

Theoretical or Methodological Article

Beyond Successful Aging 2.0: Inequalities, Ageism, and the Case for Normalizing Old Ages

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Abstract

This article reviews challenges to Rowe and Kahn's Successful Aging (SA) framework, particularly those that focus on the ways social inequalities, including ageism, stratify age groups and affect possibilities for SA. We then assess the authors' replies to these critiques. We find that SA 2.0 maintains a naturalization of outcomes of age relations, and retains both its focus on personal choice and its indifference to inequalities. We advocate a paradigm shift that recasts the problems of aging in three distinct ways: (i) avoids treating old age as a problem; (ii) avoids treating medical and other maladies as results of aging; and (iii) treats the problems of old age as results of age relations instead. By focusing on age relations, this paradigm goes beyond calls to examine inequalities over the life course, and seeks to normalize old ages, valuing both different modes of aging and old age itself.

Keywords: Age relations, Diversity in aging, Paradigm, Theory

Rowe and Kahn's (1987, 1997, 1998) iteration of Successful Aging (SA) has sparked much research and popular advice on how to "age successfully" (Pruchno, 2015). In so doing, SA focused much-needed attention on achieving and maintaining physical and mental health, and fostered optimism concerning what later life can be like.

Still, SA has not been without its detractors. Studies of its utility have been limited by inconsistent definition and measurement (Depp & Jeste, 2006; Knight & Ricciardelli, 2003; Phelan et al., 2004). Some scholars advise reform of the concept to be more inclusive of diverse groups of elders (e.g., Molton & Yorkston, 2017). A few challenge SA's individualistic approach and neoliberal recommendations, and its impact on ageism. Some of those scholars have urged that we abandon the model, or have presented alternative frameworks (Katz & Calasanti, 2015; Martinson & Berridge, 2015; Sandberg & Marshall, 2017). Here, we review these latter challenges, explore the extent to which Successful Aging 2.0 addresses them, argue for a paradigm shift, and offer suggestions toward that end.

SA: The MacArthur Model and 2.0

Gerontological interest in the notion of SA was evident in the first issue of *The Gerontologist*, which featured Robert Havighurst's (1961) article, "Successful Aging." Rowe and Kahn's version (1987, 1997) including their widely marketed book (1998), refuted the myth that steep decline was intrinsic to old age (1987, p. 144). Faulting gerontologists for their attention to frailty, they characterized that belief as a form of ageism (1998, p. 12) that leads old people to neglect lifestyles that could maintain their strength and control.

Rowe and Kahn's strategy for dispelling the myth of disease and decline was, first, to distinguish between the effects of "biological aging per se" (1987, p. 144) and psychosocial factors. They argued that the latter are subject to revision, and can mitigate the threat posed by the former. Second, they differentiate "usual" aging, that is, the "dominant patterns of aging" in a society, from "better than usual" or "successful" aging, wherein people deviate from

these patterns and show minimal decline (p. 144). Rowe and Kahn came to conceive such success in terms of high levels of mental and physical function; avoidance of disease and disability; and engagement through paid or unpaid productive activities (1998, pp. 38–40). A focus on personal responsibility for achieving SA is central to their framework: “Our main message is that we can have a dramatic impact on our own success or failure in aging” (p. 18). Though they laud shifts in law and call for more, they argued that the key lies in adopting the right lifestyle: “In short, SA is dependent upon individual choices and behaviors” (p. 37).

SA has faced critique for this emphasis on personal responsibility to control aging through health and lifestyle choices (Katz & Calasanti, 2015; Calasanti, 2016; Holstein & Minkler, 2003). It focuses on old people as a distinct group with its own problems to be managed, but treats these concerns as personal rather than as an outcome of age relations to be addressed primarily at a collective or institutional level. A second, related challenge bears upon SA’s omission of the intersecting inequities that both shape groups’ success, however defined (Katz & Calasanti, 2015; Holstein & Minkler, 2003; Sandberg & Marshall, 2017), and challenge Rowe and Kahn’s suggestion that the promotion of SA will reduce ageism.

In their recent reply to detractors and restatement of their paradigm as SA 2.0, Rowe and Kahn acknowledge “the important influence of social factors on the capacity of individuals to age successfully” (2015, p. 524). That this “was not explicit in the initial formulation” provides a major impetus for their update: “The ... concept of successful aging of the *individual* [should] be complemented with a body of theoretical inquiry and empirical research at the level of *society*” (p. 524). They propose “reengineering” core institutions to facilitate SA, to produce the goods and services needed by large older cohorts (pp. 594–595). They note group-level conflict, between “haves and have-nots” and over age-based entitlements; repeat their earlier calls for redistribution of education, work, and leisure across the life course; and call for a human-capital approach that values workers based on ability, not age (p. 595). We applaud bids to focus on aging at the level of society. Nevertheless, SA 2.0 both misses the point of focus on institutions and retains the biomedical reframing of both aging and old age as distinct problem categories that so many scholars have critiqued. SA 2.0 does those by continuing to overlook inequalities, including the power relations that categorize old people as a population in need of intervention, and the ageist call for old people to be more successful in the first place. It continues to neglect the ways that inequalities and the struggles intrinsic to them shape later life, popular conceptions of “aging per se,” and attempts to empower old people to find success.

Our analysis begins with a focus on social inequalities, as scholarship on such disparities undercuts the medicalization, naturalization, and mandates of personal responsibility built into SA and its revision. First, Rowe and Kahn’s (1987) concept “biological ageing per se” maintains

a *medicalization* of aging. Medicalization takes a social problem and reframes it in terms of pathology, posing as solutions medical care under the authority of physicians and therapists. When medicalized, old age as a social category becomes subject to professional-medical interventions, and thus discourses of healthy weight, blood pressure, avoidance of disease, and the like. The medicalization of old age turns a social grouping into an object of biomedical science and control, as well as other forms of scholarly advocacy (Estes & Binney, 1989).

Despite their bid to refocus on psychosocial factors, Rowe and Kahn seek to use lifestyle changes to counter a biological problem. In their terms, “biological aging per se” (1987, p. 144) exerts a distinct force on old age, with effects on everything from hearing and bone density to cognitive and behavioral function (p. 143). It serves as a precursor to pathology (p. 143), and requires modification of “usual aging” on the advice of medical authorities. In the terms of SA, the force of biological aging creates a situation where old people can enjoy more success in their aging only if they follow medical advice and fight the push toward pathology.

