Aging Well: Theory to Practice

A Literature Review

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By

Lisa A. Slezak-Moser

Chair: Rachelle Reinisch, DMFT

Reader: Meg Whiston, PhD

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Abstract

Theories of aging have changed over the last 60 years. The perception of what is necessary for an older adult to age well has changed in conjunction with theories of aging. The purpose of this project is to explore past and current theories and perceptions on aging and the factors believed to help older individuals age well. Major theories on aging are reviewed for the purpose of identifying the components that influence the aging trajectory of older adults as well as the factors that are believed to lead to successful aging. Lifespan theories are reviewed for their capacity to affect the aging trajectory and aging success. Physical, cognitive, and emotional components affect the aging trajectory of older adults and their perception of subjective well-being. Aging is paradoxical because many older adults believe they are aging well in spite of the many negative influences on the older adult’s aging trajectory while others believe they are aging badly in spite of positive influences. Numerous factors are identified that, if addressed, can help older adults age more successfully. Potential interventions are also presented. Aging adults may suffer many losses, as well as physical and cognitive decline, and this can take a toll on mental health. Nevertheless, older adults continue to develop, and through understanding their lifespan trajectory, the impact of current losses, and the underlying causes for current mental health issues, older adults can increase their subjective well-being and age more successfully. Utilizing Individual Psychology techniques along with opportunities for creative expression can foster an increased sense of belonging, purpose, and social interest, which could improve subjective well-being.

**Keywords:** successful aging, subjective well-being, perceived control, aging paradox, Individual Psychology
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Dedication

This thesis is dedicated to my father, Lester Slezak, who lived his life to the fullest and aged well in spite of health issues, with vigor and great life satisfaction. It is also dedicated to my mother, Rheta Slezak, who has not aged well and continues to struggle with mental health issues. The different ways you aged inspired me to seek understanding of your individual trajectories with the hope that I would find ways to help older adults who also struggle to age successfully, find meaning, and life satisfaction.
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Aging Well: From Theory to Practice

The mental health of older adults is key to their well-being and successful aging, and this is becoming an increasingly important issue as a large segment of the population approaches older adulthood (Krajci, Vail, & Golden, 2019). Between 2006 and 2016, there was a 33% increase in those 65 years and older. This percentage represents an increase from 37.2 million to 49.2 million (Thomas et al., 2016). The population aged 85 and over is projected to increase by 129% from 6.4 million in 2016 to 14.6 million in 2040. The life expectancy of individuals reaching 65 years of age now includes an additional 20.6 years for women and an additional 18 years for males. Approximately 28% of noninstitutionalized older persons live alone, and almost half of women over age 75 live alone (Thomas et al., 2016). Thirty-five percent of individuals 65 or older have a disability; of the 35%, 23% have ambulatory difficulties, and 15% have difficulty living independently. According to the United States Census Bureau’s (2018) National Population Projections, people older than 65 are projected to outnumber children under 18 by 2030, and 1 out of 5 U.S. residents will be of retirement age. The trend in population growth of individuals 65 years and older will continue to rise from 15% to 24% by 2060 (United States Census Bureau, 2018).

Mental health is a significant concern among older adults. In the literature reviewed for this project, the aging population is faced with numerous losses that can have an impact on mental health: (a) decreasing physical health and functional ability, (b) decreasing cognitive ability, (c) decreasing autonomy, (d) loss of social networks and social engagement, (e) loss of loved ones, and (f) loss of purpose and self-esteem. While individuals can suffer these losses at any time of life, it is the cumulative effect and the inability to change factors (e.g., chronic disease) that have an impact on the life trajectory. Depression, for example, is often untreated
and undiagnosed (Conner et al., 2010). Approximately 15% of individuals aged 65 and older are clinically depressed, and this number is expected to double by 2030. This diagnosis is particularly significant for older individuals as “older adults with depression experience significant disability and impairment, including impaired quality of life, increased mortality, and poor health outcomes” (Conner et al., 2010, p. 2). In addition, suicide rates are highest among this older population. Given the rapid rise in the number of adults aged 65 and older, there is a need to understand the particular physical, cognitive, and emotional challenges faced by this population and to identify the factors and therapeutic interventions that can help this population age successfully.

**Psychosocial Development**

Erik Erikson (Erikson, 1998; Erikson, Erikson, & Kivnick, 1986) contributed to the understanding of the aging process through his theory of psychosocial development, which describes eight stages of personality development. Erikson’s work was an extension of Freud’s psychoanalytic theory. Erikson (1998) focused on the impact of socialization and environment on personality as influenced by the ego rather than the psychosexual influence originating with Freud’s id.

Similar to Freud’s theory, psychosocial development was based on the epigenetic principle whereby personality develops in a specific order, and each stage builds on the previous stage (Erikson, 1998). Unlike Freud’s theory, which described development ranging from infancy to adolescence, Erikson’s eight stages described infancy through adulthood. Foundational to Erikson’s theory was the notion that tensions or conflicts develop during each developmental stage. These conflicts must be successfully resolved in order for an individual to attain a healthy, balanced personality. Erikson described the character strengths that evolved
from, and are necessary for, resolution of each conflict. If an individual did not attain balance between the two sides of the conflict, such as the tendency toward trust or mistrust in infancy, and instead excessively adopted one tendency over the other, *maladaptive or malignant* tendencies could develop (Erikson et al., 1986).

Erikson presented his developmental stages in reverse chronological order and emphasized that an individual’s psychosocial growth could only be understood within the context of the development achieved in earlier stages (Erikson, 1998). Furthermore, unresolved conflicts from previous stages had the potential to be resolved during later stages, which suggests continued growth and the possibility of an individual achieving previously unattained balance while progressing through the life cycle (Erikson, 1998; Swope, 2016). Joan Erikson (Erikson, 1998) stated that the timing of human development varied so much that no specific age could be attached to any of the developmental stages beyond that imposed by societal norms and pressures. The ages associated below with each developmental stage are one author’s interpretation of Erikson’s stages (McLeod, 2017).

