CHAPTER TWO

Losing and Gaining: About Growing Old "Successfully" in the Netherlands

Margaret von Faber and
Sjaak van der Geest

The concept of successful aging has caused confusion and misunderstanding between health professionals and policy makers on the one hand, and older people on the other. During anthropological research among 27 older (85-plus) people in a mid-sized town in the Netherlands, we found that they rejected the idea that "successfully old" meant that one was healthy and autonomous and able to live without the help of others. Physical strength and health, they argued, could hardly be called an achievement or be considered as "success." Successful aging, they emphasized, rather was the art of accepting the limitations and losses that accompany aging without becoming grumpy and bitter. Successful are those who keep their good spirits in the face of the numerous losses that come their way. Successful are also those who manage to keep their network alive and continue to attract friends and relatives in spite of their own restricted mobility. The secret of success therefore lies in adjustment. The people with whom we spoke illustrated their views with experiences from their own lives.

In a collection of essays on loss and melancholia, Eng and Kazanjan (2003a) covered a wide range of dramatic topics, but the most common type of loss that almost everyone experiences, growing old, did not draw any of the authors' attention. This chapter describes how people 85 and older in a provincial town in the Netherlands reassess the numerous losses they have

suffered in their lives and try to turn them into gains. Succeeding in doing so, we argue, should be seen as a kind of "successful aging."

The concept of "successful aging" lends itself to more than one interpretation, and while it represents a useful distinction if carefully defined, it is not (as Stephenson points out in Chapter One) without attendant problems if it takes on class connotations or ignores overall health. Rowe and Kahn describe it as the positive extreme of normal aging (1987; 1997), while others use definitions such as "the elite of the healthy older" or "robust aging" (Garfein & Herzog, 1995). In these definitions, successful aging is seen as better than a normative state of being old and can be measured objectively. Other researchers, such as Baltes and Baltes (1990), Schulz and Heckhausen (1996), and Steverink, Lindenberg and Ormel (1998) view successful aging as a meaningful adaptation of the individual to changes during the aging process or as experiencing individual feelings of well-being (Havighurst, 1963; Keith, Fry & Ikels, 1990).

In all models of successful aging, the domains of health, well-being, and social contacts are important elements. The models that focus on adaptation direct the attention at growing old in a life-span perspective and the influence of individual agency. As a consequence of all the different definitions, researchers have to choose which perspective they use as a starting point: the outsider's perspective, for example from policy makers, or the perspective of the older people themselves (see, e.g., Collins, 2001; Torres, 2001).

This chapter draws on the findings of the anthropological part of the Leiden 85-plus Study about the way in which people aged 85 and older viewed what others might call successful aging. In a sense, then, it is an ethnographic examination of how well the concept actually works when it is discussed by those at whom it is aimed. We will examine how this group of people aged 85 and older understand and define well-being in old age and demonstrate the complex relationships between declining health and social contacts. We will address questions such as these: What are the goals older people strive for in old age? What negative aspects do they try to avoid? And what coping strategies do they use to overcome loss and grow old successfully?

Older People in the Netherlands

The research was conducted in Leiden, a town of 117,000 inhabitants in the densely populated western part of the Netherlands. The city of Leiden can be characterized both as a university town and as a town of working-class people. From the seventeenth century onwards, the city was well known for its university, founded in 1575, and because the famous painter Rembrandt grew up and worked here before he moved to Amsterdam.

Until the seventeenth century, Leiden had been the centre of the textile industry, and it owed much of its wealth to this flourishing industry. In the second half of the nineteenth century, industrialization changed the character of industrial work. Factories, specializing in food, came to the fore, and the textile industry disappeared. Because of working opportunities, Leiden has always attracted various groups of refugees and workers from other European countries. Immigrants hardly appear in the research, however, as they are still a young population.

Older people in the Netherlands are regarded as being relatively privileged. A welfare state, which provides basic social security including income support, care, and housing for all members of society, was established in the 1950s and 1960s. Due in part to the increasing costs of institutional care, the Dutch government has promoted "independent living as long as possible" for older people since the 1970s. This became the dominant paradigm in policies directed at the older population (Broese van Groenou & Van Tilburg, 1996; Huijsman & De Klerk, 1997).

Because of the introduction of general pensions and social security in the development of the Dutch welfare state, people are independent of their children in financial and material matters. However, the quality of emotional contacts with their children becomes more important. Both older Dutch adults and their children[1] prefer a certain independence from each other, which can be seen in the attitudes toward living and health-care arrangements (Dykstra & Knipscheer, 1995).

When health declines and older people do become dependent, they have to call on their social contacts. However, in the Netherlands dependence is not valued positively, as it conflicts with strong ideals of autonomy and self-determination. Van der Veen (1995) writes that Dutch people contrast social relationships to more businesslike ones. In social relationships people emphasize the communication of feelings and emotions. In businesslike transactions, independence is maintained through direct reciprocity. Professional helpers are paid for their work, so there is a balance between "giving" and "taking," and older people who receive professional help remain "independent." Those who try to maintain "good" relationships with their children prefer material and practical daily care from professional workers and reserve their contacts with children and grandchildren for emotional support.

