction, might feel very guilty after her husband's death. This could very possibly result in pathological depression.

A development that could occur as a result of the

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[1] Perlin and Butler, "Psychiatric Aspects," p. 183.

[2] Marian R. Yarrow et al., "Social Psychological Characteristics of Old Age," in Human Aging: A Biological and Behavioral Study, eds. James E. Birren, Robert N. Butler, Samuel W. Greenhouse, Louis Sokoloff and Marian R. Yarrow (Bethesda, Maryland: United States Dept. of Health, Education and Welfare, National Institute of Mental Health, 1971), p. 275.

[3] Supra, p. 48.

individual being depressed about social losses should be noted. Parkes concedes that the social attitude to the bereaved is not as stigmatizing today as formerly, but notes that vestiges of these attitudes remain.[1] Thus, the researcher hypothesizes that the aged, depressed and mourning important social losses, may find that individuals sometimes avoid rather than support them. A vicious circle could be originated, in which one social loss precipitates others.

Theories of aging. Disengagement theorists might see depression as sometimes occurring in response to social losses. For example, Cumming and Henry state that after retirement, a "technical" reintegration with kin often seems to occur, replacing the peer group contact obtained from work. This substitution for the peer group is considered necessary for good morale.[2] Thus, the researcher speculates that depression might be attributed by these theorists to the fact that there are no social relationships available to replace those lost. Another perspective from which they might view depression in response to social losses is that the individual has not yet completed the disengagement

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[1]Parkes, Bereavement, p. 9.

[2]Cumming and Henry, Growing Old, p. 157. This reintegration is termed "technical" because it requires few obligations or emotional investments on the part of the aged individual.

process. Complete disengagement implies that there are few remaining social relationships to which the individual is sufficiently attached emotionally that he will grieve their loss.

Activity theorists do not directly comment on depression reactive to the loss of social relationships. However, the researcher speculates that since they state that continued activity is important to optimal aging, they would similarly feel that continued social participation is necessary. Thus, activity theorists might predict that a decrease in social relationships would precipitate lowered morale and depression.

Developmental theorists do not elaborate on depression resulting from social losses. The researcher hypothesizes that developmental theorists might see depression as sometimes resulting from decreasing social relationships, depending on factors such as personality, values and goals, or social supports. For example, the aging individual who has been socially isolated throughout life might not view physical incapacity which restricts him to his home as a significant loss. On the other hand, the individual who has maintained an active social life and finds it restricted for physical or economic reasons, might become depressed. Changing motivational patterns may also cause decreased interest in extensive social interactions.[1] In these cases,

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[1]Supra, p. 122.

developmental theorists would probably not view depression as likely to result.

New Identity

The final stage of grief is that of establishing a new identity. This can occur only after the individual has successfully withdrawn himself emotionally from the lost object, following a period of depression.[1]

Various authors have noted patterns of adjustment which appear similar to this last stage of grief. Perlin and Butler found that all subjects had had a "crisis of identity" and concluded that the use of compensation and acceptance seemed positively related to the resolution of this crisis.[2] Shanas et al. similarly refer to "structural compensation," in which individuals substituted new relationships to avoid isolation resulting from social losses.[3] These two groups would seem to have successfully completed the last stage of grief, in which they accepted losses and established new sources of gratification. Cavan also refers to this stage of development of a new identity. Referring to the widow, she states that "It is in the intangible adjustment of self-image that the heart of the problem of

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[1] Supra, pp. 50-51.

[2] Perlin and Butler, "Psychiatric Aspects," pp. 186-188.

[3] Shanas et al., Old People in Three Industrial Societies, p. 434.

adjustment lies."[1] Already noted is her comment on the importance of the grandfather modifying his self-conception from instrumentality to expressivity.[2] Thus, the male would have to successfully mourn the predominantly instrumental self-conceptions he had of himself as a working man, before he could accept the new identity of a grandfather. In this case, successful griefwork in one area -- loss of work, seems to enable new opportunities in another -- development of new social relationships.

Perlin and Butler note that some individuals seemed unable to resolve the "crisis of identity." These persons were in a "deadlock," unable to compensate for losses while also being unable to accept them. A clinical picture of intense apathy and sadness without overt depression, and of social isolation characterized this group.[3] The researcher speculates that these individuals, unable to grieve and accept their losses, were consequently unable to form a new self-identity.

Such problems might derive from several sources. Lack of alternative sources of identity and gratification, or of social supports facilitating the transition to these alternatives, might account for some difficulties. For

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[1]Cavan, "Couple in Old Age," p. 387.

[2]Supra, p. 114.

[3]Perlin and Butler, "Psychiatric Aspects," p. 182.

example, those for whom variables such as advanced age; single, retired or widowed status; lack of family or friends living nearby; and physical incapacity interacted, would be most likely to have problems at the last stage of grief. To illustrate, the individual who has recently lost significant social relationships and who is also advanced in age, physically disabled and has no relatives nearby, would find it very difficult to establish new social relationships, resolving the last stage of grief. On the other hand, the individual who has suffered similar losses but who is physically able to visit others or has children nearby to visit him, would find it much easier to compensate for these losses and to complete grief work. Blau's findings on adjustment to widowhood provide another example of the effects of availability of alternatives.[1]

Predominant social values and attitudes might also impede the last stage of grief. Despite the fact that studies have shown that remarriages in this age group are considered successful by the marital partners, they are often socially disapproved of.[2] Kimmel, Pfeiffer and others note the low social tolerance and frequent ridicule the aged receive for sexual and social liaisons.[3] Thus, the aged

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[1] Supra, p. 117.

[2] W. C. McKain, "A New Look at Older Marriages." The Family Coordinator 21 (January 1972): 64.

[3] Kimmel, Adulthood and Aging, p. 230; Pfeiffer, "Sexual Behavior in Old Age," p. 161.

individual who has successfully accepted the loss of spouse may have difficulty in finding a new identity through remarriage due to social disapproval.

Some theorists speculate that these problems may diminish in the future. Somerville states that remarriage and consensual unions will cease to be regarded negatively in the years to come. Cavan suggests innovations such as homosexual or lesbian relationships, group marriage and communal living may be a future solution to the disparity in size of the male and female populations.[1] While the researcher agrees that Somerville's estimation is reasonable, it would seem that Cavan's propositions would be acceptable to only a minority of even future generations of the older.

Thus, in the last stage of grief, the individual would grieve the loss of social relationships and form a modified self-identity based on acceptance of these losses. Lack of alternatives on which to base this new self-identity or negative social attitudes might present serious obstacles to the completion of this stage of grief. In such cases, the individual would probably remain in the depressed stage.