**Infancy: Basic Trust vs. Basic Mistrust**

Erikson’s first stage spans birth to 18 months (McLeod, 2017). The psychosocial conflict of the first stage is *basic trust vs. basic mistrust*. Infants are extremely vulnerable, use their senses to determine their needs, and rely on their primary caregiver for all aspects of care necessary to meet those needs. If this care is given on a consistent basis, and the infant can depend upon it, the infant develops trust and the hope he or she will be safe, secure, and supported by others. If the infant’s care is inconsistent and cannot be depended upon, the infant will become mistrustful, fearful, and will lack hope. This mistrust will be projected onto other individuals in the infant’s life. The *maladaptive* tendency developed during this stage results
when an infant becomes too trusting and no longer relies upon his or her senses to determine needs and limits. In later stages, the maladaptive tendency can lead to a lack of self-trust, self-esteem, and a dependence on the decision-making of others. In contrast, the malignant tendency, resulting from an inability to resolve mistrust, can lead to withdrawal, and in later stages, to a lack of participation or involvement in society. The adaptive strength developed during this stage is hope (Erikson et al., 1986).

**Early Childhood: Autonomy vs. Shame and Doubt**

A child between 18 months and 3 years (McLeod, 2017) begins to strive for autonomy and moves further from the primary caregiver (Erikson et al., 1986). In the second stage of development, *autonomy vs. shame and doubt*, the child attempts new skills and begins to make choices about behaviors such as feeding, dressing, and play. Parents who support their children in attempts at mastery and encourage them even if they initially fail, give children the opportunity for growth and independence. The child becomes confident in his or her abilities and is willing to explore further. Parents who constantly criticize their child’s attempts or who take over when impatient with lengthy attempts at mastery foster shame and doubt. The child will lack confidence and self-esteem and become hesitant and dependent (Erikson et al., 1986). *Will*, the ability to strive forward and try, is the adaptive strength developed in resolving the conflict between autonomy, shame, and doubt (Erikson et al., 1986). If the child adopts a maladaptive tendency, the child develops a shameful willfulness. If the child develops a malignant tendency, the tendency will be toward compulsion.

**Play Age: Initiative vs. Guilt**

From the age of 3 to 5 (McLeod, 2017), children continue to strive for mastery and independence (Erikson et al., 1986). Play becomes an important part of the child’s day, whether
at home or in school. Through social play, children begin to foster interpersonal skills and make attempts at leadership and initiating activities. If a child is successful in his or her attempts, the child will develop confidence in the ability to initiate and to lead. If the child is unsuccessful, he or she will lose the sense of initiative, become a follower, and may find it difficult to socially connect (Erikson et al., 1986).

According to Erikson (1998), a parent’s reaction to this growing initiative is important. Curiosity motivates children to test limits. Parents are confronted with increasing questions and the testing of boundaries. A parent who responds in a positive manner to the child’s nascent assertiveness can encourage initiative. Conversely, when parents overprotect or rebuke a child’s questions and initiatives, the child feels guilty for annoying the parents. Children project parental annoyance onto other relationships, which fosters a reluctance and lack of confidence in the ability to initiate engagement (Erikson et al., 1986). When the balance between initiative and guilt is successfully attained, the child develops the adaptive strength of purpose. An excess of initiative can develop into the maladaptive tendency of ruthlessness, and an excess of guilt can develop into the malignant tendency of inhibition (Erikson et al., 1986).

**School Age: Industriousness vs. Inferiority**

The school-age stage occurs between age 5 and 12 (McLeod, 2017). Children engage in increasingly difficult academic pursuits with expectations of growing academic competence and independence. Children face increasing demands for physical competence as demonstrated in sports and other physical pursuits. Heightened awareness of peer approval or disapproval, and the decreasing perceived importance of parents, increases the importance of peers. In order to meet the needs of this developmental stage, children industriously work to acquire the competence demanded by culture and society. Children also begin to establish an understanding
of social demands and strive to meet those social demands. An inability to master the requirements of society, academe, and physical demands can result in low self-esteem and a sense of inferiority (Erikson et al., 1986).

Successful resolution of the conflict between industry and inferiority leads to the adaptive strength of competence. Excessive industry can lead to the maladaptive tendency of narrow virtuosity. Excessive feelings of inferiority can foster hyper-competitiveness or lead to the malignant tendency of inertia (i.e., lack of movement; Erikson et al., 1986).

**Adolescence: Identity vs. Identity Confusion**

The adolescent stage occurs between age 12 and 18 (McLeod, 2017). Many changes occur during this period, in particular brain development and puberty. In the adolescent stage, the process of developing an individual identity occurs and answers the questions: Who am I, Where do I belong, Do I fit in, and What is my role in society? These questions are answered as children determine the values by which they will abide. Children evaluate the values of their parents, peers, their immediate environment, and the world-at-large. Children begin contemplating their futures, identifying potential careers, exploring romantic relationships, crafting new relationships with their parents, and establishing goals. This is also the time that children begin exploring their sexuality (Erikson et al., 1986).

During the adolescent stage, children try many different identities as they explore the numerous possibilities and options available to them (Erikson et al., 1986). Individual identity solidifies as choices are made. Identity confusion arises when children are unable to develop a sense of identity and remain unsure about who they are and how they fit in. The adaptive strength developed through resolution of the conflict between identity and role confusion is
fidelity, the ability to be loyal and accept others in spite of ideological differences (Erikson et al., 1986).

Extreme identity development can lead to the maladaptive tendency of fanaticism, or negative identity, described by Erikson (1998) as “a combination of socially unacceptable and yet stubbornly affirmed identity elements” (p. 73). The malignant tendency developed during this stage is that of role repudiation, which appears as either diffidence or as defiance (Erikson et al., 1986).