The Leiden 85-plus Study

In the Leiden 85-plus Study on Successful Ageing, which lasted from 1997 until 2002, all citizens aged 85 in the city of Leiden were enrolled and followed

for four years. The aim of the study was to investigate determinants of successful aging and preventable causes of unsuccessful aging. All the inhabitants of the city of Leiden, born between 1 September 1912 and 1 September 1914 (n=705), were invited for this study shortly after their 85th birthday. There was no exclusion on grounds of health, cognitive functioning or living situation. Data were obtained from 599 participants, a response rate of 87 per cent.

In the biomedical quantitative part of the study, successful aging was defined as *optimal states* of physical, psycho-cognitive, and social functioning and optimal feelings of well-being, which was annually measured with established quantitative instruments (von Faber et al., 2001).

In the anthropological approach, open-ended interviews were conducted with 27 participants in order to investigate their perceptions of successful aging, taking into account their health condition. Experiences and opinions of the people interviewed were not limited to the exact moment of the interview, but included past and present experiences and expectations about the future. The participants selected varied in physical condition, marital status, and housing situation and were roughly "representative" of the overall study group. People with serious loss of cognitive function were not included, because their impairment would prevent them from taking part in an in-depth interview about the abstract notion of successful aging.

Most people were visited twice or more, and a group of ten participants were visited and interviewed every three months over a period of three years. One of the participants suffered from cognitive decline during this period; she was not excluded, but structured interviews with her were replaced by conversations.

Interviews lasted for at least one-and-a-half hours, and participants were also observed in their home situation. In addition, ten general practitioners were interviewed about their perceptions of successful aging. All interviews were recorded on tape and transcribed. In the analytic process, data were examined and compared for similarities and differences. Concepts such as health, successful aging, and social functioning were elaborated in terms of their properties, dimensions, and relationships.

Understanding Notions of Success, Health and Well-Being in Old Age

From the first cross-sectional analysis of the Leiden 85-plus Study, it appeared that there were marked discrepancies between the perception of successful aging by older people themselves and the conclusions drawn from biomedical measurement.[2] According to the latter, only ten per cent of the participants in our study could be categorized as "successfully" old.[3] The qualitative interviews, however, showed that 22 out of 27 participants actually considered

themselves, individually or as a couple, to be successful in the ways in which they have aged. According to the participants we interviewed, successful aging simply means being content with one's life. One man explained,

> I feel happy! What more is there to wish? If you are at this age and you feel happy? Successful aging is how happy can you be at this age. Of course health plays an important role, however you can also feel happy if your health is poor. I mean, if you say successfulness is the same as good health, then you could say: everyone who is 85, 86, 87, and who is not in a good shape is not successful. But there is more to it. It is not only health. It is a combination. You can't control your health. You can only partially influence conditions when you grow old, for instance financial resources. But relations with others, keeping social contacts and feeling connected with society, those are things you *can* bring about yourself. In that sense you can be successful.

Although all the older people with whom we spoke mentioned and recognized the domains of physical, cognitive, and social functioning and well-being, these domains were not perceived as being equally important. Good social contacts were felt to be the most important prerequisite for well-being and hence successful aging. Being "important to others," especially children, was connected with feelings of "success" and purpose in life and was a central theme. Loneliness, like cognitive decline, was feared, and a lonely person was considered as not successful.

Physical and cognitive functioning was perceived as important, but primarily as a means of functioning on a desired social level. Most people feared cognitive decline because dementia was perceived as losing one's personality and because it means losing contact with loved ones. One couple discussed together the worst-case scenarios, i.e., becoming demented or having cancer. Referring to experiences in their own family, the man argued,

> The fact that they [others] prayed for her death, confirms my opinion that dementia is the worst there is. […] Cancer is also terrible (referring to his father and his mother), but they are still … they can talk about it, they can be with it, and so on.

In general, loneliness, loss, and grief were associated with cognitive decline. Participants often stated that although physical problems occurred, their mental state was "still all right," as if they wanted to distance themselves from peers with cognitive decline. With regard to health, participants emphasized the importance of adapting to health problems and the preservation of social contacts.

From the perspective of the people with whom we spoke, successful aging is an adaptive process that is both person- and context-bound. Character and attitude ("making the most of it") were mentioned as the main instruments in dealing with limitations. So, rather than optimal scores on clinical scales of functioning, "success" is linked by this group of people over 85 years old to ways of coping and dealing with problems. From their perspective "success" refers to something that people can try to *achieve*, rather than something that just happens to a person (like having or lacking good health). The approach of successful aging shows that people strive to maintain a feeling of well-being and self-esteem and preserving social contacts (von Faber, 2002). Examining the data from the perspective of adaptation sheds light on the challenges and difficulties they face in attaining this.