Theories of aging. Disengagement theorists do not directly refer to the necessity of the individual establishing a new identity in order to adjust to losses in social relationships. However, the researcher speculates that a new

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[1] Sommerville, "Future of Family Relationships," p. 492; Cavan, "Speculations on Innovations to Conventional Marriage in Old Age." The Gerontologist 13 (Winter 1973): 409.

identity would be seen by these theorists, not as a result of successful working through of a grieving process, but as intrinsic to the aging process. This new identity resulting from disengagement would involve the individual's participation in social relationships which are decreased in number and of a less reciprocating or emotionally demanding nature.[1] Activity theorists might see completion of the last stage of grief to be necessary because acceptance of losses in social relationships would preclude the individual being willing or motivated to engage in new social relationships or activities. Developmental theorists might also agree that attainment of the last stage of grief is necessary. Clark and Anderson refer to the substitution of alternative sources of need satisfaction as an adaptive task of aging.[2] Thus, developmental theorists might maintain that, for those individuals who had previously enjoyed a high degree of social participation, the acceptance of social losses and of a new identity as a person deriving satisfaction from different social relationships would be necessary.

Distorted Grief Reactions

Distorted grief reactions can sometimes occur in the

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[1] Supra, p. 119.

[2] Clark and Anderson, Culture and Aging, p. 407.

grieving process.[1] Examples of distorted reactions of denial, anger, and depression in response to loss of social relationships have been cited. Conversion into physical or mental illness is another form grief reactions may take.[2]

Parkes notes that many widows see physicians with physical or somatic anxiety complaints in the months following bereavement.[3] Rees and Lutkins found in their study that 4.76 per cent of the close relatives of the deceased died within a year of the death of their relative, as compared with 0.68 per cent of the control group.[4] Thus, loss of significant social relationships appears to precipitate physical illness. Parkes refers to various studies showing the increased incidence of mental illness in the bereaved.[5] The positive relationships between social isolation and schizophrenia, and between bereavement and psychoses, have been noted.[6] Kimmel, Sainsbury and others note that bereavement and loneliness often appear to precede suicide.[7] Lowenthal, however, found that social

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[1]Supra, pp. 55-56.

[2]Ibid.

[3]Parkes, "Bereavement and Mental Illness," p. 22.

[4]Fredrick, "Physiological Reactions Induced by Grief," p. 71.

[5]Parkes, "Bereavement and Mental Illness," p. 26.

[6]Supra, pp. 24, 32.

[7]Sainsbury, "Suicide in Middle and Later Years," p. 104; Kimmel, Adulthood and Aging, p. 229.

isolation was a consequence, rather than cause of, mental illness in the elderly. She hypothesized that physical illness seemed to be the antecedent to both isolation and mental illness.[1]

It should be noted that psychopathology cannot always be interpreted as a form of distorted grief. For example, Perlin and Butler found that some individuals' life-long character psychopathology helped them adapt to social losses in old age. The compulsive widower would be able to continue his day-to-day living without noticeable disorganization because of his highly elaborate scheduling and planning, while the schizoid personality would be sufficiently detached that he would not suffer from social losses that might have been devastating to another individual.[2]

Supportive role of social relationships

Social relationships have been discussed with reference to whether the aged individual suffers losses in this lifespace and to how he reacts to these losses. Another

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[1]Marjorie Fiske Lowenthal, "Social Isolation and Mental Illness in Old Age." American Sociological Review 29 (February 1964): 70.

[2]James E. Birren et al., "Interdisciplinary Relationships: Interrelations of Physiological, Psychological, and Psychiatric Findings in Healthy Elderly Men," in Human Aging: A Biological and Behavioral Study, eds. James E. Birren et al. (Bethesda, Maryland: United States Dept. of Health, Education and Welfare, 1971), p. 304.

perspective from which to view social relationships is in relation to how they help the individual to deal with losses in the various lifespaces of health, work and social relationships. Various authors attest to the importance of social relationships in helping the individual handle these losses.

Parkes refers to social support or isolation as one determinant of the outcome of the individual's reaction to grief.[1] Riley and Foner note the importance of the family in helping the individual adjust to retirement, while Berardo refers to the family's role in facilitating the widow's adjustment to her loss.[2] Birren emphasizes that the availability of a supportive environment often diminishes the individual's difficulty in coping with the declines of aging.[3] Lowenthal found that the presence of an intimate social relationship, or "confidant," was positively associated with adjustment to the stresses of the later years, such as widowhood and retirement.[4] Perlin and Butler found that those

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[1]Parkes, Bereavement, p. 121.

[2]Riley and Foner, Aging and Society, Vol. 2; Felix M. Berardo, "Widowhood Status in the United States: Perspective on a Neglected Aspect of the Family Life-Cycle." The Family Coordinator 17 (July 1968): 200.

[3]Birren et al., "Interdisciplinary Relationships," p. 303.

[4]Marjorie Fiske Lowenthal and Clayton Haven, "Interaction and Adaptation: Intimacy as a Critical Variable." American Sociological Review 33 (February 1968): 21.

subjects who were depressed in response to the losses of aging tended to be the widowed, separated, divorced or single.[1] They compared three groups of men -- those who had suffered pronounced losses and who lacked personal ties and supports, those with important losses and some supports, and those with very few losses, and found that those with social supports handled their losses more adaptively. Shanas et al. similarly found the widowed and single to be the most lonely.[2] Thus, indications are that social relationships can be very instrumental in helping the individual to adjust to the various losses of aging.

Conclusion

It is sometimes implied that the elderly engage in few social relationships and do not feel their loss as acutely as do the young. However, evidence has been presented which indicates that the old value social relationships and keenly suffer their loss. Relationships which are particularly important to the older individual seem to be those with spouse, children and friends. Variations exist among individuals in relation to which relationships they value most and the degree of social interactions in which they are involved. Loss of social relationships is different for the aged than

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[1]Perlin and Butler, "Psychiatric Aspects," p. 183.

[2]Shanas et al., Old People in Three Industrial Societies, p. 274.

the young in that death accounts for only some losses. Others derive from varied factors such as limited finances or declining health. Lack of opportunity to develop new social relationships and negative social attitudes can cause difficulties in completing the last stage of grief.

CHAPTER V

CONCLUSIONS AND IMPLICATIONS

Introduction

In this chapter, the main findings of the previous chapters have been summarized. The relationship between theories of grief and the manner in which individuals respond to the losses of aging has been clarified. Various aspects of these losses have been described. Finally, the implications of these findings to the profession of social work have been discussed. Various types of intervention at the individual, family, group and community levels have been articulated on the basis of the analysis done in Chapters II to IV. Further areas of research and education have been discussed.

Conclusions

The researcher has reached several conclusions on the basis of findings in the previous chapters. It is noted that these conclusions must be regarded as tentative, due to the small amount of data on which they are sometimes based. Literature available on the losses of aging in the life spaces of health, work and leisure, and family and friends, was adequate. However, there was very little information

describing the individual's reaction to these losses. Furthermore, the literature found on the subjective response to aging tended to concentrate on pathological rather than healthy modes of response. Thus, it is possible that the researcher has overemphasized the frequency of pathological reactions to these losses of aging. Acknowledging the above problems of the limited availability of data and the possibility of existing data being overrepresentative of a certain population group, the maladapted aging, the researcher has formulated some tentative conclusions.

