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Social Changes, Economic Status, and the Problems of Aging

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SOCIAL CHANGES, ECONOMIC STATUS, AND THE PROBLEMS OF AGING

Introduction

The social environment is recognized as one of the three sources that promote or damage the health of the individual. The other two sources are the inherent biological makeup of the individual and the physical environment. Social deprivation in infancy and childhood and social-overload stress in adolescence and adulthood are believed to play a significant role in the etiology of a number of mental disorders. Both types of stress are present in late life and compound the problems of maintaining mental health. Attitudes of social origin underlie many criteria utilized to determine the existence and influence the diagnosis of mental disease. Social relations are important in the treatment of many mental disorders, as sustained improvement cannot be assured unless the adverse social circumstances to which the patient must return are altered. Although our understanding of this complex matter of the relationship between social forces and events and health is far from satisfactory, considerably more is known than is usually acknowledged. Social class with the pathological consequences of social deprivation and hostile social influences upon the infant and the developing child and adolescent have been reported by a number of investigators. Investigation of adults indicates a relationship between lower social class and

a higher incidence of disease. The possibility that this is an apparent rather than a real correlation has been considered. Possible explanations that have been suggested include differences in community tolerance, class influences on psychiatric diagnosis, and downward social mobility as a manifestation of mental disease, particularly of biologic etiology. Although it is likely and possible that these explanations have some validity, the additional overload stresses and deprivations encountered in lower classes do appear to be a major contributor to mental disorders.

Definitions

The term "social" in its broadest usage and as applied to human beings "refers to any behavior or attitude that is influenced by past or present experience of the behavior of other people (direct or indirect) or that is oriented (consciously or unconsciously) toward other people. Normally the term is morally neutral." In this chapter dealing with social dimensions in geropsychiatry, it will be necessary not only to look at those social patterns or structures that may be neutral but to try to identify those which promote (mental) health and those that contribute to psychiatric disorders and physical illness.

The field of economics is considered to be an independent area of study and is represented by a specific discipline. However, definitions of economics

range from extremely broad to very narrow. All of the definitions do contain evidence that economic structure and process cannot, in Western society, be separated from social dimensions. One definition says “economics is a study of mankind in the ordinary business of life: it examines that part of individual and social action which is most closely connected with the attainment and with the use of the material requisites of wellbeing.” It is clear that the economic condition and economic structure of Western democratic society are key elements in influencing social factors or dimensions that are of major importance to physical and mental health.

Persons 65 years of age and over are commonly referred to as the older population. Brotman recently identified the special characteristics of those 75 years of age and over, referring to these people as “the aged.” This subdividing of the older population is of considerable value, as the important health and socioeconomic facts common to a specific group can be lost in the mass of the older population.

“Social gerontology” was first introduced into the literature in 1954 by Clark Tibbitts. Tibbitts defined social gerontology as “a part of the broader field of gerontology which is concerned with biological and physiological aging in all animal and plant species and with the psychological and social cultural aspects of aging in man and society. Social gerontology separates out: (1) the phenomena of aging which are related to man as a member of the

social group and of society, and (2) those phenomena which are related to aging in the nature and function of the social system of society itself." Unfortunately, for many individuals this term has been broadened and now includes those occupations which are concerned with delivery of services to elderly people. Hence, when one hears the term social gerontology applied to training fields, it may not be related to the training of persons concerned with the study of the societal aspects of aging, but to the training of various service occupations.

Sociological Theories[1]

Social scientists are usually concerned with the social role or place (status) of the aged in society. Aging to a social scientist may not only be a decline in social usefulness but may also be related to a change in social and often economic status. Social theories relevant to the aging and the elderly are affected by the structure of society and social change. One such theory—the rapid-change theory—holds that the status of the aged is high in static societies and tends to decline with rapid social change. Another theory is that the status of the aged is high in societies where there are few elderly and that the value and status of the aged decline as they become more numerous. A third theory is that the status and the prestige of the aged are high in those societies in which older people, in spite of physical infirmity, are able to continue to perform useful and socially valued functions. This third theory

has a particularly pessimistic quality when applied to Western society, as early retirement plus rapid social change is and will make it increasingly difficult for the elderly person to be involved in socially valued functions, unless provision for their continued participation is rapidly developed. Two recently advanced social theories are called the disengagement theory and the activity theory. The disengagement theory maintains that high satisfaction in old age is usually present in those individuals who accept the inevitability of reduction in social and personal interactions. The activity theory holds that the maintenance of activity is important to most individuals as a basis for obtaining and maintaining satisfaction, self-esteem, and health. Elaborations and modifications on these theories appear in this resume.