Loss and Its Acceptance

In their introduction on loss and nostalgia, Eng and Kazanjan (2003b: 2) write,

> We might say that as soon as the question "What is lost?" is posed, it invariably slips into the question "What remains?" That is, loss is inseparable from what remains, for what is lost is known only by what remains of it, by how these remains are produced, read, and sustained.

The older people we interviewed were well aware of what they had lost over the years—partners, friends, children, health, mobility, social reputation, public attention, sexual pleasure—but they tried to concentrate on what remained. They told us they were counting their blessings. Their adjustment to old age and its losses had two dimensions: it was a strategy of not complaining, of "impression management" to keep the affection of their children and friends, but it was also an act of personal preservation, accepting the facts of life and retaining an overall sense of meaningfulness with regard to the life they had lived.

These were people who expected health problems to occur at the age of 85 as part of "normal aging." The general expectation was that "old age comes with infirmities." When participants did not have serious health problems they regarded themselves as "lucky," "blessed," and "privileged," but they knew that this situation might change any time. In the interviews, a notion of vulnerability often emerged, which referred to the expectation that physical health problems might occur suddenly at this age:

> Sometimes I feel 85, when I am ill and not feeling very well because of my heart. But at this moment I feel all right. It is not over, but I don't have any pain. But at this age, things may happen.

Although one's own death, despite one's age, remains an abstraction, participants anticipate illness and deterioration that will ultimately cause their death:

> I still manage. But of course, I am privileged. It is normal that things get worse at my age. One cannot die healthy.

The expectation that physical decline is inevitable is linked to already experienced biological changes, like the slowing down of pace and strength, or chronic disease.[4]

Threats

There is a link between the vulnerable body and perceptions of the future. With regard to health in old age, the interviews contain statements about decline, known and unknown risks, and health problems that medical interventions cannot solve. Managing risks plays an important role. The anticipation of decline of the older people in this study can be divided into anticipating an unknown future and anticipating the "worst possible scenario" in case of a declining condition or progressive illness. Not only existing health problems, but also the anticipation of such problems, leads to specific decisions such as moving to another house, even when there is no present indication that things will happen. In the light of a future that one hopes for or fears, specific actions are undertaken or considered:

> We are not registered in any home for the elderly. He [my husband] does not want to go. Yes, I would like to stay in my own house, too, but what if things get worse? Then they can put you anywhere!

Considerations about the future often include death and dying. Many participants had thought about what they can accept as part of "normal aging," and several had decided to make a declaration in which they state under which circumstances they do not wish their lives to be prolonged by medical interventions, for example, in the case of severe cognitive decline. One woman referred specifically to the irreversible consequences: "I think it is terrible, my ability to communicate may get lost forever." Notions of suffering and dignity, religion, societal developments, and statements by members of the direct social network, especially children and partners, influence this decision making and outlook.

The most important negative outcome of health decline described by people in the interviews was a feeling of dependence. The study participants feared becoming "a burden" on others (cf. Antonucci, 1990; Minichiello, Browne & Kendig, 2000; Vatuk, 1990). Becoming "a burden" may lead to loss

of social contacts, loneliness, and a loss of a feeling of well-being. For these reasons, participants stated that they were engaged in several strategies directed at managing health problems, maintaining a feeling of well-being, and preserving social relationships.

Strategies Directed at Managing Health in Old Age

Both cognitive and practical strategies appear in managing changes in health. As a consequence of their age, the participants redefined the concept of health. Many talked about their limitations as "shortcomings," "weak spots" or "normal changes" due to old age. From their perspective, health during old age means the maintenance of basic functions and the *absence* of severe pain and life-threatening diseases such as infections or cancer. With regard to basic sensory abilities such as hearing, vision, or balance and mobility, it is accepted that these might decrease to a certain extent. Participants with chronic diseases such as emphysema, rheumatism, arthritis or high blood pressure stated that they felt healthy, although they were aware that their view contradicted biomedical perspectives on health. As one woman put it, "Of course I am very healthy. It is only my knees, they are worn-out."

A slow change in physical functioning enables people to gradually alter their practices and standards. This gradual adjustment was important for how participants perceived their functioning. For example, within the Leiden 85-plus Study, an intervention study was conducted on hearing loss (Gussekloo et al., 2003). In this part of the study, it was discovered that there was a marked discrepancy between the *etic* (externally defined) and the *emic* (internally experienced) perceptions of hearing loss. Three out of four participants with objectively measured severe hearing loss declined participation in the auditory rehabilitation program, stating that a hearing aid was not yet necessary. Among other reasons, they were conscious of their limited hearing but talked about several solutions for coping with hearing loss in daily life. Although "disability" was diagnosed from a medical perspective, it was not experienced as such by most of the elderly themselves.