Stages of grief

There seems to be adequate evidence to support the hypothesis that the aged respond to losses in the life-spaces of health, work, and family and friends in patterns which appear similar to each of the four stages of a grief reaction.

There was most evidence of denial in relation to losses in health. This would seem predictable, in that the cultural emphasis on youth and beauty would cause losses in the areas of physical and intellectual functioning to be particularly threatening and therefore the most likely to be denied. Perlin and Butler found that physical and cognitive changes were almost always seen as losses, in their community sample.[1]

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[1] Perlin and Butler, "Psychiatric Aspects," p. 172.

The helplessness and dependency seen at times in the aged has been hypothesized as related to the helplessness and dependency so often characteristic of the initial stages of grief. For example, the researcher has speculated that the longer duration of hospital stays by the elderly, psychological "losses" necessitating increased help from others, and the "role reversal" sometimes noted between adult child and aged parent, may sometimes be manifestations of these modes of response characteristic of the early part of a grief reaction.

Anger constitutes the second stage of a grief reaction. An unexpected finding was the lack of direct expression of this emotion in response to the losses of aging. When anger is expressed directly, it frequently appears to be in a maladaptive form, aggravating or perpetuating existing losses. Examples would include the "cantankerous" older person who belittles family, friends or the world in general. Such an individual may easily become progressively more isolated, suffer additional losses, and in turn become more angry, perpetuating a vicious cycle. The literature review has led to the conclusion that anger is more often expressed indirectly by the aged, in the forms of depression or paranoia. Supporting this conclusion are the high incidence of depression and paranoia in the aged, as compared to younger population groups.

The researcher speculates that this lack of direct

expression of anger by the aged may be related to dominant sociocultural values. For example, it would seem that anger could only achieve results or have an impact if the individual expressing the anger had some status or power. However, the aged in Western society tend to be devalued, so that direct expression of anger may be met by ignoral or censure. Furthermore, a certain amount of self-esteem would seem to be required before an individual would be capable of expressing anger directly. It is feasible that the aged have internalized the negative cultural values of old age and therefore lack the self-esteem required to express their anger directly.

As would be expected, there is substantial evidence to indicate that depression -- the third stage of a grief reaction, often occurs in response to the varied losses of aging. Frequently accompanying depression are social withdrawal, apathy and loss of aggressiveness. The researcher speculates that these three emotional responses are particularly likely to complicate successful griefwork by the elderly and instead to perpetuate the stage of depression. For example, the younger person who has suffered a significant loss and withdraws socially in the depressed stage of grief is conjectured to often have friends or family to support him, encouraging social reintegration after an appropriate length of time. The aged individual, on the other hand, may be more likely to lack this type of social support, so that his social withdrawal might frequently become attenuated in length, resulting

in social isolation.

This lack of social supports for the aged individual could result from several factors. The aged person often has fewer friends than the younger, due to attrition of friends by death or inability to visit one another. Various studies have been noted which indicate the importance of adult children to the older person as a source of help and emotional support. However, the researcher speculates that adult children may find it difficult to offer the intensive support which their aged parents require in this time of social withdrawal. For example, children who are geographically separated from their parents may be unable to afford to increase the frequency and length of phone calls in order to intensify support. Furthermore, adult children with aged parents are often preoccupied with responsibilities such as children and the increased financial expenses which frequently occur in middle age. The predominance of the nuclear, as contrasted to the extended family of former years, may also make increased social support of the aged parent difficult. Whereas in an extended system, family responsibilities are spread out among numerous people, in the nuclear system, responsibilities are handled by a smaller number of family members. The researcher has speculated that this limited ability of family and friends to offer intense support, may often result in the aged individual remaining in the stage of depression and social withdrawal, so that his grief

remains unresolved.

Similarly, apathy and loss of aggressiveness are speculated to particularly complicate the grief reactions of the old, as compared to those of the younger. The apathy associated with depression may prevent the individual from mobilizing himself to find substitutes for the losses or from making accommodations to minimize their effects. Loss of aggressiveness could perpetuate the failure to express anger, impairing the individual's ability to react constructively to losses. For example, it could cause the individual to be apathetic to agitating for change in order to prevent losses which are caused or aggravated by sociocultural factors.

The aged who have adjusted to aging and its losses appear to have completed the last stage of grief, that of accepting the loss and revising self-identity to incorporate the losses. Successful patterns of aging described by various theorists indicate the completion of a process in which the individual accepts the losses of aging, integrates them to form a revised self-conception, and is then able to turn to new objects, activities or values as alternative sources of gratification. The researcher has speculated that a significant number of aged individuals do not complete this stage of grief and instead remain at the depressed stage. The high incidence and prevalence of depression in the older, as compared to the younger population groups, would seem to support this conclusion. Furthermore, there appear to be few

social supports to facilitate, or alternatives to enable new identity formation. In the area of health losses, a positive social evaluation of youth, vigor and beauty are speculated to severely impair the individual's ability to find the new image of himself as a physically aged individual satisfying. Similarly, some individuals find acceptance of the loss of work and involvement in leisure activities difficult due to the positive evaluation of work and somewhat negative one of leisure. It has been noted that the growing reference group of retired persons and the more positive social evaluation of leisure today than previously, are decreasing the difficulties the individual may encounter in accepting and adjusting to the image of himself as a retired person. Individuals may also have difficulty adjusting to losses in the lifespace of social relationships. The predominance of aged females to males and negative social attitudes preclude the possibility of remarriage for the majority.

The researcher has concluded that the data available indicate that distorted grief reactions, in the forms of physical and mental illness, occur sometimes in response to losses in the areas of health, work and social relationships. Not all physical or mental illness in the aged may be related to a manifestation of distorted grief. However, it would seem that the high incidence of these illnesses in the aged, as compared to other age groups, supports the conclusion that physical and mental illness may often be caused or

increased by grief.

The researcher has therefore concluded that present data indicate that the aged respond to losses in the life spaces of health, work and social relationships in a manner similar to that predicted by grief theorists. A lack of direct expression of anger at the losses was noted, as was the possibility that many aged individuals remain in the depressed stage of grief, due to lack of social alternatives or supports. Further research on the subjective response to aging, particularly with well-adjusted aged individuals, is necessary to confirm these conclusions.

The losses

In addition to the way in which losses are responded to, the researcher has formulated various conclusions on the nature of the losses themselves. Many of the losses noted to frequently accompany aging could be avoided or minimized by preventive or compensatory measures.

Sociocultural factors appear to often inhibit use of preventive or accommodating measures and to intensify the losses of aging. For example, losses such as the diminishing of visual acuity or a decline in the tone of skin, do not essentially constitute losses, since the first may be compensated for, while the latter does not impair the individual's functional abilities. The loss of status and identity accompanying retirement seems related to the

positive sociocultural evaluation of productivity and somewhat negative evaluation of leisure. Losses in social relationships appear similarly aggravated by sociocultural values. It has been noted that the remarriage or sexual liaison of the older person is often frowned upon or ridiculed.