The Elderly—A Minority Group

Social and behavioral scientists define minority groups in a number of ways. It is possible to identify a minority group as a collection of individuals that can be identified by specific characteristics and do not as individuals or a group either voluntarily or by prohibition of the majority participate in all the life experiences of the majority. Furthermore, minority groups do not share all life experiences equally, nor do they have the same responsibilities for or expectancies of certain life experiences. Some minority groups can be in an advantageous position, such as nobility, while others can be in a very deprived relationship to the rest of society. There are some minority groups

that elect to bypass opportunities or to reject responsibilities offered by the majority in order to maintain their own value systems. Minority groups can exist in a relatively contented fashion when the advantages offered them by their own group satisfactorily meet their needs; or, if they so elect, when the opportunities of the majority are also open to them. If one accepts the views that have been expressed, then it is evident that the elderly—particularly the retired elderly person—is a member of a deprived minority group. Much of the data presented in this chapter confirms this unsatisfactory social condition.

Population Changes and Social Problems

Life Expectancy

Life expectancy is a computed projection rather than an observed or estimated phenomenon. The projection is based upon the assumption that the death rate experienced in a single year or the average of experience in a few years will remain completely unchanged in the future. Obviously, any event that influences future death rates, whether it be natural or man-made, automatically affects the accuracy implied in the prognosis of the computed life expectancy. Since the computed life expectancy cannot foresee negative events, it also cannot include positive changes. No assumed positive changes are included, e.g., changes in medical knowledge and care, sanitation and

nutrition, reduced mortality in traffic accidents and wars. Longevity is the condition or quality of being long-lived. Longevity is influenced by a complex of interacting factors, including genetic makeup, environmental and nutritional factors, and psychologic, social, and economic influences.

Death Rates

Death rates are the recorded number of deaths occurring in a population for a single calendar year. This type of information is referred to as crude death rate and has very little value when one wants to compare one country with another. The crude death rate reflects the age differences of the population rather than the age-specific death rates. Specific death rates are commonly based upon characteristics such as age, sex, and race and sometimes include marital status, place of residence, income, and other identifiable features. Consequently, they are often referred to as true death rates and are relevant to an understanding of the socioeconomic conditions that are related to life span in a given population.

The recent census concluded by the United States Bureau of the Census has added immeasurably to our understanding of the shifting characteristics of the population and their impact on social issues and planning.

In 1970, 9.9 percent of the population of the United States was age 65 and over. This means that every tenth American is considered to be an older

American. One hundred years ago, in 1870, only 2.9 percent was 65 years and over. Between 1960 and 1970, the total population increased 12.5 percent, while those 65 years and over increased 21.1 percent. This percentage increase of older Americans is even more striking when one recognizes that in the same decade (1960-1970) the rate of increase of "the aged," that is, individuals over seventy-five, was almost three times as great as that of the 65- to 74-year-old group.

From state to state there is considerable variation in the percentage of older citizens. The extremes are Florida with 14.5 percent over 65 and Alaska with 2.3 percent. Hawaii ranks next to Alaska with 5.7 percent of its population in the age 65 and over category.

Of particular importance to our society is the growing predominance of women. Even though there are more boy babies than girl babies born, the longer life expectancy for females results in the gradual shift in percentages, so that after the age of 18 there are 105.5 females per every 100 males in the total population. In the U. S. population 65 years and over, there are 138.5 females per 100 males; and after age 75, it moves to 156.2 females to 100 males.

Switzerland has a great discrepancy of aged male and female. In 1970, the ratio was 100 males to 146 females.