Another cognitive strategy is a selective comparison (Suls & Mullen, 1982) with peers who have more or worse health problems. As one participant said,

> I have reached a beautiful age. I feel healthy; I have never been to a hospital. I am even involved in voluntary work. When I see people of my age there, I think: well, I am fortunate compared to them.

The question "How am I doing for my age?" is important in self-assessment (Neugarten, 1979). In the comparison with peers, participants referred to the

general expectations of bodily decline with age. This selective comparison adds to a *relative* feeling of well-being. This contrasts markedly with the hypothesis by Suls and Mullen that in comparison to other age groups, older people make fewer comparisons with peers but more comparisons with the past. Instead, we found that all Dutch participants compared themselves with peers, despite the shrinkage of their social network. General images of older people, documentaries on television about nursing homes, and observations of peers in shops and on the street all influenced the ideas and opinions that participants had about other older individuals. The comparison even included deceased peers:

> I can still walk and hear normally. How many people that were born in the same year are able to do that? How many of them are still alive, and how many of them feel happy like me?

In addition, health problems demand *practical* strategies. Almost invisibly to the outside world, participants are involved in different kinds of "work" (Corbin & Strauss, 1988), including avoidance of risks, maintenance of functioning, and actions directed at dealing with declining abilities.

Actions based on risk assessment are ways of avoiding risk by ceasing certain activities, or reducing it by changing the character of activities, for example, staying away from busy crossroads or not going out alone in the evening. Despite difficulties, participants wanted to keep their health status as optimal as possible. They engaged in specific activities such as physical gymnastics, voluntary work or shopping as part of a deliberate strategy to maintain daily functioning. With regard to cognitive functioning, participants perceived playing cards or chess and doing crossword puzzles as "mental exercise."

Dealing with decline is therefore directed at acceptance. However, this involves handling contradictory emotions such as hope, fear, and uncertainty about bodily changes or further decline. The search for solutions, such as purchasing aids, making practical changes in daily living, and seeking alternatives, new possibilities, and new standards, all hold a prominent place in the adjustment processes related to the physical and/or mental condition.

Control involves striving for self-control or leaving the control to others, for example, children or general practitioners. In cases where participants are confronted with opinions that conflict with their own ideas and opinions, deliberate self-control is both control and an act of resistance to what are perceived as wrong interpretations of themselves or their situation. Practices concerning control ask for specific actions such as consulting different physicians and asking for a second opinion about health problems. If control is handed

over, it involves signing several papers in which it is stated that someone else represents the participant.

All these strategies are directed at continuity of a sense of self and the maintenance of self-esteem. Clearly, adaptation is a multi-dimensional process of perceptions and practices directed at different goals. The term is used frequently with regard to illness or other problems in life. However, in daily practice several actions from different categories occur simultaneously and are sometimes contradictory. Corbin and Strauss (1988: 256) point to potential conflict where bodily deterioration is concerned: "the paradoxical requirement that the ill must come to terms with disabling limitations while at the same time fighting them." The case study below illustrates this.

Case Study 1: Frans[5]

Frans lives in a home for the elderly and has had poor vision throughout his life. In 1995 an operation was performed on a cataract, and in 1996 he underwent a corneal transplant. It did not help much. In 1997 he was hardly able to see with his left eye and saw very little with his right eye. Within the next year his vision diminished further. He was referred to a specialist in vision aids:

> The man was figuring out which kind of magnifying glass was appropriate for me. He found something eventually. They like to sell something too; at least that is how I see it. However, if they could not find anything, well then they would not have sold it either. Now I get a stronger magnifying glass. I thought to myself: It won't work; I have no confidence in it. However, if the doctor sends you.… The former magnifying glass was four years ago. Maybe they have developed something new, something better.

It was common for participants to experience simultaneously the emotions of hope and fear of disappointment with regard to new aids and therapies. In time, Frans said, his vision decreased further, so every time he had to adjust to new limitations. In 1999 his general practitioner contacted him and told him, "I regret saying this, but there is nothing we can do anymore. Your eyes will get worse. Slowly your vision will diminish." The diagnosis meant a lot of uncertainty for Frans. He did not know to what extent his eyesight would diminish and over what time period. He had to accept the idea that things would get worse but did not know how to prepare himself for the unknown. Moreover, as we saw earlier, it is not only health that matters. Social contacts also appear to be important components of well-being in old age (cf. Farquhar, 1995). For this reason, the study participants also engaged in other strategies; it is to these that we now turn.