Thus, the researcher has concluded that aging does not have to be associated with as many losses as it presently is. Those losses which now accompany aging could be significantly reduced by prevention, planning and use of compensatory techniques by the older individual, and by modification of social attitudes devaluing aging. Acknowledging that many losses presently associated with aging need not exist, it seems that at present the aged suffer from multiple, interrelated losses. The researcher speculates that it is this multiplicity that often causes the losses to be so devastating in effect.

One loss might have a domino effect, precipitating other losses. For example, the individual who retires and suffers a significant loss of income may find that he is no longer able to afford to indulge in hobbies, travel or entertaining and visiting friends. He may become socially isolated and lack the intellectual stimulation of friends and interests. This, in turn, may cause declines in intellectual functioning, such as memory lapses, and in reality orientation, such as to day and time. Furthermore, the decrease in activities may precipitate physical decline or preoccupation with health problems. Thus, one initial loss

may sometimes culminate in numerous losses. Presence of factors such as few friends or family living nearby, and single or widowed status, might tend to increase the likelihood of such a self-perpetuating cycle being established, because there would be fewer social supports to intervene at one point of the cycle to help the individual handle his grief and recover from his losses.

The researcher speculates that of today's aged population, the lower socioeconomic groups and males might be most likely to have difficulty in resolving their grief reaction to the losses of aging. The importance of the economic, rather than extrafinancial meanings of work to the lower socioeconomic groups has already been noted.[1] The main loss associated with retirement for this group would thus appear to be that of decreased finances. This loss has significant implications for the individual's ability to compensate for other losses of aging, as has already been discussed.[2] Thus, the lower socioeconomic groups might be less able than the higher socioeconomic groups to complete the fourth stage of grief, in which losses are accepted and integrated into a revised self-concept. Instead, limited finances are speculated to reduce greatly the possibility of developing alternative sources of need gratification and may

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[1]Supra, p. 65.

[2]Supra, p. 116.

result in the increased possibility of the individual remaining in the depressed stage of the grief reaction.

The researcher speculates that today's aged male would have particular difficulty in resolving his grief at the losses of aging. The traditional role of women is affective, while that of men is instrumental. Retirement and aging imply a major role loss for men, whereas the roles of women remain relatively stable through time.[1] In addition, today's aged males are speculated to have fewer social supports to help them handle the losses of aging, since their traditional instrumental role may have resulted in less focus on maintaining friendship or family ties. Various studies have noted the larger proportion of males as compared with females with few or no friends.[2] Furthermore, the traditional role ascribed to the male is relatively unexpressive and stoical, which would limit him in openly grieving his losses. The researcher speculates that the lower death rate for men than for women may be a reflection of this increased difficulty of males in dealing with the losses of aging. Present trends indicate an increased sharing of affective and instrumental roles by the sexes. On this basis, the researcher speculates that men may find adjustment to the later years somewhat

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[1] A comparable grief reaction for females could occur at the "empty nest" stage, when the woman's role is modified with the departure of her children.

[2] Clark and Anderson, Culture and Aging, pp. 303-306.

easier in the future while women may find it more difficult. This might result in the average life span of males and females becoming comparable in length.

To summarize, the researcher concludes that available data support the initial hypothesis that the aged respond to losses in the various lifespaces in a sequence comparable to that predicted by grief theory. It seems that many aged individuals are unable to complete the fourth stage of grief and instead remain at the third, depressed stage. The multiplicity of interrelated losses presently suffered by the aged has been noted, as has the speculation that such a large number of losses do not necessarily have to accompany aging. It has been hypothesized that the lower socio-economic groups and males may presently have most difficulty in adjusting to aging.

Implications for Social Work

The conclusions cited above, resulting from the analysis of the losses of aging within the framework of grief theory, have enabled the articulation of a plan of social work interventions to ameliorate some of the existing problems of the aged. The three general purposes of such interventions would be to reduce or prevent those losses which need not be associated with aging, to help the individual grieve those losses which seem intrinsic to aging, and to seek to increase the alternatives or options

open to the older person so that he can complete the last stage of grief more easily. Since the losses of aging appear related to diverse factors, it is felt that a multifaceted approach is particularly necessary. Thus, interventions have been formulated at the levels of the aged individual, his family and the community, to occur at various times, such as before, during and after the losses of aging.

Preventive interventions

Various interventions would appear appropriate before the losses of old age -- both those which appear intrinsic to aging and those which need not accompany aging, occur. Anticipatory grief seems particularly relevant to preventive interventions aimed at helping the individual and his family. Lindeman refers to the role of anticipatory grief in helping the individual adjust to the future death of a significant other.[1] Kubler-Ross stresses the importance of allowing the dying individual to express his sorrow at impending losses.[2] Gerber focusses on the family of the dying person, stating that in anticipatory bereavement, the individual prepares for both the emotional and social aspects of losing the

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[1]Lindeman, "Symptomatology and Management of Acute Grief," p. 147.

[2]Kubler-Ross, Death and Dying, pp. 86-87.

significant other.[1] For example, the wife may grieve not only the impending loss of the emotional aspect of the marital relationship, but may also regret the loss of the social roles performed by her husband, such as earning the income or doing household repairs. Prichard notes the importance of the social worker in assisting the individual and his family to express their feelings and fears of the impending loss and to make plans for the future. This helps family members to not only prepare for the loss, but serves a preventive purpose in helping to avoid problems after the death of the individual.[2] Nighswonger focusses on the aspect of "grief synchronization", in which the role of the professional is that of serving as an enabling "gear," synchronizing the grief of both the dying individual and his family.[3] Lack of grief synchronization can result in such phenomena as the dying individual having accepted the fact of his death, while the family members still need to deny their impending loss and are angry at the dying

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[1]Irwin Gerber, "Anticipatory Bereavement," in Anticipatory Grief, eds. Bernard Schoenberg et al. (New York: Columbia University Press, 1974), p. 28.

[2]Elizabeth R. Prichard, "The Social Worker's Responsibility in Anticipatory Grief," in Anticipatory Grief, eds. Bernard Schoenberg et al. (New York: Columbia University Press, 1974), pp. 239, 243.

[3]Carl A. Nighswonger, "The Vectors and Vital Signs in Grief Synchronization," in Anticipatory Grief, eds. Bernard Schoenberg et al. (New York: Columbia University Press, 1974), p. 268.

individual for referring to his death. In other cases, the family may have accepted the loss before the dying individual has, so that he begins to feel unloved and isolated in his final period of life.