Medicalization tends to direct attention away from the basis of any social problem in social organization. In that respect, medicalization is a form of naturalization. We use *naturalization* to refer to the framing of problems that result from social processes as merely “the way things are.” Rowe and Kahn do this with their language of “aging alone,” “aging per se,” and “the aging process itself,” which they distinguish from “psychosocial factors” extrinsic to aging (1987, p. 143). This divide between the natural and the social frames social problems in natural terms, such that people plagued by them are left to themselves and their personal decisions rather than joined in action to address them together. Some people see low wages and bad jobs, for example, to be “the way that the economy works” and therefore take the struggles of workers or their poverty to result from personal flaws. In terms of aging, we might hear that old people are dependent or “burdensome” because they collect nationalized pensions, or, that so much is spent on care in old age that we should ration it. Naturalizing their outcomes, people take the welfare state and its work and health policies for granted as “that’s the way it is” and ignore the age-based inequities.

Naturalization often leads to individual-level mandates for the problems that ensue from the naturalized social relations. Anti-aging advocates tout exercise regimens, wrinkle-smoothing, or other habits and technologies as ways to forestall the exclusions that result from age relations. This holds each person responsible for dealing with the problems that ensue from naturalized inequalities, with or without the aid of medical authorities. It holds us responsible for the success of our aging.

Our discussion of naturalized inequalities and their role in SA is twofold. First, we discuss ageism, as such discrimination underlies the need for SA and the medical and individual framing of old age and age relations. Second,

we consider how inequalities shape later life and people's ability to achieve SA as Rowe and Kahn define it.

Social Inequalities and Their Implications for SA

Social inequalities are group-based, unearned dis/advantages that accrue to categorical status such as man/woman, young/middle-aged/old, or upper/middle/working class rather than result merely from differences in personal discipline or value. Those inequalities structure in such *social institutions* as education, family, and so forth, the repeated, taken-for-granted behaviors through we achieve such social goals as production and reproduction. As a result, although discrepancies result from power relations among groups, they tend to remain naturalized and otherwise go unseen and unquestioned. As a result, people tend to explain most outcomes of such patterned inequalities in terms of medical science, biological destiny, and personal choice. For example, what middle-class parents do with their children—driving to soccer games, reading books, paying for music lessons—assumes time and money not afforded to parents in all classes. Yet, this approach goes unquestioned as “the right way to parent” and serves as a basis for excluding children who do not possess particular skills and lifestyles (Ishizuka, 2019).

Rowe and Kahn's (1998) focus on health behaviors and personal choice comes at the expense of analysis of inequalities, and thus undercuts their fight against ageism in at least two ways. First, the respective legitimacy of diverse lifestyles results from inequality, as those with privilege can designate their own as healthy and appropriate (Katz & Calasanti, 2015, p. 28). This is the creation of problems that need not be problems. As many scholars who object to SA have asked, whose lifestyle and patterns of aging have we deemed “successful?” Given that continued citizenship relies on being so judged, much is at stake in that designation.

Power plays a role, both through imposition of personal responsibility for subordinate status and for the *biomedicalization* that renders the results of inequality as a problem for medical authorities to define and manage (Estes & Binney, 1989). For instance, SA's emphasis on avoidance of disability rests in part on ableism (Molton & Yorkston, 2017) by maintaining a medical model of disability that ignores the inequality. That is, SA overlooks how physical or mental differences become *disparities* in particular contexts (Shakespeare, 2013), and thus naturalizes social relations of access and ability. By contrast, Garland-Thomson (2002, p. 5) points to the system of medical authority that constructs disabilities, devaluing bodies that do not approach whatever standards of health may apply in any time and place. She notes how any community or society can create privileges through environmental designs that constrain some people and ease the ways of others. People become disabled when they do not fit into spaces not designed for

them, and face discrimination as a result. By ignoring this system of inequality, SA reinforces and naturalizes able-bodiedness rooted in social relations (McRuer, 2013).

Ageism and Age Relations of Inequality

Second, SA and gerontological research often ignore old age as a position of disadvantage, regardless of life-course experiences. Butler's (1969, pp. 243–244) formulation of ageism likened it to stereotyping and discrimination based on skin color and gender, and rooted those in group competitions for resources, from incomes and wealth to residential space. Ageism thus involves more than attitudes and personal characteristics; it comprises exclusion of some groups by others, through policy and law as well as informal disposition. Like sexism and racism, the power relations that advantage or disadvantage age groups are embedded in social institutions, such that doing work, or family, in the naturalized ways we usually do them, exclude some groups.

This understanding is fundamental to the concept of *age relations*, which posits that age serves as a social organizing principle (Dannefer & Settersten, 2010) such that different age categories gain identities and power in relation to one another (Calasanti, 2003). One group, those deemed “old,” are devalued and lose authority, status, and income, while others gain (intentionally or not) by enjoying less competition for resources (Calasanti & Slevin, 2006). Widespread devaluation of old people includes a profitable anti-aging industry; indeed, the persistence of its name owes to the fact that old age is so disparaged that no one objects to the use of the term. We would not tolerate an “anti-woman” or “anti-youth” industry. Many of our institutions naturalize age inequality, deeming old people unfit for paid labor or positions of status, or unable to make decisions about their bodies or own welfare (Calasanti & Slevin, 2006).

From the standpoint of age relations, and central to the critique of SA, we cannot do away with ageism by urging the excluded group to work harder and take better care of themselves, as this leaves power relations intact. Such exhortation sustains both the naturalized status of the subordinate category, and maintains those who are “not old” as the normative standard for judging whom we designate “old” and exclude as such. To argue otherwise is analogous to saying, for instance, that racism would decrease if blacks behaved more like whites. Nobody calls for successful blackness or successful race, in large part because a conflict/civil-rights approach to race relations has become the consensus view among scholars for whom inequalities are central concerns.

How does SA depart from that scholarly path and maintain ageism even while addressing it? To clarify, we see ageism expressed in two forms. The *first, overt level of ageism* posits that old age is different from young(er) ages and that old people are not valuable because they differ from youth. An obvious example is the discourse of decline, to which Rowe and Kahn object, that depicts old age as a

time of unalterable decay, a time for giving up. However, a *second, deeper and often hidden form of ageism* holds by contrast that old age can look much like young(er) ages, and that old people can be acceptable to the extent that they act as younger people do. This deeper form of ageism may seem to be more positive, giving old people a way to be valued, that is, to be like younger people. But underlying this second form of ageism, no less than the first, is the belief that those who experience decline are different from younger adults and are thus not worthy.