**Young Adulthood: Intimacy vs. Isolation**

Young adulthood spans 18–40 years (McLeod, 2017). Longer-term relationships develop as levels of intimacy increase. Psychological intimacy refers to deeply knowing another person and having a close, satisfying relationship. This relationship can be with a potential life-long partner, friend, co-worker, or family member. In addition, sexual intimacy occurs during this stage (Erikson et al., 1986).

An inability to find intimacy can lead to isolation, “a fear of remaining separate and unrecognized” (Erikson, 1998, p. 70). Resolution of the conflict between intimacy and isolation leads to the adaptive strength of love. The need for constant intimacy, often driven by a fear of isolation, can lead to the maladaptive tendency of promiscuity. Conversely, the malignant tendency during this stage is exclusivity, whereby only a narrow range of individuals is included within the sphere of relationships (Erikson et al., 1986). Exclusivity “can become vastly destructive – and self-destructive” (Erikson, 1998, p. 71).

**Adulthood: Generativity vs. Stagnation**

Adulthood ranges from ages 40-65 (McLeod, 2017). Generativity refers to the process of providing for, and nurturing, the next generation. This task is accomplished through a shift in
focus from self to others and through building a home and career. Contributions are made through community involvement, fostering positive development in children, and through work (Erikson et al., 1986). Alfred Adler described a similar concept, that of participation in the three tasks of life: love, friendship and community, and work (as cited in Oberst & Stewart, 2012). If an individual is unable to meet the objectives of generativity, stagnation results and involves self-absorption and little contribution to society. The adaptive strength fostered during the 7th stage is care. The maladaptive tendency evolving from excess of generativity is over-extension. The malignant tendency resulting from increased stagnation is rejectivity (i.e., unwillingness to care for certain individuals; Erikson et al., 1986).

Old Age: Integrity vs. Despair

Erikson’s last stage involved those who are greater than 65 years of age (McLeod, 2017). This stage typically involved retirement and a decrease in productivity. Erikson saw this stage as a time for reflection on one’s life, a coming to terms with successes and failures, and contemplation of opportunities both taken and missed. Satisfaction with one’s life leads to a feeling of integrity. Despair results when individuals feel a lack of accomplishment or sense of failure about the past. Balance between integrity and despair is obtained through the adaptive strength of wisdom. The maladaptive tendency of presumption results when the past is perceived as excessively (and unrealistically) successful. The malignant tendency of disdain results in an attempt to counter excessive feelings of despair, hopelessness, and depression (Erikson et al., 1986). Erikson later commented on his previous writings as he went through his 80s, indicating that “the outcome of stage eight …is not predetermined or foreclosed by the way life has been lived up to this point” (Erikson et al., 1986, p. 40); therefore, the eighth stage was not necessarily the last stage of development.
The Ninth Stage: Elders

Joan Erikson (Erikson, 1998) developed the extended version of the life cycle and added a ninth stage applicable to those 80 and older and referred to as elders. This new stage was needed due to the increase in longevity and the elder population’s confrontation with greater physical and cognitive demands, difficulties with daily activities, and the reevaluation of life (Brown & Lowis, 2003). The premise of the ninth stage was that elders once again experienced the *ego-syntonic* (i.e., acceptable to the ego; “Ego-syntonic,” n.d.) and the now predominate *ego-dystonic elements* (i.e., unacceptable to the ego, “Ego-dystonic,” n.d.) of earlier stages. For example, due to their changed life circumstances, elders might have more mistrust than trust or hope, greater shame and doubt than autonomy and will, and increasing isolation and discouragement (Erikson, 1998; Swope, 2016). Swope (2016) reflected that Joan Erikson focused primarily on despair as the primary element in the ninth stage, possibly due to her own circumstances. In spite of her negative perspective, Joan Erikson (Erikson, 1998) indicated if elders were able, in the ninth stage, to resolve the dystonic elements experienced during their lifetime, elders could move toward *geotranscendence*, a natural and individual process of maturity and wisdom with increased life satisfaction.

Subsequent research on the ninth stage has confirmed a more positive perspective of the elder stage of life, with “transcendence of the self, the rediscovery of joy, and continued psychological growth” (Swope, 2016, p. 31). The elder stage of life continues to be a time of psychological development and spiritual growth (Brown & Lowis, 2003). Swope (2016) confirmed an increase in geotranscendence in her review of literature on the ninth stage and suggested that the elements of vitality, enthusiasm, and appreciation were key to elder subjective
well-being. Additionally, the presence of Erikson’s generativity (Erikson, 1998), or caring for others, strongly predicted enjoyment of life in the elder population.

Theories of Aging

*To me, old age is always 15 years older than I am.*

– Bernard Baruch

Numerous definitions of successful aging have been postulated and revised as the research into aging has progressed over the last 60 years although no consensus on the definition of successful aging has yet been achieved (Kim & Park, 2017). Current perceptions of aging are based on numerous theories such as disengagement theory (Jent, 2004), activity theory (Havighurst, 1961), the influence of personality (Neugarten, 1972), selective optimism (Baltes, 1997), Rowe and Kahn’s (1987, 1997) theory of successful aging, socioemotional selectivity theory (Carstensen, 1995), preventive and corrective proactivity (Kahana, Kelley-Moore, & Kahana, 2012), the spectrum model of aging (Martin & Gillen, 2014), and the lifespan model of successful aging (Erikson, 1998).