Declining Health and the Preservation of Social Contacts

Older people without children are often perceived as the most vulnerable group in society because they lack direct family support. In general it is assumed that social relationships influence health positively, so social support is seen as acting as a "buffer" and increasing feelings of well-being when older persons experience problems such as declining health or the loss of a partner (see, e.g., Rowe & Kahn, 1987; 1997). Other researchers have criticised this "buffer" hypothesis by pointing to stressful relationships, unmet expectations, loss of autonomy, and psychological "costs" as important factors (e.g., Antonucci, 1990; Bengtson, 2001; Lefrançois et al., 2000). Bengtson (2001) distinguishes between different intergenerational relationships. He argues that conflict is an important aspect of parent–child relationships that deserves more attention in research. Within intergenerational relationships, feelings both of distance and proximity, and of attachment and detachment, are found, and both are important.

In the Leiden 85-plus Study, the majority (84 per cent of all participants) had one or more children alive (Gussekloo, De Craen & Westendorp, 2000). Of the 27 participants in the qualitative part of the study, six had no children. However, other relatives, such as nephews and nieces, and neighbours or friends undertook support roles and became important for participants without children. Only one couple with children had severed all contact with their children due to conflict in the past. Two participants had contact with their children only on special occasions. The rest reported regular contact (weekly or monthly) with their children and described their relationship with them as "good." Contact with grandchildren varied from regular and intimate to an annual visit.

Social Strategies

Almost all relationships between our study participants and their adult children involved a mix of detachment and attachment. Just as children do not tell their parents everything, older people do not share all of their thoughts and "secrets" with their adult children. Participants emphasized that their children had grown up and now "lead their own lives." The autonomy of their children was perceived as important, and participants were careful not to interfere in business that they perceived to be a personal matter for their children. Even in relationships described as "good," involving regular contact and exchange of support and affection, participants weighed up which thoughts and feelings to share with their children and which to keep to themselves. Especially when there was a conflict *between* children, parents kept silent to prevent becoming a part of the conflict. It was one of their social strategies,

since conflict with children was seen as something that the older person has to prevent. One woman remarked,

> If older persons say that they have severed all contact with their children, I always think this is their own fault. I too have to mind what I say. When my children are here to visit me, I leave the living-room and go to the kitchen when I get angry with them.

According to the participants in this study, health problems in particular call for adjustment in social relationships. Even participants who were in good health emphasized this point. However, complexity and ambiguity came to the fore in the conversations about their social relationships in the context of declining health. Good social relationships do not necessarily mean that older people talk about the things that bother them. That this may turn out to be very difficult is illustrated by the following case study.

Case Study 2: Bea

Since her husband died five years ago, life has lost its appeal to Bea. She had been married for 60 years and has two children. Bea and her husband ran a shop in a village near Leiden. However, when her husband fell sick with emphysema they moved to Leiden to be closer to their daughter. After a year Bea's husband died and Bea now lives alone in an apartment in a new housing estate where she has hardly any contact with neighbours.

Bea's daughter visits her almost every day, and a grandson visits her weekly. Although Bea loves these visits, she does not want to be "a burden." She suggests to her daughter to visit her less frequently and she asks for as little help as she can. Despite feeling lonely after the death of her husband, Bea does not confide her feelings to her daughter. She is also afraid that health problems that might occur in the future will make her life a misery. She has signed a declaration stating under what circumstances she does not wish her life to be prolonged by medical interventions. Within the Dutch media there is much debate about "quality of life" and whether older people who suffer have the right to decide to end their life if they consider it no longer worthwhile. Bea is an advocate of self-determination when it comes to the end of a person's life. She feels that her life is useless and that it will become even worse if severe health problems occur.

When Bea was 87, she suffered for months from severe stomach pain, an oesophageal infection, and a blockage of her bowel. She felt sick but did not tell her children: "They did not even know how sick I was. I never told them. I thought, if I tell them, they will think, 'She is nagging. All people at that age have their complaints.' When they came to visit me, I tried to be as good as

possible. After they went home, I went straight to bed. If they phoned and asked me how I was doing, I turned the conversation to another subject." Only after she had been admitted to hospital in critical condition did the children find out about their mother's illness.

Bea is afraid of the future. She fears decline to the extent of total dependence: "It will get worse, not better." In her opinion, there is nothing meaningful she can still do for others. In line with this, her wish for ensuring control, at least about the end of her life, is influenced by her fear about discontinuity and becoming "a burden." Although she states that adaptation is important, she also admits that she has difficulty accepting her own situation. Like many other respondents she presumes that it is better to maintain a cheerful appearance in order to preserve social contacts. Bea even engages in active "impression management" by hiding her complaints from her children.

On Becoming a "Burden"

Exposure to the threats of declining health and a shrinking social network makes people engage in strategies for not becoming a burden. But what does it mean "to burden" social relationships? Sometimes older people perceive practical support as "over-burdening" a person who is already busy providing support. In other cases, it means that the problems are perceived as too serious to ask for help. Factors that also influence the notion of being a burden are the division of roles between parent and child in the past, the perceived supporting ability of the person, and the condition of the care provider involved. The children may themselves be in their 60s and involved in taking care of their own children and grandchildren, or sometimes suffer from serious medical problems themselves. For example, one woman was afraid of a sudden death because of heart failure. She wanted to arrange for an alarm system but did not want to "bother" her daughter with this because her daughter was recovering from radiation treatment for cancer. These kinds of considerations highlight the close interconnection of the threats faced by different members of social networks. Because older people have the problems of their adult children to consider, their own physical and psychological vulnerability can be exacerbated.