Negroes have a shorter life expectancy, as older Negroes compose only 6.9 percent of the total Negro population. The discrepancy in male-female ratio is also apparent in Negroes, as females 65 years and over accounted for 115 to every 100 males in 1960. In 1970, there were 131 black females to every 100 black older males.

Why Do Women Outlive Men?

In the United States prior to 1900, the average life expectancy favored the male over the female. However, there have been remarkable changes in the status of humans. The pendulum is swinging strongly in favor of women. In many undeveloped countries the unfavorable position in regard to female longevity continues to exist. For example, in India in 1968, the male life expectancy was 41.9 years, while the female expectancy, 40.5 years. In addition to the reduction of maternal mortality, it is claimed that the decline in tuberculosis added substantially to the gain in life expectancy of American females. The question arises as to whether this favorable trend for females is predominantly on a biological basis or whether the socioeconomic environment is the major determinant. The biological explanation is held to be substantiated by the sex differences found in the life span of a number of animals. For those searching for an environmental explanation, one would have to look for groups of men and women with similar social roles and physical environment. A study of male and female Catholics involved in

teaching orders indicated that the female religious order has a higher life expectancy than the male. But even this finding is now open to question, as the male members of the Catholic teaching orders apparently are overweight and smoke heavily. Although it will take a number of years to obtain information, it does appear that the current trend of women to assume social roles similar to that of men will throw light on this situation.

The demographic yearbooks published by the United Nations are extremely helpful when one wishes to compare population differences in various countries throughout the world. Little data is available on the population of a number of countries throughout the world. Information regarding Africa is gradually emerging, and it is possible that with the reentry of China into the affairs of the world, knowledge will become available regarding the needs of the elderly adult in this extremely populous country that, for years, is reported to have had a very positive social attitude toward its older citizens.

Living Arrangements

The majority of elderly people are living in the community. Only one in twenty-five lives in an institution such as a rest home, nursing home, or medical facility. There are, however, some striking differences between the way the men and the women live. Two-thirds of the men live with their

spouses, but only one-third of the women have husbands. Moreover, only one-sixth of the men live alone or with nonrelatives. Less than three-quarters of a million elderly people require some type of institutional care. Consequently, greater emphasis must be given to making certain that the living arrangements for the elderly within the community are conducive to the maintenance of health.

Surveys of older people indicate that they want to live apart from their children but close to at least one of them. Consequently, housing units for the elderly should be conveniently placed so that the old person can have controlled intimacy in terms of frequency and distance. The units should be located so that it is not only possible but relatively easy for old people to see their families often and call upon them for help if and when needed. Unfortunately, a small percentage of older people, probably around 4 percent, have no human contact for as long as a week. This small minority of aged individuals is truly isolated, and although such individuals are few, they are so scattered that they are difficult to find. When found, they are difficult to approach, usually rejecting any offer of assistance.

In a national study of older Americans, 59 percent of those living alone had been visited by an immediate neighbor the previous day, 46 percent by a friend, and 50 percent by relatives, including children.

As indicated above, most older men are married, whereas most older women are widows. There are almost four times as many widows as widowers. It should be noted that about two-fifths of the older married men have wives under 65 years of age. Furthermore, there are at least 35,000 marriages a year in which the groom, the bride, or both are 65 years of age or over. The number of marriages among elderly people has been steadily increasing.

The difference in married and unmarried status for older patients is of significance to the physician, for it has been noted that the hospital admission rates and stays of unmarried exceed those of the married.

There are about 5 million couples with one partner over the age of 65. In this group couples, or 7 percent, have annual incomes of $10,000 or more. Nine hundred and forty thousand couples, that is, 18 percent, have incomes between $5,000 and $10,000. The remainder of such couples, that is, 75 percent, have an annual income of under $5,000, 52 percent under $3,000, and 7 percent under $1000.

Unfortunately, the income distribution of persons age 65 and over who are living alone indicates that the majority are living in poverty. Eighty-nine percent have an annual income of less than $3000, and 62 percent are under $1500. It is evident that men 65 years of age or older not only are likely to

have more money than surviving women but are much more likely to have a spouse. Although a man is less likely to live as long as a woman, the years he spends as an older citizen appear to be better ones than the many years spent in old age by a woman.