**Cumming and William - Disengagement Theory**

Elaine Cumming and William E. Henry originally developed the disengagement theory in 1961, one of the earliest theories of successful aging (Jent, 2004; Johnson & Mutchler, 2013; Martin et al., 2015). *Disengagement* was defined as a natural process where social relationships, engagement with society, and activity were curtailed or altered as aging proceeded. Disengagement was viewed as a period of inevitable decline and loss of power (Baltes & Carstensen, 1996). Disengagement was perceived as a desired outcome prompted by declining skills and limited time remaining before death. Once disengaged, Cummings and Henry stated that the aged enjoyed “static, tranquil, somewhat self-centered lives, which suit them very well
and appear to provide smooth passage from a long life to an inevitable death” (as cited in Jent, 2004, p. 179); however, there were several weaknesses with the disengagement theory (Jent, 2004; Johnson & Mutchler, 2013). The examined population was not representative of the population at large (Jent, 2004). The results of several studies revealed that older adults were demoralized, although Cummings and Henry’s research indicated not all older adults are demoralized (Jent, 2004). Evidence of life satisfaction existed with continued engagement and activity into old age, which contradicted the belief that disengagement was the norm (Johnson & Mutchler, 2013). Further research revealed that the aged are not disengaging and preparing for death, but instead, they are continuously future oriented (Kim & Park, 2017).

**Havighurst - Activity Theory**

Activity theory contradicts the disengagement theory. Havighurst (1961) proposed that successful aging meant keeping active, replacing lost roles in society with new ones, and remaining socially engaged rather than disengaging from life (Baltes & Carstensen, 1996; Havighurst, 1961; Martin et al., 2015). Havighurst (1961) acknowledged that some disengagement took place with aging, but he argued this was a consequence of society withdrawing from those who were aging, often against the choice of the older adult (Havighurst, 1961; Jent, 2004). As summarized by Martin and Gillen (2014), Havighurst described four factors involved in successful aging:

1. A way of life that is socially desirable for this age group;

2. Maintenance of middle-age activity;

3. A feeling of satisfaction with one’s present status and activities; and

4. A feeling of happiness and satisfaction with one’s life. (p. 54)
In spite of advocating for the activity theory, Havighurst (1961) noted perhaps there was no single, all-encompassing definition of successful aging.

**Neugarten - Influence of Personality**

Bernice Neugarten continued the discussion on successful aging in 1972 by including the influence of personality (Johnson & Muetchler, 2013; Martin et al., 2015). Aspects of personality influence successful aging and include a person’s “coping style, prior ability to adapt, and expectations of life, as well as income, health, social interactions, freedoms, and constraints” (Martin et al., 2015, p. 17). Taking these influences into account, individuals’ aging processes can be predicted from their past. Neugarten incorporated aspects of a lifespan model regarding successful aging and viewed people as active rather than passive (as cited in Kelly, Martin, & Poon, 2012). Neugarten’s (1972) indicator of successful aging was an individual’s life satisfaction.

**Baltes and Baltes - Selective Optimization with Compensation**

Baltes and Baltes conceptualized successful aging as a life span process of minimizing losses and maximizing gains through selection, compensation, and optimization (Baltes, 1997; Freund, 2008; Johnson & Mutchler, 2013; Martin et al., 2015). Baltes and Baltes suggested that when faced with physical, social, or psychosocial losses, individuals adjust expectations and increase satisfaction and self-efficacy by focusing on their remaining strengths and remaining resources (Baltes & Carstensen, 1996; Johnson & Mutchler, 2013; Kahn, 2004; Martin et al., 2015). *Selection* involved narrowing goals or domains to what an individual could attain while giving up those goals that could no longer be attained. *Optimization* referred to optimizing resources that could aid in achieving goals to reach a higher level of functioning. *Compensation* referred to the process of acquiring new resources in order to compensate for those that have
been lost. The emphasis of the selective optimization with compensation model was based on what individuals could do to compensate or adjust for the losses incurred due to the aging process.

**Rowe and Kahn - Theory of Successful Aging**

The next major development in defining successful aging was Rowe and Kahn’s theory of successful aging. The theory of successful aging was initially developed in 1987, and then refined through work with the MacArthur Network on Successful Aging (Kahn, 2004; Rowe & Kahn, 1997). Rowe and Kahn first sought to differentiate usual aging from successful aging (Martin et al., 2015; Rowe & Kahn, 1987). *Usual aging* was perceived as an inevitable change or decline that most individuals endured solely due to increased age; however, Rowe and Kahn (1997) believed the concept of usual aging ignored the heterogeneity among the aging population and that the impact of aging could be affected by each individual’s lifestyle.

Rowe and Kahn (1997) subsequently expanded their theory with a multidimensional construct based on three factors: “low probability of disease and disease-related disability, high cognitive and physical functional capacity, and active engagement with life” (p. 433). Rowe and Kahn (1997) discussed risk factors for disease and disability, acknowledging that, while some risk factors involved heritability, many other risk factors were the result of an individual’s lifestyle and environment (Martin & Gillen, 2014; Martin et al., 2015; Rowe & Kahn, 1997). Predictors of sustained cognitive function included

- a higher level of education,
- a perceived self-efficacy,
- the level of strenuous activity, and
- pulmonary peak expiratory flow rate (Rowe & Kahn, 1997).
Predictors of sustained physical function included

- Socio-demographic and health status characteristics;
- Behavioral predictors, which included moderate or strenuous leisure activity; and
- Emotional support from friends and family (Rowe & Kahn, 1997).

Active engagement with life had two components: (a) maintenance of social relations and (b) productive activities (Rowe & Kahn, 1997). Rowe and Kahn (1997) stated it was the necessary interaction of all three factors (i.e., cognitive function, physical function, and active engagement) that enabled successful aging.