Out of fear of putting the relationship to a test, older people seldom talk with their children about their *perceived feelings* of "being a burden." For example, when Bea was asked whether her daughter shared her idea about being a burden, she answered, "No, it is difficult to talk about it. I think it is a burden to her, but I am afraid to talk about it because then I think, 'Maybe, she will stop coming everyday,' and that would be terrible." Whether this fear is realistic or not remains obscure.

According to older people, health problems at this age have to be accepted,

and non-complaining is one social strategy for dealing with such problems. One woman who suffers from pain due to arthritis explained, "I won't complain about my ailments to my children, I'm afraid that otherwise they won't come to visit me anymore." In general, complaining is perceived as negative, and several participants spoke proudly of the fact that "no-one shall hear me complaining," although they also mentioned their difficulties in accepting pain, losses or disability. This does not mean that older people do not complain; however, they are cautious in talking about their problems. Peers are very direct with negative remarks if they think someone is complaining.

Finally, participants tried to preserve social ties by rewarding social support with material, financial or other incentives; this is a way of counteracting dependence. Rather than admitting feelings of disappointment, they tried to explain away unmet expectations of reciprocity and emphasize the busy lives of their children. It is a cognitive strategy to mask feelings of disappointment and it prevents them from asking themselves (often painful) questions about the willingness of children and grandchildren to provide support. Few older people dare to admit to others that they wish to be dependent to a certain extent.

Most of the participants we interviewed wished for reciprocity and hoped that the social contacts with friends, children, and relatives would continue in old age. As one woman put it,

> Your social contacts are important. You have to invest in them from an early age and then you hope that you get something in return when you're old.

Conclusion

This ethnographic research among those over 85 in the Netherlands shows aspects of accommodation to loss in old age and suggests we should reconfigure how we use the term "success," for it does not appear to mean the same thing to those who describe it from the outside as it does to those who experience it directly. Those who are able to cope with declining health and to preserve their social contacts feel content and hence consider themselves to be successful in doing so. At the same time they are aware of what they have lost and are bound to lose in the near future; they may face stressful declines in health to the point of possible dependency, loneliness, and loss of social esteem. Consequently, older people put considerable effort into dealing with declining health, especially with the help of both cognitive and practical strategies. Cognitive strategies, such as selective comparison and explaining away disappointment, are directed at maintaining a feeling of self-esteem and emotional well-being. The use of strategies may be regarded as a kind of emo-

tional intelligence and not merely as a cognitive task. The social consequences of certain kinds of loss, like dependence and loneliness, hold a prominent place in the narratives of older people precisely because they are augurs of a declining ability to adapt.

Although it is obvious that lack of social contact may result in loneliness and loss of well-being, older people can also feel lonely despite social contacts because they don't have people they can really confide in. Both the statements of older people and their actions reveal the ambiguity of old age. On the one hand, those who do not complain act according to cultural norms and preserve a feeling of dignity, which their social environment positively rewards. On the other hand, it may be very difficult to share feelings of fear, loss or bereavement. Although participants perceived dependence and decline as a normal part of aging, they found it almost impossible to talk about it. Talking about negative things could easily be perceived as complaining or whining, which could also result in a potential loss of social contact.

We have described older people's attempts to turn their losses into gains. For them, successful aging is the art of accepting the limitations and losses that accompany old age without growing bitter. Those who can keep their good spirits in the face of the numerous losses that come their way, and who manage to keep their network alive and continue to attract friends and relatives in spite of their own restricted mobility, regard themselves as successful. The secret of success lies in adjustment—no matter what kind of external definition of success might be imposed by others.

For one category of older people, however, those with grave cognitive decline, the possibility of transforming loss into gain was felt to be beyond their grasp. In the anthropological research arm of the study, people in cognitive decline were excluded, but a glimpse into the subtle realities of this part of aging, as opposed to the deep fears attached to it by many, can be acquired from reading the chapters by Pia Kontos (Chapter Seven) and Janice Graham (Chapter Eight). If conversations and meetings with older people lose their direct gratification and become unsatisfactory or boring due to the cognitive limitations of the other older person, the latter risks becoming lonely, without "deserving" it (i.e., in spite of his or her social investments in the past). In such a situation life can seem to end unfairly, as "total loss" (van der Geest & von Faber, 2002). It is ironic that older people in the Netherlands who want to prevent this happening to them by requesting a "good death" (euthanasia) before they are "demented" are not able to acquire that favour. The law stipulates that a request for euthanasia should be voluntary and well considered, and from a patient who is competent enough to express his or her will. Older

people suffering from dementia are said not to meet that criterion, even if they expressed their wish very clearly before they were affected by the disease (cf. Niekamp & van der Geest, 2003).