The marital status of the aged group reflects the social tradition for men to marry younger women. Twice as many aged men as women are married, and only one-third of them have wives 75 and over. About half have wives between 65 and 74 years of age, and one-fifth have wives under 65 years of age.

Of men 75 years of age or older, 33.9 percent are living with their wives. In contrast, of women 75 years of age and older, only 17.8 percent are living with their husbands. Of these women who are 75 years or older, 3 percent have husbands under 65 years of age; roughly 20 percent have younger husbands between the ages of 65 and 74; and the remainder have husbands their own ages or older. Each year approximately 2000 women age 75 or older marry, and 6000 men 75 years or older go to the altar. Both of these groups are usually moving out of widowhood. Of these 8000 marriages, over 4,000 involve partners under age 75.

The Productive and Dependent Aged

Cottrell utilizes a technologic theory base for studying changes in

society. He utilizes levels of actual physical energy that flow through the society as a basis for changes in social structure and patterns. He refers to low-energy societies and high-energy societies. Cottrell is providing a measure for differentiation between undeveloped, that is, the low-energy societies, and highly developed nations, the high-energy societies. The high-energy societies depart more from natural energy—an agrarian society—and depend upon man-created energy through the use of technology. This change in energy also alters work patterns so that an increasing number of any population is not required to work, but is dependent on those who by working monitor the increasing energy that has been harnessed by that society. This, then, differentiates the population into the "productive" and "dependent" people. Hence, dependency ratios have appeared. However, dependency ratios clearly are not totally related to the level of energy utilized by the group but also relate to mortality and fertility. Dependency ratios are usually calculated for the part of the population under twenty and over sixty-five as opposed to the productive population that is considered to be between the ages of twenty and sixty-four. The dependency-ratio refinement is actually an outgrowth of the so-called index of aging that is based upon the population sixty years and over and under 15 years, as contrasted with the population between fifteen and sixty. Utilizing the index of aging, Mexico as of 1964 has an index of aging of 12.5 as contrasted to the United States with an index of aging of 41.2. Clearly, this does indicate that the United States has a

much higher portion of its population who are relatively nonproductive and who are dependent upon those remaining in the labor force.

Psychoneurotic Reactions to Social Stress

The impression is often conveyed that psychoneurotic reactions in adults are chronic disorders that are sometimes fortuitously alleviated but usually require psychotherapeutic intervention. Longitudinal studies suggest that there are older individuals who, after a period of time, develop psychoneurotic reactions in response to an unfavorable environment. Furthermore, recovery is quite possible if the individual is removed from the stressful life situation or is provided the means of restoring self-esteem.[2] Two psychoneurotic reactions, depression and hypochondriasis, are frequently found in elderly persons. The possibility of a transient psychoneurotic reaction appears to be especially true of hypochondriasis and mild-to-moderate depressions. Careful evaluations conducted over more than ten years strongly support the view that the signs and symptoms of a psychoneurosis are unconsciously selected by the person so that he can maintain his self-esteem in a particular situation. If the sign or symptom is not an adequate defense in that particular situation, he will abandon that defense mechanism for one that is appropriate to the particular circumstances in which he is living. Hence, some psychoneurotic signs and symptoms “come and go” over a period of time. The exacerbations and

remissions are largely determined by an identifiable constellation of socioeconomic conditions. Therefore, in some individuals the hypochondriacal pattern dominates, while in others the depressive attitude is the major factor. In general, the hypochondriacal elderly person is more likely to be a female of low socioeconomic status with little change in her work role, relatively younger and less socially active, with patterns of activities suggesting that they are not conducive to a good adjustment. More specifically, the person is forced into a situation, hopefully temporary, where criticism is the rule and appreciation and work satisfaction are absent. This is compounded by the restricted social activity, so that rewards are few and far between.