Criticism of Rowe and Kahn’s theory focused on several points. At the core of Rowe and Kahn’s theory was the concept that successful aging could be objectively measured with an emphasis on physical health and functioning (Rowe & Kahn, 1997); however, from an individual’s viewpoint, successful aging is a subjective evaluation (Strawbridge, Wallhagen, & Cohen, 2002). When Rowe and Kahn’s measures were applied to the population under review, only 18.8% were aging successfully. When subjective measures were also applied, 50.3% of the study’s respondents believed they were aging successfully. Using Rowe and Kahn’s measurement, most people age unsuccessfully (Peterson & Martin, 2015). Rowe and Kahn emphasized individual responsibility for aging well (e.g., exercise; Kahn, 2004; Rowe & Kahn, 1997). In other words, Rowe and Kahn implied that those who did not age well were responsible for that outcome (Stowe & Cooney, 2015). Rowe and Kahn did not take into account the impact of personality or mental health on successful aging (Peterson & Martin, 2015). Finally, Rowe and Kahn’s model of successful aging did not include the impact of positive spirituality, which research suggests holds an association with successful aging (Crowther, Parker, Achenbaum, Larimore, & Koenig, 2002).
**Socioemotional Selectivity Theory**

In socioemotional selectivity theory, Carstensen (1995) proposed affective well-being in old age could be fostered by focusing on future-related expectations within the constraints of older individuals’ perception of their remaining time. Carstensen, Isaacowitz, and Charles (1999) posited that older adults prioritize emotional and social goals for the purpose of optimizing immediate well-being, rather than prioritizing knowledge-related goals observed in younger adults where the goal or purpose is to optimize future resources. In comparison with their younger counterparts, older adults are more selective in their choices of social partners and make their social interactions more emotionally satisfying.

**Kahana and Kahana – Preventive and Corrective Proactivity**

Rowe and Kahn’s narrow, though widely accepted, definition of successful aging set a standard for success that could only be attained by a small segment of the aging population (Kahn, 2004; Martin et al., 2015; Rowe & Kahn, 1997). Kahana and Kahana (as cited in Kahana et al., 2012) developed the preventive and corrective proactivity model of successful aging that would be more inclusive of individuals faced with normative stressors of aging such as chronic ill health, functional limitations, and family or other social losses. The preventive and corrective proactivity model introduced the concept of proactive preventive and corrective measures that can be taken when individuals are faced with stressors related to their quality of life. The preventive and corrective proactivity model was “predicated on the view that older adults continue to set goals and engage in proactive efforts to attain those goals as a means of constructing their own lives and maintaining their identities” (Kahana, Kahana, & Kercher, 2003, p. 157). *Preventive adaptations* included health promotion, helping others, and planning ahead. *Corrective adaptations* included marshaling support, role substitution-engagement, and activity-
environmental modification (Kahana et al., 2003). Emerging adaptations were also described, including the use of technology, health care consumerism, and self-improvement (Kahana et al., 2003).

**Martin and Gillen – Spectrum Model of Aging**

Martin and Gillen (2014) sought to incorporate many of the earlier theories into a new interdisciplinary framework, the *spectrum model of aging*, which brought together objective and subjective influences on successful aging. Martin and Gillen (2014) hoped to enable the creation of interventions specific to an individual as life domains change. Martin and Gillen (2014) suggested the aging process could be viewed through four lenses, specifically, biological, social, spiritual, and psychological. The individual’s current life situation could be evaluated subjectively and objectively through one of these four lenses. Components of the subjective evaluation include examination of the individual’s happiness, well-being, self-rated health, resilience, life satisfaction, and faith. Objective components of the evaluation include factors such as age, gender, genetics, education, financial security, childhood influences, functional ability, and the presence of disease, residence, and relationships. Martin and Gillen (2014) postulated that this process enabled the development of individualized aging plans, which improve the prospect of successful aging.

**Erikson - Life Span Theory of Aging**

Erik Erikson contributed to the understanding of the aging process through his theory of psychosocial development, which described eight stages of personality development (Erikson, 1998; Erikson et al., 1986). The notion that tension or conflicts are developed during each developmental stage was the foundation of Erikson’s theory. These conflicts need to be
Successfully resolved in order for an individual to attain a healthy, balanced personality (Erikson, 1998).

Erikson’s eighth stage involved those who were greater than 65 years of age (Erikson, 1998). This stage typically involved retirement and a decrease in productivity. Erikson saw this stage as a time for reflection on one’s life, a coming to terms with successes and failures, and contemplation of opportunities both taken and missed. Satisfaction with one’s life led to a feeling of integrity. Despair resulted when individuals felt a lack of accomplishment or sense of failure about the past (Erikson, 1998).

It was during the eighth stage that the individual evaluated accomplishments. For instance, if individuals felt they had successfully lived their lives, they would have feelings of pride and contentment and would be considered successful in the aging process (Martin & Gillen, 2014). It should be noted that unresolved conflicts from previous stages had the potential to be resolved during later stages, which suggests continued growth and the possibility of achieving previously unattained balance. Balance between integrity and despair is obtained through the adaptive strength of wisdom (Erikson, 1998).

It is clear there is no consensus on the definition of successful aging as illustrated by the multidimensionality of the previously reviewed theories. Successful aging can be influenced by psychological, biological, cognitive, and personality factors, but successful aging also depends on the individual’s perception of his or her subjective well-being. Phelan, Anderson, LaCroix, and Larson (2004) confirmed this lack of consensus on the definition of successful aging when they compared aging individuals’ views of successful aging with the broad array of researchers’ definitions. Phelan et al. (2004) found successful aging included (a) two factors relating to physical health, (b) one factor relating to functioning, (c) eight factors relating to psychological
or mental health, (d) one factor relating to perceptions of autonomy, control, and coping, and (e) two factors relating to social health.

**Aging Well**

In the last two stages of the life cycle, specifically the young-old (ages 65-80) and the very-old (80 and older), individuals are confronted by the possibility of physical and/or cognitive decline, which potentially contributes to a decline in morale and well-being and fewer opportunities to affect control over various domains of life (Drewelies, Wagner, Tesch-Römer, Heckhausen, & Gerstorf, 2017). Nevertheless, the aged exhibit a greater sense of well-being than expected (referred to as the *paradox of aging*), and the paradox of aging is primarily attributed to the individual’s subjective well-being (Jeste & Oswald, 2014; Wettstein, Schilling, & Wahl, 2016). Understanding this paradox and the components that influence subjective well-being are key to understanding and fostering successful aging.