According to critics, this is what SA implicitly advocates: that old people can minimize their difference from youth so long as they age successfully, or do not seem to age at all, but that *usual* aging remains a problem to be solved, one that results from personal choices in an ageist society (Calasanti, 2016; Holstein & Minkler, 2003; Strawbridge, Wallhagen, & Cohen, 2002). Unquestioned in SA is, what if an old person is *not* like middle-aged people? What if one is frail? Both forms of ageism naturalize age relations and treat many of the problems resulting from them as personal problems, ill conditions to eradicate or banish through personal discipline or medical treatment. The difference is that the deeper form of ageism regards most old people as capable of slowing the process of degradation far more than they usually do. The rhetoric of “you are only as old as you feel” or “75 years young” serves to protect *some* of those older than age 65 by placing the stigma of old age on those who can no longer age successfully. But it does not change the stigma and exclusion of old age itself, of those who *do* differ from young(er) adulthood.

Indeed, SA may exacerbate this deeper ageism. By urging an ideal of success based on age-related ideals of health and engagement, and by targeting an age group for that promotion, it aggravates the second, deeper ageism in its attempt to battle the first one. It advocates similarity to young(er) ages and implicitly blames a person for failure to achieve that by treating it as a matter of choice of lifestyle. A recent qualitative study (Calasanti, 2016) of middle-aged men and women found that their belief that SA was worth striving for, and their engagement in activities geared at reaching this goal, did not decrease their ageism or fears of what would happen when they were seen to be old. SA did not supplant the disease-and-decline rhetoric so much as work in tandem with it. Ageism was not confronted so much as redefined, and perhaps intensified by adding a work ethic and sense of personal blame for failure. By not challenging the age relations that give rise to ageism, and by placing the responsibility for SA on individuals, the SA framework sustains the deeper ageism.

Unequal Access

Inequalities not only structure the assumptions and goals of SA, they also shape barriers to and opportunities for achieving it. For instance, the persistent gender wage gap among full-time workers (e.g., Hegewisch &

Williams-Baron, 2018) owes not merely to personal choices but holds regardless of the education women obtain or jobs they work (AAUW, 2013, p. 10; Hegewisch & Williams-Baron, 2017). Furthermore, an intersectional analysis shows that white men receive the highest pay, men of color earn less, while white women's fare somewhat *better* than black men (Hegewisch & Williams-Baron, 2018). These disparities have many effects over the life course that are relevant to SA, including financial status in later life that in turn affects health, function, and even engagement. For example, because Social Security benefits are earnings-based, women's monthly benefits lag behind those of men, \$1,244 versus \$1,565, respectively (Social Security Administration, 2018). Employment and income also shape health and care. Racial and ethnic minority group members are likely to find unstable and low-waged employment, in conditions most deleterious to health and increase disability risk, while not providing incumbents the financial wherewithal to access health care (Brown, 2009; Williams, 2004). They are likely to enter old age in poorer health, able to afford fewer options for health care. Chronic stressors of gendered racism on black women raise risks of hypertension in later life (Richardson & Brown, 2016). Although Medicare provides access to doctors, out-of-pocket costs remain too high for those with low incomes; and old racial and ethnic group members receive less care than white people do (Williams, 2004; Zuckerman et al., 2008).

Subordinate status forecloses some avenues relevant to SA, but may open others. For instance, given the gender division of labor, women tend to be more engaged in kin-keeping and domestic labor that men are (Repetti & Calasanti, 2018) and this might enhance their engagement in old age. The extent to which such differences influence SA is an empirical question; the point here is that such patterns result from more than personal choice.

Inequalities in the Welfare State

Decades of scholarship by political economists have shown how power relations shape policies on income, health, and social services (Estes & DiCarlo, 2019; Kail, Quadagno, & Keene, 2009, p. 560). For instance, the availabilities of universal health care and state-funded childcare shapes gender relations, as people call upon women to do them. Changes to Medicare that speed release from medical care affect women most, as they assume caregiving duties (Glenn, 2010). Intersections of race, gender, sexuality, and class likewise shaped the U.S. Social Security Act of 1935, which covered (heterosexual) women's reproductive labor only to the extent that it reinforced gender inequities in family. Women's eligibility required marriage to a man, and limited benefits to half that of husbands. Occupations typical of racial and ethnic minority men and women were not covered (Poole, 2006). Thus, white women who were unmarried were excluded, as were women of color or working-class women either for not fitting the white, middle-class ideal or

for having married men who did not (Calasanti & Harrison, 2011). Sexual inequalities embedded in the state have meant that the longstanding inability of same-sex couples to marry limited both their income in later life and recognition of their family ties (Sandberg & Marshall, 2017).

Age relations also are embedded in the welfare state. Indeed, political economists argue that old-age dependence itself results from social policies based on such statuses as age and gender (Phillipson, 1982; Walker, 2009). Today, old people find themselves depicted as a “burden” or a “silver tsunami” whose increased numbers will overpower national budgets (Binstock, 2010; Sandberg & Marshall, 2017), and thus welfare-state retrenchment often targets them, particularly in relation to pensions (Walker, 2009). These depictions of old people rest upon such “objective” measures as dependency ratios, despite the general lack of demonstration of actual dependence (Calasanti, 2020; Walker, 2009). Study of such ratios across a century, including projections to 2040 (when all baby boomers will have reached full retirement age), shows that the highest total dependency occurred in 1965, when this boomer cohort were children. No discussion of spending cuts for children occurred then, even though a child under age 10 is far more likely to be dependent upon others than is a person aged 66–76. Pundits never constructed the nation’s children as burdens to be lifted (Calasanti, 2003, 2020).

In sum, social inequalities shape state-level struggles, which both distinguish old people as a group in need of intervention and maintain disparities in access to resources such as health care. All of this influences SA and is not reducible to personal choice. These life-course cumulative disadvantages increase in later life (Dannefer, 2003), their impacts heightened by their intersection with age relations as the example of welfare-state burden makes clear. Based on intersecting inequalities, groups bring different resources to bear on resistance to the outcomes of age relations. Ignoring inequalities allows us to cast blame to persons and fails to challenge the social forces that both constrain them and shape our judgments of success.

The Failure of Successful Aging 2.0

The extent to which Rowe and Kahn (2015) intend SA 2.0 to address such critiques remains unclear. Though they re-focus on social factors, their treatment of these, and their arguments concerning future directions, often remain situated at the individual level and do not address inequalities, particularly the age relations that produce ageism. SA 2.0 continues to foreground personal responsibility and overlook the ways that social inequalities shape both later life and our attempts to help old people succeed.