It should be mentioned that, in contrast, there are elderly people who utilize a neurotic mechanism of denial; that is, they fail to realistically deal with important physical diseases. This type of person, a persistent optimist, should not automatically be seen as a person with courage, for the courageous person does have a realistic appraisal of the situation. The type of older person who is likely to utilize denial is a male of fairly high economic status who is not burdened with financial responsibility and a demanding work role yet has many and suitable opportunities for social activity.

Economic Influences

Poverty Level in the Aged

According to a working paper prepared for the Special Committee on Aging of the United States Senate and published in 1971, there has been an increase in both the number and proportion of aged poor between 1968 and 1969. In 1969, there were approximately 4.8 million people aged 65 and older who were living in poverty; almost 200,000 more than in 1968. The older poor in 1969 represented 19.7 percent of all persons 65 and older. This was a rise from 8.2 percent found for 1968. Brotman, in another recent report, indicated that only 15 percent of the total poor in 1959 represented the aged population. Brotman also points out that older citizens in 1969 made up approximately 10 percent of the total population, but contributed 20 percent of the poor. Within the older population, every fourth person is poor. Two-thirds of the aged poor in 1969 were women; 85 percent of the aged poor are white. The poverty level for a person of sixty-five or over, living alone or with nonrelatives in 1969, averaged $1749 and ranged from $1487 for a woman in a farm area to $1773 for a man in a nonfarm area. The poverty level for a couple, with the head age 65 or over, averaged $2194 in 1969, with a range from $1,861 to $2,217.

A report concerned with the situation of aged blacks states that 50 percent of all Negroes 65 years of age or more live in poverty compared to 23 percent of whites. Approximately 47 percent of aged Negro women and 20

percent of elderly Negro men have annual incomes below one thousand dollars. Another 42 percent of Negro women and 37 percent of Negro men have incomes from $1000 to $1999. The Negro living in a rural area is much harder hit, as two out of every three rural blacks are living in extreme poverty.

The poverty status of older people is not only complicated by the lack of opportunity for employment but by the threat of social-security-benefit reductions if work income exceeds $2520 a year. The elderly person is unlikely to want to accept part-time work in view of this threat, and the employer is reluctant to adjust procedures to accommodate older persons working fewer than forty hours a week.

Standard of Living and Adequacy of Income

No psychiatrist or behavioral scientist would dispute the fact that the social and physical environment in which an individual lives plays a significant role in determining his health and life expectancy. Furthermore, if his health is to improve, the opportunity for upgrading the environment must exist and money is often necessary for an individual to upgrade his standard of living. Unfortunately, although we are willing to accept the fact that we should provide people with an acceptable standard of living, it is most difficult to devise a method of measuring and expressing what constitutes an

acceptable standard of living. In this search it has become apparent that certain social patterns that are adverse to health cannot be altered by merely providing money or opportunities for change. This has led, more and more, to oversimplification of an acceptable standard of living by expressing it in terms of an "adequate income."

The difficulties of definition continue when one realizes that the lowest standard of living is expressed by the concept of poverty. Poverty, in turn, is a relative status and cannot be tied solely to income, as income in one area of the United States may be adequate, but in another it would be too little to exist on. This realization has resulted in a gradual refinement of the methodology utilized to designate a poverty level.

One of the first attempts to establish poverty levels was made by the Council on Economic Advisers in January 1964 in their *Economic Report of the President.* This council arbitrarily chose a $3000-per-year family income as the dividing line and analyzed the data on incomes in 1959 as presented in the 1960 census reports. This led quickly to the recognition that this system was inadequate since it did not give consideration to age, size, and composition of the family unit, and its geographic location. Consequently, by 1964 the Department of Agriculture had started to define poverty on the basis of a food budget. Utilizing detailed data collected by it concerning the relationship between expenditures for food and total expenditures for

various types of families at low-income levels, the dollar cost of the economic food budgets was multiplied by the appropriate factors to provide an estimate of the total cost for the family unit. These determinations resulted in poverty levels being established for 1964.