**The Paradox of Aging and Subjective Well-Being**

Subjective well-being has been variously described as life satisfaction, low negative affect, positive affect, a positive view toward aging, feeling happiness, experiencing personal growth, satisfying social relationships, and autonomy (Braun, Schmukle & Kunzmann, 2017; Kunzmann, Little, & Smith, 2000). Blanchflower and Oswald (2008) described the progression of well-being throughout the life cycle as a U-shaped curve. Subjective well-being remains (a) relatively stable throughout early stages of the life cycle, (b) decreases to reach its lowest point in middle age, and (c) rebounds in the aged population to approximately the same level as that found in the younger population. Numerous factors have been examined in an attempt to identify the causes or contributions to the paradox of aging and the stability of subjective well-being. For example, Kunzmann et al. (2000) examined the impact of functional health
constraints, the impact of positive affect (e.g., enthusiasm, pride, and interest), and the impact of negative affect (e.g., anger, anxiety, and distress) on the aging population. Carstensen (1995) examined the regulation of emotions, and George (2010) examined the discrepancies between aspirations and achievements. Other contributions to well-being include the use of social comparisons and the strategic investment of social and psychological resources such as those described by the selective optimization with compensation theory developed by Baltes and Carstensen (2003).

Pruchno, Wilson-Genderson, Rose, and Cartwright (2010) sought to determine how early influences and contemporary characteristics might influence successful aging. McAdams, Lucas and Donnellan (2012) evaluated the role of domain satisfaction in the paradox of aging well. McAdams et al. (2012) suggested overall life satisfaction does not decline, because while satisfaction in some domains of life (e.g., health) decrease with age, satisfaction in other domains (e.g., social life) increase with age.

Wettstein et al. (2016) evaluated the aging paradox by examining subjective versus objective health indicators. Subjective functioning was assessed based on subjective health, subjective vision, subjective movement ability, and the number of perceived symptoms. Objective functioning was assessed based on everyday competence, visual acuity, the chair stand test, and grip strength. The results demonstrated stability over time in subjective functioning. The objective measures revealed a statistically significant decline over a 5-year period, and only subjective functional mobility changed over time (i.e., a slight decline). Wisdom, both individual and societal, has also been linked to the paradox of aging and subjective well-being, with individual wisdom contributing to subjective well-being (Jeste & Oswald, 2014).

According to George (2010), over 50 variables have been examined as contributors to
subjective well-being and the paradox of aging. The factors affecting successful aging can be loosely categorized into the following categories: perceived control, physical, emotional, and social involvement. These factors are inter-related, often act in concert, act sequentially or in a feedback loop, and aid or detract from subjective well-being. For example, strategies for health promotion protect against functional limitations, which protects against depressive symptoms. Social support can increase or decrease self-efficacy and affect goal attainment, which affects primary and secondary control strategies (Infurna & Okun, 2015). Perceived control affects the physical and emotional status of aging individuals, and conversely, the physical and emotional status can affect the individual’s perceived control.

**Perceived Control**

Perceived control has been identified as a major mechanism whereby individuals throughout their lifespan are able to influence their life circumstances, and thus their subjective well-being (Infurna & Okun, 2015). The ability to influence one’s life is a fundamental component of successful aging, and as people reach the later stages of life and face new challenges, they alter their strategies and concentrate on their remaining resources in order to retain a sense of control (Drewelies et al., 2017). Perceived control affects, and is affected by, physical health, mental health, and social domains. Perceived control acts as a resource used to maintain and enhance functioning (Infurna & Okun, 2015).

Heckhausen and Schulz (1995) developed a life-span theory of control composed of primary control and secondary control strategies. *Primary control* refers to an attempt to control or change the world in order to accommodate an individual’s developmental needs and typically involves active behavior or action on the environment. Primary control strategies include investing skill and time, effort expenditure, persistence, and task modification (Stewart,
Secondary control refers to changing perspective in order to adapt to a new environment or set of challenges. Secondary control primarily involves cognitive, rather than behavioral, processes and involves adjusting attributions, goals, and expectations. Primary control is directed outward to meet established goals, and secondary control is directed inward to enable adjustment to a changing environment, a relinquishing of goals that are no longer attainable, and-or setting new, attainable goals (Heckhausen & Schulz, 1995; Stewart et al., 2013; Swift & Chipperfield, 2013).

Primary control is the dominant form of control throughout youth and middle age since individuals typically remain physically and cognitively able to adjust to new situations and have time to set and meet developmental goals (Heckhausen & Schulz, 1995). As individuals age, they may no longer be able to control their environment as they did when younger, particularly as they face physical challenges through disease or natural decline, social and emotional challenges through loss of spouses or social relationships, and declining opportunities, which can affect self-esteem and self-efficacy. This loss of primary control changes expectations about the ability to have an impact on life circumstances. With the loss of primary control, secondary control strategies are activated and act as a protective mechanism, especially for the aging population (Heckhausen & Schulz, 1995).

When primary control strategies fail as a consequence of physical and cognitive decline, secondary control strategies compensate for these losses, and protect self-esteem and emotional well-being with strategies such as disengagement or the enhancement of alternative goals (Heckhausen & Schulz, 1995; Swift & Chipperfield, 2013). Failure to engage in secondary control strategies can result in frustration, diminished self-esteem and self-efficacy, a reduction in activity, depression, and a lack of motivation in pursuing developmental goals (Heckhausen &
Primary and secondary control strategies are not unidirectional. For instance, as primary control is lost, secondary control strategies enable the selection of new alternative goals and the re-stabilization of well-being. A feedback loop is created, with primary control strategies and secondary control strategies interacting through physical and cognitive decline as a result of aging (Heckhausen & Schulz, 1995; Infurna & Okun, 2013).