First, SA 2.0 maintains an emphasis on personal attributes by avoiding discussion of the inequalities and political economy that give rise to ageism. Rowe and Kahn’s mentions of social factors “include *personal characteristics such as race, gender, sexual orientation, and socioeconomic*

status” as well as “more distant but powerful macrosocial influences, such as economic conditions, access to high-quality affordable health care, public transportation, and urban design” (2015, p. 594). Gender, race and the like remain “personal characteristics,” not social locations within systemic power relations. Rowe and Kahn do not consider the ways that inequalities are embedded in “macrosocial influences” that reflect power struggles within the welfare state. This becomes clearer when they outline what they believe are the “three main goals for scholars: re-engineering core societal institutions, adopting a life course perspective, and focusing on human capital” (p. 594).

Beginning with *reengineering core societal institutions*, we find that Rowe and Kahn write of the need to alter schools and workplaces, in relation to population aging. Their recognition that such changes are necessary is well-taken, and an important addition to SA. However, their treatment of major inequalities as matters of “personal characteristics” both suggests a confusion about how such institutions sustain inequalities and undercuts their argument. Rather than attend to age inequality, Rowe and Kahn focus on impending intergenerational tensions, warning of conflicts “between generations fighting over increasingly scarce resources amid burgeoning entitlement demands” (p. 595). Such prognostications do not challenge the implicit apocalyptic demography and the depiction of elders as a “silver tsunami.” They also ignore the fact that, despite predictions of intergenerational conflict, and of a “race/age war” that pits the welfare of poor children of minority groups against elders that emerged in the 1980s, neither have come to pass (Binstock, 2010; Minkler & Robertson, 1991). SA 2.0 challenges neither the age relations that underlie these depictions nor the assumption that improving the situation of one group detracts from the condition of another. Rowe and Kahn indulge in a popular overstatement of generational conflict. National pensions, including Social Security, continue to be popular among the majority, despite population aging, economic fluctuations (Quadagno & Pederson, 2012; Walker, 2009), and ageism. Whether and how the mere facts of population aging and cohort sizes require reengineering of institutions remain open questions and require an understanding of critical social factors.

Confusion about the nature of social inequalities also appears when Rowe and Kahn (2015: 595) turn to the importance of *adopting a life course perspective*

that includes the redistribution of life’s major activities (e.g., education, work, childrearing, leisure, and retirement) across the entire life span. Currently, our youth is spent in education, our midlife too often dedicated completely to work, and our later life to “leisure,” which too often is a roleless role, lacking in meaningful engagement.

Several questions arise. First, to whose life course do they refer? The notion of linear progress from education, to work, to retirement does not reflect the lives of many

members of racial and ethnic minority groups, sexual minorities, the working class, or women. The SA model takes much about the life course for granted, including heterosexual coupledness and reproduction (Sandberg & Marshall, 2017). Their assertion also ignores research on shifts in work and retirement. For instance, scholarship on globalization and neoliberalism shows how economic changes have destabilized both the institutions of retirement and the welfare state, and that the increased risks of insecure employment and the decrease in protections for workers reshape old age. Inequalities intersect to distribute such risks (Phillipson, 2009; Walker, 2009). One example: structurally unemployed middle-aged workers face poor prospects of reemployment and thus experience long-term reduction of earnings (Johnson, 2009), an ageist situation made all the more difficult for women (McMullin & Berger, 2006). Such conditions do not result from personal choice of disengagement. The linear trajectory described by Rowe and Kahn represents a minority, in which white, well-heeled, heterosexual men are overrepresented.

Second, ageism remains embedded in the assumption that old people are “lacking in meaningful engagement” (Rowe & Kahn 2015, p. 595). Aside from the problems in assessing what counts as such engagement (and for whom), Rowe and Kahn overlook data on the extensive paid and unpaid labor that elders do, and how this is shaped by inequalities. Many elders are employed, reflecting a long-term trend of rising labor force participation rates since the 1990s (***Federal Interagency Forum on Aging-Related Statistics, 2016). In 2014, 19% (23% of men, 15% of women) of those aged 65 and older were employed; this rate is expected to increase to 22% (23% of men, 18% of women) by 2024. Among those aged 75 and older, 14% of men and 8% of women will be employed (Bureau of Labor Statistics, 2015). This increase owes mainly to financial concerns rather than to desire to age successfully; and nearly twice as many women than men report working to meet economic need (25% vs 12%; Kochhar & Morin, 2009, reported in Sayer, Freedman, & Bianchi, 2015).

Likewise, elders engage in a range of unpaid labor for families, communities, and organizations; and inequalities shape the amounts and types of such work. For instance, women report very different retirement experiences than men do as they maintain their domestic and other reproductive duties (Repetti & Calasanti, 2018; Barnes & Parry, 2004). Women continue to spend more time than do men on household labor (about 30 hr a week vs 20 hr for men); and men continue to enjoy more leisure time than do women (Bureau of Labor Statistics, 2009; Sayer et al., 2015). Grandparents—overwhelmingly grandmothers—are pressed into childcare when mothers need to work and formal childcare is not available (Di Gessa, Glaser, Price, Ribe, & Tinker, 2016). At the community level in the United States, in 2013, those aged 65 and older log the greatest amount of time in volunteer work, with a median of 86 hr per year; a full 10% report 500 or more hours per year

(Bureau of Labor Statistics, 2014). State policies mandate such labor by retracting welfare state supports for all age groups and communities, which requires that all people—especially women—take on more unpaid work.

Neglecting these disparities, Rowe and Kahn (2015) assert that “the life course perspective urges the identification of opportunities for creating new roles and responsibilities for older adults. The result could be gains for all generations rather than competition among them” (p. 595). Again, questions arise: Whose life? Which roles and responsibilities? Who has “leisure” in retirement/old age? This assertion reinforces ageism, by implying that elders do not contribute unless they labor and also by using the rhetoric of intergenerational conflict despite empirical evidence that contradicts both these premises. Finally, Rowe and Kahn assert that, “A society-wide discourse on these issues also may have the benefit of stimulating people to view their own place in the life course more critically and use a full life span strategy for allocating their activities and commitments as they move through the years” (p. 595). The discourse remains focused on personal choice, implying that subsequent actions are not notably constrained; that people face comparable opportunities over their lives; and that they need mainly to be urged to contribute in particular ways.