The researcher speculates that these aspects of anticipatory grief could be effectively used by social workers to help the aged individual and his family prepare for the losses of aging. Such a focus would diminish grief felt at the time of loss and therefore decrease the disabling emotional responses to grief mentioned in previous chapters. For example, the researcher has elaborated in another context on the importance of retirement planning programs to help individuals prepare in groups for retirement and to deal with the initial adjustment period. It was suggested that such programs be offered over a period of time, prior to and following, retirement. Aspects of family relationships, work and leisure, finances and health would be the main focus. A social worker could coordinate the program in order to facilitate group process, while resource personnel would be used to offer specialized information on topics such as health or finances. Sponsorship by local community centres was suggested to encourage reintegration into the community and strengthening of community ties.[1]

The researcher speculates that such retirement

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[1] Nancy Campbell, "Preretirement Programs," McGill School of Social Work, 1975. (Typewritten).

planning programs would facilitate the process of anticipatory bereavement. Discussion of family relationships, work and leisure, finances and health, would prepare the individual for losses he might suffer not only at the time of retirement but throughout the latter part of life. Coordination by a social worker would facilitate expression and working through of feelings of denial, anger and depression, and the elaboration by the group of various ways in which they could resolve their losses, completing griefwork. As well as serving the purpose of emotional preparation for the losses of aging, such a program would also prepare the individual factually for the losses. In other words, provision of more specialized information by resource personnel, such as on pension plans or health status of the elderly, would offer factual and undistorted data on the losses the individual may or may not expect to suffer in aging. In this way, distortions might be corrected, so that the possibility of the older person either over- or underestimating the losses of aging would not be so likely. This would enable the individual to prepare for some losses by familiarizing himself with various compensatory techniques and to begin measures to avoid other losses. Heterogeneity of personality characteristics and modes of relating must be acknowledged in program planning. Thus, although sponsorship of retirement programs by local community centres has certain advantages such as reintegration with the community and extension of social

contacts, similar programs could be offered in alternate forms. For example, social service agencies should be prepared to help individuals or couples with planning emotionally and concretely for retirement and aging.

The influence of the family on the expression of anticipatory grief and the importance of a professional focus on grief synchronization has been noted. Thus, whenever appropriate, spouse and family might be included in the above programs. The spouse or adult children may be anxious about the impending losses of the aging individual, either because of the increased responsibility these losses may place on them or because it forces them to face their own old age. As a result, family members may become overprotective or patronizing in interactions with parents, or may withdraw emotionally so as to detach themselves from parents before the loss occurs, minimizing its emotional effects. At other times, anxiety may result in family members denigrating the efforts of the aged individual to plan for the losses. The role of the social worker would be that of helping spouses or children to grieve those losses which may occur, while dissipating anxieties based on cultural stereotypes of the losses of aging. These interventions would help adult children to prepare for both their own and their parents' old age, and would assist the aged individual by assuring him of the assistance and support of family members in working through losses.

The concept of anticipatory grief could also be applied to interventions at the community level. Caplan refers to the importance of primary prevention of mental disorders.[1] Maddox and Morris note that preventive preparation for aging, such as fostering mental and physical health and an integrated lifestyle of work and leisure, should ideally begin in the earlier years.[2]

Social workers could implement this preventive function in the early years by interventions in the educational system. For example, school social workers could modify their traditional focus on behavior problems in order to extend more services of a preventive nature. Groups which discuss and prepare for various phases of the life cycle could be formed, or courses offered on family living. Although these programs would not focus solely on old age, this stage of life would be included along with the others. The researcher speculates that it is fear and anxiety of old age which are responsible for the avoidance or mockery of the old by some young people. If school age individuals were enabled to work through their anticipatory grief at the losses of aging, they might become less likely to fear their own old age and to avoid grandparents or other older

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[1]Gerald Caplan, Principles of Preventive Psychiatry (New York: Basic Books Inc., 1964), p. 16.

[2]Maddox, "Growing Old: Getting Beyond the Stereotypes," p. 16; Morris, "Aging and the Field of Social Work," p. 25.

people. The researcher speculates that such preventive programs would have the positive results of preparation of the young for satisfying, meaningful living in the middle and later years, modification of existing negative social attitudes and cultural stereotypes of aging, and promotion of intergenerational contacts and understanding.

Social workers could therefore intervene effectively in relation to the individual, his family and the community, helping to prepare for the eventual losses of aging. The concept of anticipatory grief could be used as a basis in planning these interventions. The individual would be helped to mourn and accept some losses of aging, while misconceptions of other losses would be clarified. Attitudes could be modified by working through of previously unexpressed fears and anxieties.

Interventions after losses

Social workers could also function effectively at various levels of intervention to help individuals deal with losses after their occurrence. Lindeman and others refer to the role of the therapist in helping the bereaved individual to express feelings of loss, working through these emotions so that he can accept the loss.[1] Fulton adds that it is necessary for the professional to be able to accept different

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[1]Lindeman, "Symptomology and Management of Acute Grief," p. 147.

responses to death, depending on the individual's attachment to the lost object and on whether anticipatory grief has been expressed.[1] For example, an individual who has already grieved the object loss may be less upset when the loss occurs than an individual who has not proceeded through anticipatory grief. The former individual may feel guilty if professional staff or family members expect him to grieve profusely.

These concepts can be useful to the social worker in helping the aged person to proceed through the various stages of grief. Referrals to social workers are frequently in the nature of "disposition", such as finding new living arrangements for the older person.[2] In such cases, the social worker may focus on providing the concrete service requested, forgetting that it is equally important to help the individual to openly express feelings of denial, anger and depression over the losses necessitating contact. Only then will the older person be able to engage himself in working on a suitable plan with the social worker, accepting and utilizing it. Fulton's comment on anticipatory grief should be considered when working with the individual. It becomes important for the social worker to be able to discern

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[1] Robert Fulton and Julie Fulton, "A Psychosocial Aspect of Terminal Care: Anticipatory Grief." Omega 2 (1971): 97.

[2] Butler and Lewis, Aging and Mental Health, p. 231.

whether absence or minimal expression of grief is due to the individual's denial of grief felt at losses or whether it results from the fact that the individual has already grieved his losses. Whereas the expression of feelings of loss is therapeutic in the first case, similar expectations in the second might evoke a response of guilt.

Recognizing that dependency, helplessness and disorganization are characteristic of the early stages of grief, the worker should be willing to assume a supportive and somewhat directive role initially, while expressing the expectation that the individual will soon be able to take a more active role in his planning. The therapist must be particularly sensitive to achieving a balance between recognition of dependency needs resulting from loss and of the necessity of expecting more self-direction from the client at an appropriate time. Assessing how the individual has dealt with past losses would help the social worker to determine what degree of support is most therapeutic. Particular difficulty has been noted in the direct expression by the aged individual of anger at losses. The therapist should encourage expression of anger, seeking to focus it constructively. For example, the client could be informed of citizen's groups he could join in order to agitate for political change in areas such as those of improved income plans. These interventions would have the additional therapeutic goal of improving self-esteem. Problems have also

been noted in completing the last stage of grief. For this reason, it is particularly important that the therapist's attitude be positive and hopeful, emphasizing future possibilities for growth and fulfillment, while acknowledging pain felt at losses suffered.