Secondary control in the aging population has been linked to lower levels of depression, reduced hospital stays, decreased regret, greater life satisfaction, positive emotion, and survival into later life (Swift & Chipperfield, 2013). Strategies involved in secondary control include psychological adjustment and acceptance (Swift & Chipperfield, 2013), selection, optimization and compensation (Baltes & Carstensen, 2003), goal disengagement or shifting goal priorities (Dunne, Wrosch, & Miller, 2011; Infurna & Okun, 2015), social comparisons, positive reappraisal, and distancing (Heckhausen & Schulz, 1995; Stewart et al., 2013).

Physical Status

Rowe and Kahn (1997) stressed the importance of physical health in their groundbreaking work on successful aging. Despite arguments that their definition of successful aging was too narrow, research has supported the fact that maintenance of physical health is a major contributor to successful aging (Drewelies et al., 2017).

Conscientious maintenance of physical health contributes to successful aging in several ways. Individuals who are in better health may be able to more easily achieve their goals, which will enhance perceived control and protect against depressive symptoms (Drewelies et al., 2017; Dunne et al., 2011). Common physical issues faced by the aging population include cardiovascular disease, cancer, stroke, and diabetes (Infurna & Okun, 2015), and a decrease in visual acuity, auditory acuity, and mobility (Wettstein et al., 2016). Poor health can contribute to
functional disability, which can have a negative impact on activities of daily living and contribute to a lack of subjective well-being. Examples of activities of daily living that can decline include bathing, climbing stairs, walking limited distances, self-care, performing housework, preparing meals, and grocery shopping (Dunn et al., 2011).

Downward social comparisons (Stewart et al., 2013), or comparing the self to others who are less fortunate, are effective in increasing well-being and reducing depression in aging individuals with physical limitations when there is a perception of lowered personal control and when goals are blocked. If an aged adult can modify or continue to perform desired goals despite decreases in functional ability, downward social comparison does not have a significant impact and could undermine goal striving (Stewart et al., 2013). Goal disengagement and adjustment are also effective secondary control strategies for regaining subjective well-being when faced with physical limitations.

**Emotional Status**

Many people are able to maintain a positive outlook on life as they proceed through the later stages of the life cycle in spite of a decrease in functional ability, social relationships, and cognitive ability. This has been partially explained by socioemotional selectivity theory, the positivity effect (an increase in positive emotional information processing), and selection, optimization and compensation (Baltes & Carstensen, 1996). Scheibe and Carstensen (2010) described the positivity effect where older adults are more sensitive to positive than negative information. Physiological changes in the brain of the aging individual also explain this positivity effect (Mather, 2012). In spite of the numerous ways older adults could regulate their emotions in order to remain positive and exhibit well-being, depression and loneliness continue to be identified as the most significant mental health challenges for the elderly.
**Depression.** Depression has been identified as the most common mental health problem faced by older adults (Stewart et al., 2013). Depression has been positively related to lower levels of perceived control across midlife and old age and has an impact on persistence, fosters a decrease in the motivation and behaviors necessary for attaining goals, and contributes to health problems (Dunne et al., 2011; Infurna & Okun, 2015). Functional disability is a contributor to depressive symptoms because functional disability can result in experiences of failure and decreased social interactions and social activities. An aging person with functional disabilities may no longer be able to pursue valued goals such as independent living, socializing outside of the home, or driving a car (Dunne et al., 2011). Goal adjustment and disengagement have been identified as a mechanism for the reduction of depression and an increase in subjective well-being. Goal disengagement refers to the ability to decrease effort and commitment to goals that are unattainable and leads to a reduction in negative mood, lower cortisol levels, a decrease in depressive symptoms, a decrease in systemic inflammation, and better health (Dunne et al., 2011).

**Loneliness.** Loneliness has also been identified as a major contributor to a lack of subjective well-being in the aging population. Loneliness is defined as the “perceived discrepancy between desired and actual social relationships and is characterized by a perceived lack of control over the quantity and especially the quality of one’s social activity” (Luhmann & Hawkley, 2016, p. 943). Loneliness in aging adults has been attributed to more single households due to death and divorce, smaller social networks, and the increase in functional disabilities (Luhmann & Hawkley, 2016). Loneliness relates directly or indirectly to health through physiological effects (e.g., blood pressure and immunity), stress, quality of sleep, and health behaviors such as exercise and smoking (Newall, Chipperfield, Bailis, & Stewart, 2013;
Loneliness increases more rapidly after the age of 75 due to poor health and the loss of loved ones (Luhmann & Hawkley, 2016; Schoenmakers et al., 2012) and has been connected to mortality (Newall et al., 2013). Weiss originally proposed two theories of loneliness in 1973 (as cited in van Baarsen, Snijders, Smit, & van Duijn, 2001). First, loneliness due to social isolation occurs when a person is not socially integrated or embedded as evidenced by a lack of meaningful social relationships. Second, loneliness due to emotional isolation occurs when an individual does not have a reliable attachment figure such as a spouse or other partner or a comparably close confidant.

Schoenmakers et al. (2012) examined coping strategies for dealing with loneliness. Two major strategies were identified: (a) increasing efforts to improve and-or intensify social relationships, and (b) lowering the importance of, or expectations about, relationships. The level of individual resources, such as self-esteem and mastery, affects efforts toward improving social relationships, particularly where initiative on the part of the lonely individual was required; however, Schoenmakers et al.’s (2012) research results indicated older adults often combine both strategies for reducing loneliness, and the sampled group of older individuals believed that loneliness could be ameliorated. Barlow, Liu, and Wrosch (2015) also examined strategies for combating loneliness when chronic illness was a contributing factor. When older adults used self-protective strategies such as reappraisals or external attribution and avoidance of self-blame, they had lowered levels of loneliness in spite of the chronic illness (Barlow et al., 2015).