These problems reemerge in the brief discussion of Rowe and Kahn’s third goal, advocating more *focus on human capital*. Here, they exhort societies to take more advantage of the “unimagined numbers of older people” who could contribute (p. 595). Their recognition of ageist exclusion and their encouragement of developing norms about productivity less based on chronological age than on abilities are laudable. However, as discussed above, their admonition takes no account of the unpaid work already performed by elders, nor does it acknowledge that intersecting inequalities influence the ways that human capital translates into labor market placement. Beyond this, however, their approach retains the underlying equation of “productivity” and abilities with value. This deeper ageism encourages elders to emulate the economic activities of younger age groups; old people are worthy to the extent that they do not differ appreciably from those who are not old. Rowe and Kahn are diligent in countering the ageist myth that old people cannot work, but, they maintain the deeper ageist presumption that old people must work to be valuable.

Rowe and Kahn (2015, p. 595) close by urging that we view challenges to their model as recommendations for more work on SA, and that “understand[ing] the complex relationship between aging at the societal and individual levels is perhaps the greatest gerontological challenge of our time.” Nevertheless, despite reference to the social realm, SA 2.0 retains problems built into the original. It takes an important step in urging that we reckon with such institutions as education and the workplace. However, by leaving the inequalities that structure those institutions

unexamined, while maintaining its call to personal responsibility, SA 2.0 ends up reinforcing them.

Discussion: Normalizing Old Ages

We appreciate Rowe & Kahn's efforts to combat ageism, and, in SA 2.0, to acknowledge the importance of social factors. Their 2015 essay is brief, and meant to stimulate further research. That said, our critique is not one of nuance that might be answered with elaboration of their points or more research, but of embedded assumptions about social inequalities, and particularly age relations. The answer is not one of tweaking SA or studying it further, but of uprooting these assumptions altogether.

Where do we go from here? That so many gerontologists have joined in this effort to manage and discipline a marginal group speaks to pervasiveness of the ageism that links old age to disease and dysfunction. To the extent that we try to imbue it with value by holding up some models of aging as better than others, we privilege the views and lives of younger groups as less prone to problems by virtue of age, less subject to management, and less targeted for intervention. Medicalization, which tries to solve the problematic status of old age by recasting it as amenable to medical intervention, adds to ageism by naturalizing the status and activities of younger groups as healthy. Naturalization reifies the outcomes of social relations of age, as well as their intersections with other inequalities.

We can do more than discard SA. The issues we raise go beyond this program, and so we call for a paradigm shift within gerontology, one that more closely aligns us with the realities of contemporary old age and the inequalities that helped to make it an object of study and policy in the first place. This entails both avoiding ageism and valuing old age as an equally worthy time of life; acknowledging different ways of being old, and different *old ages*; and neither disparaging the usual ways of aging, nor focusing on aging itself as an object for professional intervention.

We urge instead that gerontology refocus on *age relations* as the cause of much of what burdens old age. With an eye on the inequalities that target old age for measurement and management in the first place, we can avoid the evaluative scrutiny that prescribes particular forms of engagement, for instance, for the sake of quality of life in old age.

This paradigm shift would not demand that we ignore the research findings that SA and similar frameworks have generated, which we can view from new angles and use in many ways. It does mean that we use research on measures of health, function, and indicators of engagement with caution and resist the urge to treat those as revealing essential truths of age. For instance, theories of disease and function can incorporate intersecting inequalities over the life course, including their cumulative nature (Richardson & Brown, 2016). Focus on such measures and avoidance of medicalization of the outcomes of social arrangements

will allow us to avoid both ableism (Molton & Yorkston, 2017) and ageism, and negative judgments that might accrue to particular findings. Further, those keen to examine health or engagement can denote this without reference to "successful aging." The rhetorical link between aging and disease or health is part of the problem; research can proceed without it.

To these ends, we propose three guiding principles for a new paradigm that avoids ageism while speaking to diverse groups of elders:

1. Avoid spurious correlations of problems with the categorical status of old age.

Many problems associated with old age are not unique to it and should not be tied to it. Our new paradigm would treat the hidden and more insidious form of ageism as a central concern and ensure that research avoids bolstering it. It would cleave more closely to Butler's (1969) analogy of age to gender and race, and address both the overt ageism about which Rowe and Kahn are rightfully concerned, and the deeper one that celebrates old people only when they act like young ones. The goal is to *normalize old ages*, to lighten the burden of managerial attention on them, rather than treat old age as a problem to be solved. This paradigm reserves our use of "old" to indicate the disadvantaged social location, and avoids tying it to pathology.

In that sense, and in reference to feminist scholarship, *old age* is to *gender* what "*biological aging per se*" is to *sex*. In each field of study, the latter term results from a naturalization, in terms of biological or physiological science, of the outcome of a social inequality. We urge doing this only with restraint. The term Successful Aging and its marketing as a form of gerontology focus on usual aging *as a problem*. Our position emulates that of feminist scholars of sex and gender, who have urged over the last two decades that we drop our focus on "sex" as biology distinguishable from culture. In line with that scientific critique,¹ we urge that gerontologists more closely follow Rowe and Kahn's initial insight, that most of the problems faced in old age are not "age-intrinsic" or owing to "biological aging per se" (1987, p. 144).

We urge greater care with imputations to biology for two reasons. First, as Rowe and Kahn (1987) observe, and as Ferraro (2018) echoes in his discussion of the causal effects of aging, those effects may not be very strong and are not as determinative as many fear. Second, as feminist scholars of sex point out, we have few ways to observe or measure the effects of biology as distinct from those

¹Springer and colleagues (2012, p. 1818) "avoid the use of the term sex (read: 'sex-not-gender') as a standalone indicator of biology, or as a broad reference to males and females (as in 'sex differences') because it is rarely specific enough to guide particular investigations, and because it is too easily confused with the more accurate composite phenomenon of sex/gender that we use here."

of social structure, such that the best scientific practice is to avoid a term such as “sex” when we mean it that way (Fausto-Sterling, 2005, p. 1516; Springer, Mager Stellman, & Jordan-Young, 2012, p. 1818).

Like many critical gerontologists, we use “old” to designate a social location instead, one of exclusion, of stigma for visible signs of that categorical membership. We discourage uses of the term *aging*, as in SA, that treat the categorical status “old” as an outcome of “aging per se” understood in biological terms. If we are going to focus on old people as a distinct group, as gerontology does by definition, then we serve them best by treating their social location as one of disadvantage within age relations and avoid treating that disadvantage as result of biomedical conditions or pathology that require our management.