Refinements have continued, and by 1968 two major revisions were introduced, in addition to the base determinants of 1964. The first major revision was the use of the percentage change in the total consumer price index over the year for the annual change in the poverty levels rather than change in food prices alone. The second was the computation of farm area poverty levels as 15 percent below the levels for nonfarm areas, rather than the 30 percent differential previously used. It is therefore apparent that it is very difficult for any relatively uninformed individual to appreciate the significance of poverty reports and to know whether the existence of a guaranteed annual income that cannot possibly keep up with inflation will actually substantially alter anything other than the definition of a poverty level.

Using the revised poverty levels, the data regarding poverty has been computed for all years from 1959 to 1969.

Prediction of Longevity

Longitudinal studies of elderly men and women have reinforced the

conviction that health and longevity are strongly influenced by the complex interaction of inherent physiological changes and life experiences. Actuarial life expectancy at birth is less than the predicted years of remaining life for those who have achieved advanced age. As birthdays pass, life expectancy lengthens. Therefore, it is important to look at people who have reached a specific age, say sixty-five, and find out why some of these individuals will achieve an age that considerably exceeds the predicted longevity. Multidisciplinary studies of such individuals have given us some important clues as to the relative importance of physical, mental, and social factors in predicting longevity for various age, sex, and race categories. Once a person has reached old age, the theory that longevity runs in families is not sustained. The age at death of the father and the mother showed no correlation with either the longevity index or the longevity quotient as devised by Palmore.

According to Palmore, the six strongest independent variables that affect longevity in late life are: (1) work satisfaction; (2) happiness rating; (3) physical functioning; (4) tobacco use; (5) performance intelligence quotient; and (6) leisure activities.

The work satisfaction score represents a person's reaction to his general usefulness and his ability to perform a meaningful social role. The overall happiness rating is unquestionably influenced by work satisfaction,

but reflects a person's general satisfaction with his life situation. The physical function rating is determined by the examining physician, and although it is the third most important factor, it does appear that satisfaction and happiness can compensate for and overcome some physical disability. The use of tobacco is a negative predictor, and it is recognized that it is a complex habit that apparently adversely affects physical functioning yet must play a role in providing some sort of satisfaction to the users. The use of tobacco among the elderly people does show differences between certain age, sex, and racial groups. Tobacco use is a particularly strong negative predictor of longevity among the younger white men and among Negroes. It is probable that both of these groups use a greater amount of tobacco. Palmore concludes that these findings suggest that, in general, the most important ways to increase longevity, once you have moved into the latter part of your life span, are to: (1) maintain a useful and satisfying role in society; (2) maintain a positive view of life; (3) maintain good physical functioning; and (4) avoid smoking.

Lowenthal is concerned with the ambiguities of social stress, particularly the range of responses to what appeared to be stressful events that can be found in elderly people. She points out that certain social events usually considered stressful, such as residential moves or retirement, often produce conflicting results. With respect to these changes she believes that it is necessary to take into account the voluntary or involuntary nature of the

event. Furthermore, the characteristic social life style of the individual, that-is, how he or she copes with life, is essential to the type of response to stress and whether or not such a response contributes to mental illness. For example, Lowenthal believes that lifelong isolation is not associated with poor adaptation in late life and does not increase the likelihood of developing a mental illness or more accurately be requiring treatment for mental illness. In contrast, lifelong marginal social relationships are associated with poor adaptation, including serious mental illness. However, both patterns are associated with a history of parental deprivation in childhood. One style represents a relatively successful protective pattern, while the other produces excessive strain. These lifelong, marginally socially adjusted individuals constitute a population at serious risk in later life. Lowenthal also contends that some challenging work remains to be done in regard to stressful events that produce negative or decremental results as opposed to those which are neutral, that is, do not seem to alter the individual, or positive ones, those which are actually conducive to a better life adjustment. No doubt there is some validity for this concern. It is evident that individuals can only learn when they are required to adapt to a new stress or demand, but they can be overwhelmed when they lack the capacity to develop coping mechanisms. Lowenthal is also concerned with the issue of physical health status as a stressor or as the result of stress. Obviously, illness can be both, and both features can be present simultaneously in the same individual.