We do not romanticize growing old in this chapter as an almost automatic process of gaining by losing, for people do not become wise and attractive to others merely by adding years. Growing old without being destroyed by the losses one may have to endure is an achievement that many people may fail to realize. But those who do understand the importance of this aspect of aging turn out to be winners in spite of their losses, by contesting the assumptions of what successfully aging actually means to them.

Acknowledgements

The Leiden 85-plus Study on Successful Ageing was funded by the Dutch Ministry of Health, Welfare and Sports and was carried out with the help of several colleagues, in particular Rudie Westendorp, Jacobijn Gussekloo, Annetje Bootsma-van der Wiel, Eric van Exel, and Inge Mooiekind. We would also like to thank Emily Grundy, Ruly Marianti, and Elisabeth Schröder-Butterfill for their useful comments and suggestions on earlier drafts.

Notes

1. Older people without children are reported to have more social relationships with other family members such as brothers, sisters, nieces, and nephews than older people with children (Dykstra & Knipscheer 1995).
2. Physical functioning was measured using the Groningen Activity Restriction Scale (GARS). Social functioning was measured with the Time Spending Pattern Questionnaire. Psycho-cognitive functioning was measured with the Mini-Mental State Examination (MMSE) and the short Geriatric Depression Scale as a screening instrument for depression. Well-being was assessed by Cantrill's Ladder, a visual analogue scale on perceived quality of life varying from 1 to 10 points and by a general question: "Are you, in general, satisfied with your present life?" Loneliness was screened by a questionnaire developed by De Jong-Gierveld & Kamphuis. The biomedical instruments, the classification, alternative criteria, and the discussion about outcomes of biomedical and anthropological findings are described in detail elsewhere (von Faber et al., 2001).
3. In the quantitative part of the study, participants were classified as successful if they had minor physical disabilities, regular social activities, absence of cognitive impairment, and absence of marked depressive feelings. Besides this they had to

have a high mark on quality of life, satisfaction with present life, and the absence of marked feelings of loneliness.

4. At the age of 85 years, more than half of the participants of the study (*n*=599) suffered from one or more chronic diseases that had started before the age of 85.
5. The participants in the research wished to be called by a first name. Most of them chose their own pseudonym.

References

Antonucci, T.C. 1990. "Social Supports and Social Relationships." Pp. 205–26 in R.H. Binstock and L.K. George (Eds.), *Aging and the Social Sciences*. London: Academic Press.

Baltes, P.B., and Baltes, M.M. 1990. "Psychological Perspectives on Successful Aging: the model of selective optimization with compensation." Pp. 1–34 in P.B. Baltes and M.M. Baltes (Eds.), *Successful Aging: perspectives from the behavioral sciences*. Cambridge: Cambridge University Press.

Bengtson, V.L. 2001. "Beyond the Nuclear Family: the increasing importance of multigenerational bonds." *Journal of Marriage and Family* 63 (2): 1–16.

Broese van Groenou, M., and Van Tilburg, T. 1996. "The Personal Network of Dutch Older Adults: a source of social contact and instrumental support." Pp. 163–82 in H. Litwin (Ed.), *The Social Networks of Older People: a cross-national analysis*. Westport, CT: Praeger.

Collins, P. 2001 "'If You Got Everything, It's Good Enough': perspectives on successful aging in a Canadian Inuit community." *Journal of Cross-Cultural Gerontology* 16: 127–55.

Corbin, J.M., and Strauss, A. 1988. *Unending Work and Care: managing chronic illness at home*. San Francisco: Jossey-Bass.

De Jong-Gierveld, J., and Kamphuis, F.H. 1985. "The Development of a Rasch-type Loneliness Scale." *Applied Psychological Measurement* 9: 289–99.

Delor, F., and Hubert, M. 2000. "Revisiting the Concept of Vulnerability." *Social Science and Medicine* 50: 1557–70.

Dykstra, P.A., and Knipscheer, C.P.M. 1995. "The Availability and Intergenerational Structure of Family Relationships." Pp. 37–58 in C.P.M. Knipscheer, J. de Jong-Gierveld, T.G. Van Tilburg, and P.A. Dykstra (Eds.), *Living Arrangements and Social Networks of Older Adults*. Amsterdam: VU University Press.

Eng, D.L., and Kazanjian, D. (Eds.). 2003a. *Loss: the politics of mourning.* Berkeley: University of California Press.

Eng, D.L., and Kazanjian, D. 2003b. Introduction: mourning remains. Pp. 1–25 in D.L. Eng and D. Kazanjian (Eds.), *Loss: the politics of mourning.* Berkeley: University of California Press.