We regard these as practical matters, ones bearing literally on life and death. Marking out old age per se as an overarching medical problem contributes to *ageism*, the categorization and naturalization of such other problems as matters of old age. Cancer, incontinence, use of wheelchairs, sepsis, falls, dementia, and death are either inevitable hardships, treatable as distinct threats to health, or amenable to changes of routine. Use of age (as in “usual aging”) as a proxy for risk of such challenges and conditions is common but does not take advantage of the best science and most critical gerontology. It can lead to undertreatment by physicians who regard old age as the most salient disease. At the same time, it can lead to a form of statistical discrimination (Bielby & Baron, 1986), wherein “old” becomes a master status and a person’s treatment begins on the basis of age-based averages rather than on information that could be acquired with greater accuracy. Both situations can result in neglect of treatable conditions, and to overtreatment of aging itself via anti-aging regimens.

2. Focus directly on age relations and on their intersections with other inequalities.

Problems that *are* particular to old age result from age relations. Age exclusion, elder poverty, ageist stigma, for example, can vary with changes in labor markets, household organization, medical care, and retirement policies. Gerontology should address these as matters of age relations rather than with medical interventions or as subject to personal discipline. To do otherwise assumes the force of biology, medicine, and the individual as deterministic in a realm where relations of inequality have obvious effects.

We advocate research on disparate groups of elders, to uncover their needs and desires, the barriers to and opportunities for achieving these, and appropriate interventions. We would bring our knowledge to bear without presupposing what aging per se does to shape those, or prescribe what aging should look like for different groups. Inequalities become central to the gerontological enterprise as we acknowledge the tremendous diversity of people and thus of elders. Often, this entails study of intersections of age with other inequalities, such that, for example, poor old

people of color become targets of fiscal austerity policies, scorned as “dependents”; or unpaid carework goes even more devalued when performed by old spousal or partner caregivers, especially old women. We can study the differential policy treatment of disabled people, wherein old people face exclusion from programs that benefit younger disabled people (Jönson & Larsson, 2009).

3. Value old age.

Much of what marks old age as a problem, from wrinkles to the end of strenuous activity, need not be problems at all. A new paradigm would challenge the construction of such aspects of aging as problematic by confronting ageism and shifting age relations. We can value old age as a worthwhile time of life, not merely to the extent that we fight disease and disengagement but also as our growth into old age is shaped by social relations of inequality. Our proposed paradigm eschews any universal model for an ideal old age, just as we would reject models for ideal womanhood or for being healthy people of color in a racist society. We can celebrate many ways of aging, from full-time engagement to senescence and disability, including dementia (Sandberg & Marshall, 2017). To counter discourses of both intrinsic decline and anti-aging’s valorization of youth requires valuing old age no less than we honor other times of life. Incontinence in a 1 year-old does not lead to designations of failure; it need not in those who are old either. We can stop trying to make “old” palatable by promoting proximity to (apparent) youthfulness of earlier years. We can use the word *old* itself for all elders, and not only to refer to those unable to pass for younger. On a policy level, programs that provide for health and social services for all draw less stigma. Therefore, we can advocate for social insurance programs that address all age groups, rather than distinguish any for diagnoses and cures, such as universal health care rather than Medicare.

Toward these ends, and under a different rubric, social gerontology can pursue research agenda that include, for example, studies of the following:

- particular medical conditions, as they affect people in all sides of power relations.
- the effects of disciplinary, motivational, personal-choice programs on the internalized ageism of diverse groups
- the effects of inequalities on conceptions of success and well-being
- disparities in access to work, care, housing, authority, and other resources and opportunities
- rhetorics, including stigma, that groups use to justify the disparities listed above
- use of the state to defend or advantage some groups over others, such as congressional debates over pension and social insurance programs swamped by a “silver tsunami,” and other apocalyptic demography
- the role of the state and interest groups that lobby it, to undervalue care work, underpay care workers, and keep the labor scarce

- the traffic in labor from the global South to meet caregiving needs in the global North

Other scholars, particularly critical gerontologists, have proposed refinements of gerontology aimed to combat ageism. The spirit of Estes and DiCarlo's (2019) notion of an "emancipatory gerontology" that attends to many intersecting inequalities certainly is in sync with our argument. It reminds us of the many inequalities that intersect with age and of the role of a welfare state in mitigating damage done by retirement policies. Likewise, Ferraro's (2018) call for greater attention to diversity in aging complements our critique, as does his admonition to attend to and fight ageism. Our contribution is to go beyond the promotion of more diverse and positive images of old people, and revival of the welfare state, and add a critique of the age relations at the heart of ageism. We also focus on the age relations that underlie so much contemporary gerontology, in addition to the intersection of other inequalities in old age.

In sum, SA 2.0 does not address the most compelling critiques of the earlier version and, given the ageism implicit in the framework, cannot. We urge a change in paradigms, and a focus on age relations. We combat ageism by avoiding the naturalization of age-based decline and by imbuing all modes of aging with worth rather than treat them as problems for gerontologists to help solve. Gerontologists can explore structures that facilitate or hinder ageism, without subjecting aging per se to medical or other disciplinary authority. We can imbue dignity to old lives, no matter how defined by intersecting inequalities; and our research and practice can illuminate and aid in those struggles.