It is of importance to note that when Palmore is using predictors of longevity, he is dealing with many types of variables. For example, the work satisfaction and happiness ratings are types of social adaptation; the use of tobacco, a psychological, physical dimension; and the physical functioning scale, an estimate of health determined by an examining physician. However, his work does suggest that methods of psychosocial adaptation may be more important to longevity than physical habits and physical health.

Social Position and Retirement

Social Position and Longevity

The disagreement between President Nixon and Congress regarding appointments to the Supreme Court rekindled interest in the apparent longevity of Supreme Court justices, their effectiveness as members of the Supreme Court, and the fact that all federal judges "shall hold their offices during good behavior."

There is little doubt that Supreme Court justices are unusually long-lived men. Since the turn of the century the average age at appointment has been 54.3 years. Chief justices have been appointed at an average age of 57.5 years. Supreme Court justices have remained in office for much longer periods than any other government officials. Exactly half, or forty-eight, of the

justices died while on the bench. Twenty-two retired; fourteen resigned; and three became disabled. It would appear that this social role of fulfilling the heavy responsibility of a Supreme Court justice does not actually interfere with longevity. In fact, it obviously encourages it. Lawyers in the United States appear to have only a small advantage over white men in the general population. Furthermore, Supreme Court justices have a considerably better prospect of long lives than do Congressmen and cabinet officers. Since many are drawn from the same pool of professional training and experience, one cannot help but wonder if the position of a justice of the Supreme Court does not in itself make a major contribution to longevity. It would, in this writer's opinion, appear that the prolongation of a useful social role, the continuation of prestige, plus financial security are all major factors in this selective longevity.

Compulsory Retirement

On June 22, 1971, Congressman William Frenzel introduced in the House of Representatives a joint resolution proposing an amendment to the Constitution to provide an age limit and a single six-year term for the president of the United States. The resolution states that "no person who has attained the age of 70 years shall be eligible for election to the office of the President or Vice President." Earlier, on June 14, two senators (C. E. Miller and William Brock) introduced into the Senate Joint Resolution 113, which

proposes a constitutional amendment to establish a mandatory age retirement of 72 for senators, representatives, and federal judges. Senator Miller presented to the Senate the following arguments in support of the measure:

> Modern day private industry has set the pace when it comes to retirement. The great majority of industrial organizations make retirement mandatory generally at age 65. The reason is that greater efficiency means better profits. Why should not the government adapt a similar policy, recognizing that the greater efficiency means better service for the people? Of course, a balance should be struck between efficiency and experience, both of which are needed for the best results. But a balance does not now prevail.
>
> The traditional argument against a mandatory retirement age for members of Congress is that if the electorate of a state or congressional district wishes to elect an older person, that is their right. Of course, such an argument has little relevance to federal judges. But there is an answer to the argument as far as members of Congress are concerned; namely, that the right of the electorate within a state or congressional district should not take precedence over the general welfare of the nation, which depends in a considerable degree on the efficiency of Congress, [p. 2.]

As of June 1971, there are fifteen congressmen and fourteen senators who are age seventy or over. These individuals would be permitted to complete the term for which they are elected. If over seventy-two, at the end of that term, they could not run for reelection.

It is interesting to note that in his arguments Senator Miller states that there should be a balance between efficiency and experience, but implies that experience does not contribute to efficiency. It is clear to any careful observer

that experience is an important component of efficiency, particularly when it relates to including all of the factors in a complex decision process. If the senator means by efficiency speed of response or the energy to work for long periods of time, then these components are indeed important in evaluating final results. No rationale is given for selecting 70 as a turning point for the office of president or vice president nor why it is 72 for senators, representatives, and federal judges. Perhaps it is a compromise of importance of position and greater assurance of efficiency.

Industry is claimed to be setting a pace for retirement that is clearly related to efficiency. This is questionable as no studies are available that indicate young corporate leaders make more or less mistakes than do presidents of corporations older than age 65.

Some determinants setting age of retirement are more rooted in the social sanctions of competitiveness and of achieving financial success (and reward). Certainly, a man who has become the head or a leader in a large industrial organization has accumulated some wealth by the time he has reached the age of 65. There are many young men and women below him who are striving to achieve a similar kind of security as well as an opportunity to spend less time and energy competing and more of both in other activities. Furthermore, one cannot disregard the basic competitiveness and strivings of younger persons to displace older persons. Competitiveness is common

throughout most of the animal kingdom and is basic to the free-enterprise system devised by the human animal.