Other theorists advocate a similar approach in work with the elderly. Butler and Lewis note three directions in which to move in therapy with the elderly.[1] The first is that of restitution capacity, or the ability to compensate for, and recover from, deeply felt losses. The second is that of growth and renewal, or a striving to discovery and utilization of innate potential. The last is that of perspective, or the ability to see one's place in the world from a longitudinal perspective. Cath also refers to restitution capacity, stating that multiple losses may result in diminished libidinal energy and lowered restitution capacity. Family, friends and therapist can function to replenish the individual's restitution capacity through support and encouragement.[2]

Thus, the therapist should focus on helping the aged person progress through the stages of grief. When the aged individual is closely involved with his adult children, it is often strategic to include them in therapy. Blenkner

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[1]Butler and Lewis, Aging and Mental Health, p. 141.

[2]Cath, "Dynamics of Middle and Later Years," p. 181.

refers to the concern of children for their aged parents and willingness to be involved in helping them.[1] Grief theorists have formulated conceptualizations of family mourning which support this inclusion of adult children. Jensen and Wallace note that the loss of one person produces shifts in the inter-individual demands on members, as needs formerly satisfied through relationships with the deceased are no longer met.[2] Goldberg refers to family mourning tasks, stating that completed mourning is necessary before instrumental and socio-emotional functions can be redistributed to replace those performed by the lost person.[3]

It may therefore be necessary for adult children to grieve the losses of their aged parents, because of the implications these losses may have for them in relation to roles and functions previously performed by the aged individual. For example, adult children may find that physical declines in their parents mean that the latter can no longer babysit. They may discover that their aged parents have become preoccupied with their own losses and are no longer

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[1]Margaret Blenkner, "Social Work and Family Relationships in Later Life with Some Thoughts on Filial Maturity," in Social Structure and the Family: Generational Relations, eds. Ethel Shanas and Gordon F. Streib (Englewood Cliffs, New Jersey: Prentice Hall, 1965), p. 48.

[2]Gordon D. Jensen and John G. Wallace, "Family Mourning Process." Family Process 6 (March 1967): 64.

[3]Stanley B. Goldberg, "Family Tasks and Reactions in the Crisis of Death." Social Casework 54 (July 1973): 401.

able to support them with their own worries. The adult child who has not yet mourned these losses may be resentful of the parent's need for help or support, or may need to deny the losses.

Blenkner refers to a similar process of adult children resolving the losses of their parents when she proposes the developmental stage of "filial maturity". The filial maturity stage would occur when the adult child is in his forties or fifties and finds he can no longer look to his parents for as much support as he did previously. He becomes the one who is increasingly asked to support. The task of filial maturity would be that of seeing parents as individuals with their own rights, needs and limitations, and of viewing oneself as being depended upon by them. Thus, a slight modification of the identities of both parent and child would occur. Blenkner notes the role of the professional in helping his middle-aged client to complete this task, which will achieve the dual purposes of aiding the individual to help his parent adjust to the changes of aging and to face his own task of growing old with more equanimity.[1] Thus, one aim of including adult children in therapy would be to enable them to successfully grieve their parents' losses and to form modified images and expectations of their parents. The additional function of preparing for one's own old age

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[1]Blenkner, "Social Work and Family Relationships in Later Life," pp. 57-58.

would be served as well.

Once children have been able to express grief at the losses of their parents, the social worker can use them as supports to complement or replace the supportive function of the worker. The supportive role of family and friends in helping the individual to deal with loss has already been noted.[1] Cath states that family and spouse can replenish the libidinal energy of the individual who has been depleted by multiple losses.[2] The social worker would need to be familiar with the relationship between parent and child in order to assess the extent to which to involve adult children in helping aged parents. Wasser similarly notes the importance of understanding the older person's family ties in order to plan therapy effectively.[3] When the child is emotionally independent of his parent and has achieved the stage of filial maturity, he could probably support the parent adequately. In other cases, where the parent-child relationship is characterized by conflict and guilt, the role of the social worker would be that of enabling the child to help his parent, while limiting the extent of this help. For example, such an adult child might, because of

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[1] Supra, pp. 137-139.

[2] Cath, "Dynamics of Middle and Later Years," p. 181.

[3] Edna Wasser, "Family Casework Focus and the Older Person." Social Casework 47 (July 1966): 425.

guilt feelings, wish to have his parent move into his home, which would ultimately result in further conflict and resentment. The social worker would seek a compromise solution, allowing both the child and parent to achieve some need gratification. The current life situations and responsibilities of adult children would also have to be considered when integrating them into the supportive function of therapy. For example, those children who are in a period of stress or who have multiple responsibilities would be less able to provide support.

A final role of the social worker in relation to children would be that of interpreting the aged parent's responses to loss, such as increased dependency, apathy or depression and of offering suggestions as to how the aged individual can best be helped. Information about available services and resources would also be provided.

Group therapy could also be used effectively to either accompany or replace individual or family therapy. This type of intervention would seem particularly helpful for those individuals with few social relationships. Butler and Lewis, and Shere refer to the successful use of groups for purposes of socializing and emotional catharsis. Shere notes the initial reluctance of most individuals to commit themselves to group participation, indicating that

an initial period of individual therapy might be helpful.[1]

Social worker's role on the health team

The researcher speculates that the social worker could be particularly helpful to the aged person through his role on the health team. Hospitalization can have many negative emotional connotations for the individual. Hospitalization may have occurred in a crisis period, when the individual is no longer able to function within the context of multiple losses and is "depleted" emotionally. It may represent the end of the road to the individual, resulting in depression and despair. Hospitalization may threaten previous defensive denial of aging changes. For the individual already upset by the illness or losses necessitating hospitalization, removal from the familiar surroundings of his home and from established routines may result in further decreases in physical or mental health.

It is vital that medical staff recognize these dynamics and be aware of their relevance to the patient's attitude to treatment. As the individuals with whom the aged patient interacts throughout the day, the attitudes of staff can have a decisively beneficial or detrimental effect on the individual's progress. For example, if staff is unaware of

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[1]Butler and Lewis, Aging and Mental Health, p. 237; Eugenia S. Shere, "Group Therapy with the Very Old," in New Thoughts on Old Age, ed. Robert Kastenbaum (New York: Springer Publishing Co., 1964), p. 159.

the social situation of the older person and of the dynamics of loss and grief, they may become irritated and impatient with the older person's apathy and depression, rather than endeavor to appropriately support and encourage the individual through this period. It thus becomes particularly important that the health care of the elderly include a careful balancing of psychotherapeutic techniques and regular medical attention.[1] The negative attitudes of staff may result in failure to implement this type of integrated treatment approach or to understand the patient's response to illness and hospitalization. In such circumstances, the patient's progress is likely to be poor, further confirming the pessimistic expectations of staff.