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Conflict of Interest

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References

- AAUW. (2013). The simple truth about the gender pay gap. Retrieved from <http://www.aauw.org/files/2013/03/The-Simple-Truth-Fall-2013.pdf>
- Barnes, H., & Parry, J. (2004). Renegotiating identity and relationships: Men and women's adjustments to retirement. *Ageing and Society*, 24(2), 213–233. doi:10.1017/S0144686X0300148X
- Bielby, W. T., & Baron, J. N. (1986). Men and women at work: Sex segregation and statistical discrimination. *American Journal of Sociology*, 91(4), 759–799. doi:10.1086/228350
- Binstock, R. H. (2010). From compassionate ageism to intergenerational conflict? *The Gerontologist*, 50(5), 574–585. doi:10.1093/geront/gnq056
- Brown, E. (2009). Work, retirement, race, and health disparities. In T. C. Antonucci & J. S. Jackson (Eds.), *Annual review of gerontology and geriatrics (life-course perspectives on late-life health inequalities)* (Vol. 29, pp. 233–249). New York: Springer.
- Bureau of Labor Statistics. (2009). Hours spent doing unpaid household work by age and sex, 2003–07. *The Economics Daily*. Published August 6, 2009. Retrieved from https://www.bls.gov/opub/ted/2009/ted_20090806.htm
- Bureau of Labor Statistics. (2014). Volunteering in the United States. Retrieved from https://www.bls.gov/news.release/archives/volun_02252014.htm
- Bureau of Labor Statistics. (2015). Civilian labor force participation rate by age, gender race, and ethnicity. Retrieved from https://www.bls.gov/emp/ep_table_303.htm
- Butler, R. N. (1969). Age-ism: Another form of bigotry. *The Gerontologist*, 9(4 Part 1), 243–246. doi:10.1093/geront/9.4_Part_1.243
- Calasanti, T. M. (2003). Theorizing age relations. In S. Biggs, A. Lowenstein, & J. Hendricks (Eds.), *The need for theory: Critical approaches to social gerontology for the 21st century* (pp. 199–218). Amityville, NY: Baywood.
- Calasanti, T. M. (2013). The continuing struggle for old-age security. In R. E. Ray & T. M. Calasanti (Eds.), *Nobody's burden: Lessons from the Great Depression on the struggle for old-age security* (pp. 291–316). New York: Lexington Books.
- Calasanti, T. M. (2016). Combating ageism: How successful is successful aging? *The Gerontologist*, 56(6), 1093–1101. doi:10.1093/geront/gnv076
- Calasanti, T. M. (2020). Brown Slime, the Silver Tsunami, and Apocalyptic Demography: The importance of ageism and age relations. *Social Currents*. doi:10.1177/2329496520912736
- Calasanti, T. & Harrison, J. (2011). Race, class, gender, and the social construction of "Deservingness". In R. Ray & T. Calasanti (Eds.), *Nobody's burden: Lessons on old age from the great depression* (pp. 223–243). NY: Lexington Books.
- Calasanti, T. M., & Slevin, K. F. (2006). Introduction: Age matters. In *Age matters: Realigning feminist thinking* (pp. 1–17). New York: Routledge.
- Dannefer, D. (2003). Cumulative advantage/disadvantage and the life course: Cross-fertilizing age and social science theory. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 58, S327–S337. doi:10.1093/geronb/58.6.s327
- Dannefer, D., & Settersten, R. A. (2010). The study of the life course: Implications for social gerontology. In *The SAGE handbook of social gerontology*, (pp. 3–19). Newbury Park, CA: Sage.
- Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *The American Journal of Geriatric Psychiatry*, 14(1), 6–20. doi:10.1097/01.JGP.0000192501.03069.bc
- Di Gessa, G., Glaser, K., Price, D., Ribe, E., & Tinker, A. (2016). What drives national differences in intensive grandparental childcare in Europe? *The Journals of Gerontology, Series B: Psychological*

- Sciences and Social Sciences*, 71, 141–153. doi:[10.1093/geronb/gbv007](https://doi.org/10.1093/geronb/gbv007)
- Estes, C. L., & Binney, E. A. (1989). The biomedicalization of aging: Dangers and dilemmas. *The Gerontologist*, 29, 587–596. doi:[10.1093/geront/29.5.587](https://doi.org/10.1093/geront/29.5.587)
- Estes, C. L., & DiCarlo, N. B. (2019). *Aging A–Z: Concepts toward emancipatory gerontology*. New York, NY: Routledge.
- Fausto-Sterling, A. (2005). The Bare bones of sex: Part 1—Sex and gender. *Signs: Journal of Women in Culture and Society*, 30(2), 1491–1527. doi:[10.1086/424932](https://doi.org/10.1086/424932)
- Federal Interagency Forum on Aging-Related Statistics. (2016). *Older Americans 2016: Key indicators of well-being*. Washington, DC: U.S. Government Printing Office. Retrieved from <https://agingstats.gov/docs/LatestReport/Older-Americans-2016-Key-Indicators-of-WellBeing.pdf>
- Ferraro, K. F. (2018). *The gerontological imagination: An integrative paradigm of aging*. Oxford University Press.
- Garland-Thomson, R. (2002). Integrating disability, transforming feminist theory. *NWSA Journal*, 14(3), 1–32. Retrieved from <http://ezproxy.lib.vt.edu:8080/login?url=http://search.proquest.com/docview/233237596?accountid=14826>
- Glenn, E. N. (2010). *Forced to care: Coercion and caregiving in America*. Cambridge, MA: Harvard University Press.
- Havighurst, R. J. (1961). Successful aging. *The Gerontologist*, 1(1), 8–13. doi:[10.1093/geront/1.1.8](https://doi.org/10.1093/geront/1.1.8)
- Hegewisch, A., & Williams-Baron, E. (2017). *The gender wage gap by occupation 2016 and by race and ethnicity*. Pay Equity & Discrimination. Retrieved from <https://iwpr.org/publications/gender-wage-gap-occupation-2016-race-ethnicity/>
- Hegewisch, A., & Williams-Baron, E. (2018). *The gender wage gap by occupation 2017 and by race and ethnicity*. Pay Equity & Discrimination. Retrieved from <https://iwpr.org/publications/gender-wage-gap-occupation-2017-race-ethnicity/>
- Holstein, M. B., & Minkler, M. (2003). Self, society, and the “new gerontology”. *The Gerontologist*, 43, 787–796. doi:[10.1093/geront/43.6.787](https://doi.org/10.1093/geront/43.6.787)
- Ishizuka, P. (2019). Social class, gender, and contemporary parenting standards in the United States: Evidence from a National Survey Experiment. *Social Forces*, 98(1), 31–58. doi:[10.1093/sf/soy107](https://doi.org/10.1093/sf/soy107)
- Johnson, R. W. (2009). The recession’s impact on older workers. *Public Policy & Aging Report*, 19(3), 1–31. doi:[10.1093/ppar/19.3.1](https://doi.org/10.1093/ppar/19.3.1)
- Jönson, H., & Larsson, A. T. (2009). The exclusion of older people in disability activism and policies —A case of inadvertent ageism? *Journal of Aging Studies*, 23(1), 69–77. doi:[10.1016/j.jaging.2007.09.001](https://doi.org/10.1016/j.jaging.2007.09.001)
- Kail, B. L., Quadagno, J., & Keene, J. R. (2009). The political economy perspective of aging. In M. Silverstein, V. L. Bengtson, M. Putnam, N. M. Putney, & D. Gans (Eds.), *Handbook of theories of aging*. New York: Springer.
- Katz, S., & Calasanti, T. (2015). Critical perspectives on successful aging: Does it “appeal more than it illuminates”? *The Gerontologist*, 55, 26–33. doi:[10.1093/geront/gnu027](https://doi.org/10.1093/geront/gnu027)
- Knight, T., & Ricciardelli, L. A. (2003). Successful aging: Perceptions of adults aged between 70 and 101 years. *The International Journal of Aging and Human Development*, 56(3), 223–245. doi:[10.2190/CG1A-4Y73-WEW8-44QY](https://doi.org/10.2190/CG1A-4Y73-WEW8-44QY)
- Kochhar, R., & Morin, R. (2009). Recession turns a graying office grayer. *Pew research center*. Retrieved from <https://www.pewresearch.org/2009/04/01/recession-turns-a-graying-office-grayer/>