Retirement—Process and Impact

Retirement is both an individual problem and a social pattern of modern industrialized nations. It is the result of a complicated set of factors that has emerged primarily in Western industrialized societies. In the less well-developed social systems, retirement is likely to be the consequences of aging, that is, the development of a disability. In a modern society, retirement is determined by the economic status rather than by the capabilities of the individual. Streib and Schneider have attempted to investigate and differentiate the process of retirement and the actual status of the individual in retirement and its impact upon him. These investigators have attempted to combine the activity and disengagement theories, ending up with what they refer to as "differential disengagement" or changes in roles for the aged that result in "activity within disengagement."

The Streib and Schneider longitudinal study is described as being based upon role theory. Role theory may be described as "through a system of mores, or social norms, society requires that a person enact roles in accordance with his position in the social system." Roles may, in turn, be defined by the subgroups to which a person belongs. Persons often must

enact several roles at one time, and it is necessary to integrate these multiple roles and sometimes resolve the conflict between roles. A person may discard a role or define it in ways that are more congenial to him. There is no doubt that retirement does bring about a redefinition of roles, and these investigators have focused upon this particular aspect. Role theory has two major but overlapping components, one called the structural orientation, and one the interactional or social-psychological orientation. The first is a more static identification of the individual and his relationship to groups and institutions. The other is a study of change and reaction to change.

These investigators conclude that there are two age foci for retirement —age 65 and age 70. Their data indicate that both men and women of higher income levels, higher educational attainments, and higher levels of occupational structure tend to work longer than their counterparts with lower socioeconomic status. Women who are widowed, divorced, or separated are likely to work longer than those who are married. It is also clear that persons who are reluctant to retire are actually able to postpone retirement, while the more one is disposed to retirement, the sooner he is likely to retire. These investigators believe that their data show that the early retirees are more likely to be satisfied than those who retire later. They conclude, "The data tend to support the proposition that one's prior attitude is more important than the mode of retirement, that is, administrative or voluntary, in determining whether a person is satisfied with retirement or

with life in general."

E. W. Burgess first described the status of the retired elderly as "a roleless role." Streib et al. claim that the retired individual alters his roles, but is not roleless. There is disengagement from such roles as those associated with work, but they believe that many retirees are capable of coping with this role realignment. Streib and Schneider report that a "clearly defined role is not as important to older persons as it is to younger persons."

As to health, the investigation depended largely upon subjectively rated health. Although a decline in health occurred between age 65 and 70, the authors do not believe that this decline in self-assessment of health was significantly different between those who worked as opposed to those who did not work.

They refute the idea that retirement causes a decline in health. The authors do point out that for certain subgroups, for example, clinical and semiskilled, there does appear to be a decline in health among those who retire as opposed to those who continue working. However, they also believe that the unskilled actually improve in health after retirement. The authors do recognize that their health information is "clearly a subjective self-evaluation measure," but they consider the information sufficiently reliable for their objectives. Although they say that poor health itself may lead to retirement

and that those in good health tend to remain employed, this is not thoroughly explored. They do devote considerable effort to looking at health in retirement and do conclude, in general, “that in the impact year, the year after retirement, there is little evidence to suggest that health declines at retirement.” They add, “There is a very slight tendency for white-collar occupations to have a decline in reported health in the impact year compared to those in blue-collar occupations.” The improved health in the unskilled workers is recognized as possibly related to the fact that these individuals “are more likely to have engaged in more demanding or more onerous physical activity at work then retirement may be viewed as a possible respite and hence an improvement in health may be the result of stopping work.” Occupation before retirement influences health after retirement.

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Notes

1 Biological and psychological terms and theories applicable to aging and geriatrics are defined and described in Volume 4, Chapter 3 of this *Handbook.*

2 Additional information is presented in Volume 4, Chapter 3 of this *Handbook.*