These negative attitudes of staff could be related to several factors. Hinton notes the tendency of the living to withdraw from the dying.[2] Similar responses of emotional or social withdrawal could occur in relation to the aged patient. For example, staff sometimes infantilize the older person, calling him by his first name and speaking to him in a condescending manner. These reactions may represent the anxieties of staff in facing their own old age or death. Negative attitudes might also be a result of ignorance or

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[1]Verwoerdt, "Psychiatric Aspects of Aging," p. 139.

[2]John Hinton, Dying (Baltimore, Maryland: Penguin Books, 1967), p. 86.

misinformation based on cultural stereotypes.

The researcher concludes that, for these reasons, an active teaching and interpretive role is necessary for the social worker in relation to the medical team. Health workers should be made aware of the particular importance of psychosocial factors to both the physical and mental illnesses of the elderly. Stereotypes, such as those of the neglected aged parent or the aged person with no sexual needs or desires, should be clarified. Interpretation to staff of the patient's former pattern of functioning and of available social supports would help them to become interested in the patient as a person and to adequately support and encourage him. Explanation of pertinent aspects of grief theory would facilitate the staff's understanding of the older person's behavior on the ward and of his reaction to illness and hospitalization. It is important that attitudes and feelings of anxiety or anger by staff be acknowledged and worked through. As in relation to the social worker's role with adult children, these interventions with the medical team would help them deal better not only with the patient, but with their own old age or that of their parents.

These social work functions of teaching, interpretation and working through of feelings could be performed in various ways, such as in informal conversations on the ward and at team meetings. Butler and Lewis refer to the effective use of staff groups to modify attitudes to old age,

illness and death among staff.[1] Social workers could become more actively involved in teaching presentations to medical staff, focussing on psychosocial aspects of illness and on heightening awareness of existing gaps in community services.

Education, Policy and Programming, and Research

Various needs exist in education, policy and programming, and research in relation to the aged. These have been briefly outlined in the following section.

There is a need for more extensive social work education on aging, focussing on factual information and on attitudes. Field refers to the need for more social work courses on the aged.[2] Social work curriculi usually cover the life cycle, from problems of childhood and adolescence through to those of adulthood and the married years. Often, however, the later years are given little attention. This deficiency is particularly harmful, given the increasing proportion of elderly in the population.

Factual information is one aspect that should be included in such courses. For example, social workers should be familiarized with the organic process and with the developmental tasks and stresses of aging.[3] The relevance of

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[1]Butler and Lewis, Aging and Mental Health, p. 237.

[2]Field, Aged, Family and Community, p. 186.

[3]Morris, "Aging and the Field of Social Work," p. 54.

theories of grief and loss to planning therapy should be considered. Attitudes to the aged should also be discussed. Butler and Lewis remark that professionals such as psychiatrists and social workers see few aged and that, when they do, it is often for purposes of diagnosis and "disposition." He notes the need for both indepth and supportive psychotherapy with the older.[1] Kastenbaum refers to the "reluctant therapist", attributing this phenomenon to three sets of attitudes. The practitioner may feel work with the old is low in status, because of the low status attributed to both the aged individual and to supportive therapy. He notes that both assumptions are false. The old are not low in status, except as valued by cultural stereotypes, while supportive therapy can demand great therapeutic skill. Further, supportive therapy is not the only mode of therapy which can be used with the old. The therapist's anxieties about his own aging and death can also cause reluctance to involve himself in therapy with an aged person. Thirdly, the market orientation, in which it is not considered worth the effort to invest time and energy in an individual who has few years left to live, may adversely affect the therapist's willingness to involve himself.[2] It would appear

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[1]Butler and Lewis, Aging and Mental Health, p. 231.

[2]Robert Kastenbaum, ed., "The Reluctant Therapist," in New Thoughts on Old Age (New York: Springer Publishing Co., 1964), pp. 140-143.

that such issues should be discussed thoroughly in the social work student's educational training. This dual focus on provision of information and on clarification of existing attitudes, would have the beneficial results of preparing workers to deal better with their aged clients, unrestricted by cultural stereotypes.

Another area of particular need is that of social work policy and planning. Morris refers to the fact that specialized institutions have developed on an "ad hoc" basis to deal with needs as they arose.[1] As a result, there are presently few preventive services available for the aged, while there is an overuse of institutions with their frequent negative effects on the aged individual.[2] The researcher speculates that this overuse of institutions is illustrative of society's need to deny the eventuality of old age and death by keeping the old "out of sight and out of mind." Morris notes the responsibility of social workers to reshape programs for the aged.[3] Such improved programs would appear to have certain characteristics.

One essential feature of services would be that of variety. The old, like every other population group, are a

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[1]Morris, "Aging and the Field of Social Work," p. 20.

[2]Isabel Banay, "Social Services for the Aged: A Reconsideration," in New Thoughts on Old Age, ed. Robert Kastenbaum (New York: Springer Publishing Co., 1964), p. 206.

[3]Morris, "Aging and the Field of Social Work," p. 27.

heterogeneous population with differing backgrounds, interests and needs. Program planning must take this variability into account. The present, mainly institutional approach implicitly assumes that most aged are incapacitated. Morris notes that existing community programs involve only a small minority of the aged and that a variety of programs are necessary to appeal to different groups and to larger numbers of the aged.[1] Maddox similarly states that the heterogeneity of the aged population mitigates against a "single, simple, sovereign solution" to the problems of the elderly.[2] Verwoerdt comments on the need for comprehensive services to deal with physical, psychological, interpersonal, cultural, economic and environmental factors.[3]

Analysis of aging in the framework of grief theory indicated that many of the losses which frequently accompany aging are not inevitable. Some may be prevented, while others can be compensated for. Thus, the main purposes of services would be those of prevention of some losses and of minimization of the effects of others. Some preventive services have already been discussed.[4] In relation to the

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[1] Ibid., pp. 32-33.

[2] Maddox, "Growing Old: Getting Beyond the Stereotypes," p. 13.

[3] Verwoerdt, "Psychiatric Aspects of Aging," p. 139.

[4] Supra, pp. 155-159.

prevention of physical losses, Verwoerdt suggests the establishment of well-aging clinics. Preventive mental health services could also serve a useful function. For example, preretirement counselling, help to families caring for disabled or emotionally disturbed old, and intervention in acute situational problems, such as death of spouse, would help to prevent one loss from multiplying into others.[1] Other services could be organized to reduce the effects of those losses already suffered and to help the individual compensate for them. Shanas, Verwoerdt, Morris and others comment on the importance of increasing and diversifying the number of services to the aged, which would accomplish this goal. They note the need for community nursing and health care for the bedfast and housebound elderly, home help services, visiting services, day care centres and increased income.[2] Such services would enable more individuals to remain in the community by lessening both the number of and effects of losses. For example, the loss of spouse might not be so devastating in effect to the individual who is able to spend his days at a day centre or who is visited by a friendly volunteer.