Farquhar, M. 1995. "Older People's Definitions of Quality of Life." *Social Science and Medicine* 41 (10): 1439–46.

Garfein, A.J., and Herzog, A.R. 1995. "Robust Aging among the Young-old, Old-old, and Oldest-old." *Journal of Gerontology: Social Sciences* 50: S77–87.

Gussekloo, J., De Bont, L.E.A., von Faber, M., Eekhof, J.A.H., De Laat, J.A.P.M., Hulshof, J.H., Van Dongen, E., and Westendorp, R.G.J. 2003. "Auditory Rehabilitation of Older People from the General Population—the Leiden 85-plus Study." *British Journal of General Practice* 53: 536–40.

Gussekloo, J., De Craen, A., and Westendorp, R.G.J. 2000. "Gezondheid en functioneren van de oudste ouderen in Nederland. De Leiden 85-plus Studie." *Medisch Contact* 55 (13): 473–76.

Havighurst, R.J. 1963. "Successful Aging." Pp. 299–320 in R.H. Williams, C. Tibbits, and W. Donahue (Eds.), *Processes of Aging*. New York: Atherton Press.

Huijsman, R., and De Klerk, M. 1997. "Succesvolle zorgverlening aan ouderen in Nederland." *Tijdschrift Sociale Gezondheidszorg* 75: 406–16.

Keith, J., Fry, C.L., and Ikels, C. 1990. "Community as Context for Successful Aging." Pp. 245–61 in J. Sokolovsky (Ed.), *The Cultural Context of Aging: worldwide perspectives*. New York: Bergin and Garvey.

Lefrançois, R., Leclerc, G., Hamel, S., and Gaulin, P. 2000. "Stressful Life Events and Psychological Distress of the Very Old: does social support have a moderating effect?" *Archives of Gerontology and Geriatrics* 31 (3): 243–55.

Minichiello, V., Browne, J., and Kendig, H. 2000. "Perceptions and Consequences of Ageism: views of older people." *Ageing and Society* 20: 253–78.

Neugarten, B.L. 1979. "Time, Age and the Life Cycle." *American Journal of Psychiatry* 136: 887–93.

Niekamp, A-M., and van der Geest, S. 2003. "Ageism and Euthanasia in the Netherlands: questions and conjectures." *Mortality* 8 (3): 296–304.

Rowe, J.W., and Kahn, R.L. 1987. "Human Aging: usual and successful." *Science* 237: 143–49.

Rowe, J.W., and Kahn, R.L. 1997. "Successful Aging." *The Gerontologist* 37 (4): 433–40.

Sahlins, M.D. 1974. *Stone Age Economics*. London: Tavistock Publications.

Schulz, R., and Heckhausen, J. 1996. "A Life Span Model of Successful Aging." *American Psychologist* 51 (7): 702–14.

Steverink, N., Lindenberg, S., and Ormel, J. 1998. "Towards Understanding Successful Ageing: patterned change in resources and goals." *Ageing and Society* 18 (4): 441–67.

Strauss, A., and Corbin, J. 1998. *Basics of Qualitative Research: techniques and procedures for developing grounded theory*. London: Sage.

Suls, J., and Mullen, B. 1982. "From the Cradle to the Grave: comparison and self-

evaluation across the life-span." Pp. 97–128 in J. Suls (Ed.), *Psychological Perspectives on the Self*. New York: Erlbaum.

Torres, S. 2001. "Understandings of Successful Ageing in the Context of Migration: the case of Iranian immigrants in Sweden." *Ageing and Society* 21: 333–55.

van der Geest, S., and von Faber, M. 2002. "Een slordig einde? Reciprociteit en 'succesvol oud' nader beschouwd." *Sociologische Gids* 49 (4): 409–20.

van der Veen, K.W. 1995. "Zelfbeschikking in afhankelijkheid? De ambiguïteit van ouderenzorg in Nederland." Pp. 57–65 in S. van der Geest (Ed.), *Ambivalentie/ Ambiguïteit. Antropologische notities*. Amsterdam: Het Spinhuis.

Vatuk, S. 1990. "To be a Burden on Others." Pp. 64–88 in O.M. Lynch (Ed.), *Divine Passions: the social construction of emotion in India*. Berkeley: University of California Press.

von Faber, M. 2002. *Maten van Succes bij Ouderen: Gezondheid, aanpassing en sociaal welbevinden*. PhD Thesis. University of Amsterdam. Rotterdam: Optima.

von Faber, M., Bootsma-van der Wiel, A., Van Exel, E., Gussekloo, J., Lagaay, A., Van Dongen, E., Knook, D.L., van der Geest, S., and Westendorp, R.G.J. 2001. "Successful Aging in the Oldest Old: who can be characterized as successfully aged?" *Archives of Internal Medicine* 161: 2694–700.