- pewresearch.org/wp-content/uploads/sites/3/2010/10/americas-changing-workforce.pdf
- Martinson, M., & Berridge, C. (2015). Successful aging and its discontents: A systematic review of the social gerontology literature. *The Gerontologist*, 55, 58–69. doi:10.1093/geront/gnu037
- McMullin, J. A., & Berger, E. D. (2006). The case of unemployed older workers. In T. M. Calasanti & K. F. Slevin (Eds.), *Age matters: Realigning feminist thinking* (pp. 201–224). New York, NY: Routledge.
- McRuer, R. (2013). Compulsory able-bodiedness and queer/disabled existence. In L. J. Davis (Ed.), *The disability studies reader* (Vol. 4, pp. 369–378). New York: Routledge.
- Minkler, M., & Robertson, A. (1991). The ideology of ‘age/race wars’: Deconstructing a social problem. *Ageing and Society*, 11(1), 1–22. doi:10.1017/S0144686X00003809
- Molton, I. R., & Yorkston, K. M. (2017). Growing older with a physical disability: A special application of the successful aging paradigm. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 72, 290–299. doi:10.1093/geronb/gbw122
- Phelan, E. A., Anderson, L. A., Lacroix, A. Z., & Larson, E. B. (2004). Older adults’ views of “successful aging”—How do they compare with researchers’ definitions? *Journal of the American Geriatrics Society*, 52(2), 211–216. doi:10.1111/j.1532-5415.2004.52056.x
- Phillipson, C. (1982). *Capitalism and the construction of old age*. London: Macmillan.
- Phillipson, C. (2009). Reconstructing theories of aging: The impact of globalization on critical gerontology. In V. L. Bengtson (Ed.), *Handbook of theories of aging* (2nd ed., pp. 615–627). New York: Springer.
- Poole, M. (2006). *The segregated origins of social security: African Americans and the Welfare State*. Chapel Hill: University of North Carolina Press.
- Pruchno, R. (2015). Successful Aging: Contentious past, productive future. *The Gerontologist*, 55, 1–4. doi:10.1093/geront/gnv002
- Quadagno, J., & Pederson, J. (2012). Has support for social security declined? Attitudes toward the Public Pension Scheme in the USA, 2000 and 2010. *International Journal of Social Welfare*, 21(s1), S88–S100. doi:10.1111/j.1468-2397.2012.00877.x
- Repetti, M., & Calasanti, T. (2018). “Since I retired, I can take things as they come. For example, the laundry”: Gender, class and freedom in retirement in Switzerland. *Ageing and Society*, 38(8), 1556–1580. doi:10.1017/S0144686X17000174
- Richardson, L. J., & Brown, T. H. (2016). (En)gendering racial disparities in health trajectories: A life course and intersectional analysis. *SSM—Population Health*, 2, 425–435. doi:10.1016/j.ssmph.2016.04.011
- Rowe, J. W., & Kahn, R. L. (1987). Human aging: Usual and successful. *Science (New York, N.Y.)*, 237, 143–149. doi:10.1126/science.3299702
- Rowe, J. W., & Kahn, R. L. (1997). Successful aging. *The Gerontologist*, 37, 433–440. doi:10.1093/geront/37.4.433
- Rowe, J. W., & Kahn, R. L. (1998). *Successful aging*. New York: Pantheon Books.
- Rowe, J. W., & Kahn, R. L. (2015). Successful Aging 2.0: Conceptual Expansions for the 21st Century. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 70, 593–596. doi:10.1093/geronb/gbv025
- Sandberg, L. J., & Marshall, B. L. (2017). Queering aging futures. *Societies*, 7(3), 21. Retrieved from <https://www.mdpi.com/2075-4698/7/3/21>
- Sayer, L. C., Freedman, V. A., & Bianchi, S. M. (2015). Gender, time use, and aging. In *Handbook of aging and the social sciences* (pp. 163–180). Amsterdam, The Netherlands: Elsevier.
- Shakespeare, T. (2013). The social model of disability. In L. J. Davis (Ed.), *The disability studies reader* (4th ed., pp. 214–221). New York: Routledge.
- Social Security Administration. (2018). *Fast facts & figures about social security, 2018*. Washington, DC: U.S. Government Printing Office. Retrieved from https://www.ssa.gov/policy/docs/chartbooks/fast_facts/2018/fast_facts18.pdf
- Springer, K. W., Mager Stellman, J., & Jordan-Young, R. M. (2012). Beyond a catalogue of differences: A theoretical frame and good practice guidelines for researching sex/gender in human health. *Social Science & Medicine*, 74(11), 1817–1824. doi:10.1016/j.socscimed.2011.05.033
- Strawbridge, W. J., Wallhagen, M. I., & Cohen, R. D. (2002). Successful aging and well-being: Self-rated compared with Rowe and Kahn. *The Gerontologist*, 42, 727–733. doi:10.1093/geront/42.6.727
- Walker, A. (2009). Aging and social policy: Theorizing the social. In M. Silverstein, V. L. Bengtson, M. Putnam, N. M. Putney, & D. Gans (Eds.), *Handbook of theories of aging* (Second ed., Vol. 595–613). New York: Springer.
- Williams, D. R. (2004). Racism and health. In K. E. Whitfield (Ed.), *Closing the gap: Improving the health of minority elders in the new millennium* (pp. 69–79). Washington, DC: Gerontological Society of America.
- Zuckerman, I. H., Ryder, P. T., Simoni-Wastila, L., Shaffer, T., Sato, M., Zhao, L., & Stuart, B. (2008). Racial and ethnic disparities in the treatment of dementia among Medicare beneficiaries. *The Journals of Gerontology, Series B: Psychological Sciences and Social Sciences*, 63, S328–S333. doi:10.1093/geronb/63.5.s328