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[1]Verwoerdt, "Psychiatric Aspects of Aging," pp. 141, 144.

[2]Shanas et al., Old People in Three Industrial Societies," p. 437; Verwoerdt, "Psychiatric Aspects of Aging," pp. 142-143; Morris, "Aging and the Field of Social Work," pp. 36-39.

These types of services would be valuable for both those individuals with and without family ties. For the individual without family, services would function as supports in the grieving process. The limited ability of family to help in times of crisis has already been noted.[1] For the individual with family, provision of services would lessen the burden on family to support the aged relative, thereby reducing feelings of resentment or guilt.

Another problem noted in the analysis of aging was that of lack of alternatives or possibilities to enable the individual to complete the last stage of grief. Diversified programs could provide the basis for a new identity or alternative sources of gratification. Garfunkel and Grunebaum refer to the provision of education programs for the elderly by the staff of homes for the aged, family agencies or community centres. They found that these programs were particularly interesting to those previously involved in intellectual pursuits.[2] Silverman refers to "Widow-to-Widow" programs in which one widow helps a newly bereaved widow, providing support and serving as a role

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[1] Supra, p. 145.

[2] Florence R. Garfunkel and Gabriele H. Grunebaum, "A New Use of Education in Programing for the Aged." Journal of Jewish Communal Service 45 (1968): 110.

model.[1] Cowen refers to the use of the older as foster grandparents or mental health aides.[2] Each of these programs would appeal to differing individuals, serving as alternative sources of identity and need gratification, helping the older individual to resolve his grief. Many additional possibilities exist. For example, the aged could be involved in various programs, such as meals-on-wheels, day centres, visiting services and citizen's action groups, in the varied capacities of administration, coordination, planning or as volunteers, depending on the individuals' needs, interests and capabilities. Thus, the aged could be involved, not only as consumers, but as providers of services. Such involvement would have the additional gain of increasing self-esteem.

Essential to the success of these services would be accessibility. Physical or economic limitations often inhibit use of public transportation by the elderly. Thus, services should either reach out into the home or transportation to the service should be provided. Morris also comments on the need for accessibility of services.[3]

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[1]Phyllis R. Silverman, "Widowhood and Preventive Intervention." The Family Coordinator 21 (January 1972): 95.

[2]Emory L. Cowen, Ellen Leibowitz and Gerald Leibowitz, "Utilization of Retired People as Mental Health Aides with Children." American Journal of Orthopsychiatry 38 (October 1968): 907.

[3]Morris, "Aging and the Field of Social Work," p. 48.

Accessibility need not be achieved by each agency or institution having its own bussing service. A preferable approach would be that of modifying structural aspects of existing public transportation so that it is physically accessible, and of reducing rates for senior citizens or providing them with a more adequate income so they can afford to pay existing rates.

The researcher speculates that many of the services discussed do not necessarily have to be oriented exclusively to the old. Many programs are relevant to all age groups. For example, preventive mental and physical health services, community health care and home help programs, visiting services, adult education programs, and foster grandparent programs are pertinent to some adults of any age. Another reason for the undesirability of focus on a particular client age group is that it might perpetuate existing cultural stereotypes and fears of aging. Age heterogeneity in many community programs might help dissipate the anxiety associated with aging through face-to-face interaction with the aged.

The benefits of this age heterogeneity would apply to social work as well. For example, family agencies could incorporate aged persons into the general caseload, helping to modify social workers' reluctance to work with the old. Wasser discusses the problem of caseload specialization, concluding that the best combination is an integrated

caseload for most workers, with a few workers specializing in practice with the aged, in order to further develop practice expertise and theory.[1] The researcher suggests that these workers could function as resource persons, both in the agency itself and in the community, coordinating seminars or in-service training and providing case consultation.

The final point relevant to planning and policy is the importance of flexibility. Because of the rapid rate of social change, the problems of the elderly may shift in focus with time and social workers should remain alert to the need to reorient services. For example, it has been speculated that today's generation of older men may have particular difficulty in adjusting to the later years. However, the researcher has hypothesized that this may not be true for future generations.[2]

The past years have seen a dramatic increase in research on the later part of the life cycle. Further studies on the individual's response to the losses and changes of aging and on his process of adaptation to these losses is necessary. Focus on those individuals who have successfully adjusted to their old age would be particularly valuable, since present research tends to focus on pathological modes of response.

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[1]Wasser, "Family Casework Focus and the Older Person," p. 429.

[2]Supra, pp. 151-152.

Summary

Thus, conclusions derived from an analysis of aging within the framework of grief theory have numerous implications for the profession of social work. Preventive interventions have been presented, serving the role of dealing with anticipatory grief. Social workers can also be helpful at the time of, and following, the losses of aging by helping the individual and his family to complete griefwork. The role of the social worker on the health team has been emphasized. Programs incorporating features of diversity, prevention, support and accessibility have been outlined. The need for more courses on social work with the aging and for further research on aging was noted.

CHAPTER VI

SUMMARY

Demographic changes in the last seventy-five years have resulted in the increase of those over sixty-five in both numbers and in the proportion of the total population which they constitute. Numerous problems in areas such as financial security, health care and use of leisure time have arisen consequently. Although much research has been conducted in recent years on various aspects of aging, existing knowledge is not integrated into one theory of aging. It was speculated that the development of such a comprehensive framework of viewing aging, integrating the diverse research findings and theories of aging, would facilitate understanding of the aging process and the diversity of individuals' reactions to it, thereby facilitating improved professional practice, planning of service delivery, and formulation of future areas of research.

Since loss is often noted as central to the various lifespaces of aging, grief theory, which explains the individual's response to loss, was speculated to be a helpful conceptual framework within which to study aging. As a result, a review of the literature was used to study the

nature and extent of losses in the life-spaces of health, work and social relationships and the individual's response to these losses, in order to ascertain if the reaction to the aging process is in fact similar to that of a grief reaction. The principal findings were that the individual appears to respond to the various losses of aging according to the stages of a grief reaction -- denial, anger, depression and new identity formation. Denial was most evident in response to health losses. The direct expression of anger was noticeably lacking. Depression, high in incidence among the aged population as compared to other age groups, seemed to often be reactive to losses suffered. Many individuals appear to have problems in completing the last stage of a grief reaction -- formation of a new identity, because of lack of socially valued alternatives on which to base their new or revised self-identities.

Various social work interactions were formulated on the basis of these findings. Therapy with the aged would focus on facilitating progress through the four stages of grief, focussing particularly on helping the individual express anger in a direct and functional manner, such as through participation in citizens' groups. The need for professional intervention to modify prejudicial or negative social attitudes and consequently increase alternative sources of identity for the aged, was noted. The need for improved educational preparation for social work with the

aged and for research on the modes of response to aging, particularly those which are nonpathological, was noted.

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