Social Isolation

Researchers studied social isolation as a potential contributor to declining physical and mental health and social involvement as a contributor to subjective well-being. According to Cornwell and Waite (2009), there is a link between social isolation and loneliness, higher
morbidity and mortality rates, depression and cognitive decline. There is also a strong circular connection between social isolation and diminishing physical health. The loss of social roles as a result of retirement, death of a partner, and the decrease in social networks through attrition can have an impact on social connectedness (Cornwell & Waite, 2009).

Social support and social integration, on the other hand, are protective factors and both have a positive impact on health (George, Ellison, & Larson, 2002). Social support consists of instrumental support (i.e., material aid), informational support (i.e., advice or guidance), and emotional support (i.e., empathy, reassurance, trust, and care; Cohen, 2004). Social support is defined as “a social network’s provision of psychological and material resources intended to benefit an individual’s ability to cope with stress” (Cohen, 2004, p. 676). The availability of social support buffers the effect of stress on psychological distress, depression, and anxiety (Cohen, 2004).

Volunteering has been recognized as an effective means of remaining socially involved, integrated, and actively engaged in life. Volunteering has been perceived as a form of leisure, a job, and an altruistic activity (Chen, 2016a, 2016b). Volunteering fosters increased learning and wisdom and benefits aging adults by strengthening networks, increasing self-efficacy and self-esteem, and strengthening emotional supports (Chen, 2016a, 2016b). Volunteering provides the opportunity to build new roles and creates new life goals and opportunities for development, reduces depression, and has a positive effect on physical and subjective well-being (Chen, 2016a, 2016b). Chen (2016a, 2016b) reported that the informal learning acquired through volunteering is “a holistic approach to SA [successful aging] that includes physical, psychological, social, and spiritual dimensions” (p. 227).
Self-Expression

There is no finish line. Aging does not have to be the end: It can be another beginning.

- Connie Goldman

As older individuals retire, become empty nesters, lose spouses and friends, and encounter physical and cognitive challenges, they must adjust to their new reality in order to continue to experience a sense of well-being and fulfillment. Aging, despite being a period of physical and cognitive decline, continues to be a time of growth and individual development. Creative arts, storytelling and reminiscence, and spirituality and religion have been identified as factors that can foster continued development for aging individuals and allow them to feel like valued members of society.

Creative Arts

At one time, the perception of aging individuals was that they lost the capacity for artistic creativity unless they had previously demonstrated abilities in the arts. Instead, aging individuals are able to process their past, create new future perspectives, and continue psychological development through artistic expression (Cohen, 2000; Cohen, 2006; Stephenson, 2006). Cohen (2006) tested the physical and cognitive health benefits of artistic endeavors and reported that older participants developed an increased sense of self-mastery, self-confidence, an increasing perception of control, and increased social engagement. Cohen also noted increases in self-mastery lead to enhanced immune functioning (as cited in Patterson & Perlstein, 2011). Hickson and Housley (1997) cited research that associated participation in the arts with health, well-being, and life satisfaction. The benefits of visual and musical performance and literary artistic endeavors for the aging are described below.
**Visual arts.** A difference exists between artistic endeavors and arts and crafts. According to Patterson and Perlstein (2011), arts and crafts are perceived as activities that can keep a person occupied. While there are benefits to engaging in crafts (e.g., socialization and increased community involvement), artistic endeavors “engage the mind, body, and emotions, sparking curiosity, problem solving, and artistic accomplishment” (Patterson & Perlstein, 2011, p. 28). Rugh (1991) described three themes that emerged in evaluating one aging woman’s engagement with visual arts, “(1) the need to tell one’s own unique story in an artistic way, (2) the desire to share and lovingly relate to others through the creative process, and (3) the use of art for personal healing and problem solving” (p. 28). Fisher (1999) postulated that artistic creativity offers opportunities for growth because it requires the use of problem-solving skills, an openness to challenges, and the need for flexibility and innovation. Visual art interventions reduce distress, alter thinking patterns and behavior, increase self-reflection and self-awareness, and have a positive impact on cortisol levels, blood pressure, and heart rates (Bolwerk, Mack-Andrick, Lang, Dörfler, & Maihöfner, 2014). Lindauer (as cited in Zausner, 2009) identified art as a creative experience; however, Bolwerk et al. (2014) refuted this supposition by contrasting the impact of visual art production with cognitive art evaluation. Participants involved in visual art production displayed significant improvement in psychological resilience while those involved in cognitive art evaluation did not.

**Music and performance arts.** Creech et al. (2014) explored the impact of music-making on aging and found that even when older individuals had no previous musical experience, music-making contributed to a sense of control and autonomy, an ability to contribute to the community, an increase in confidence, the ability to make connections with positive memories, and the development of a future-oriented identity they called the musical
possible self. Duffey, Somody, and Clifford (2006/2007) reported listening to music enables the (a) sharing of activities and interests, (b) creates opportunities for socialization and an opportunity to share stories, memories, and emotions elicited by one’s musical past, and (c) creates opportunities for reminiscence, self-reflection, and integration of past experiences.

Teater and Baldwin (2014) evaluated the impact of a community-arts singing program for older adults in the UK and found that participating in the group reduced social isolation and increased social contact, provided therapeutic benefits that resulted in an increased sense of well-being, and offered a new future perspective. A study conducted by Helga and Tony Noice revealed that when older adults participated in a theatre course, they had improved problem solving and psychological well-being (as cited in Patterson & Perlstein, 2011). The Noices attributed these results to the fun associated with the activities, which could decrease stress and increase potential for social engagement, physical activity, and cognitive challenges required in theatre arts (as cited in Patterson & Perlstein, 2011).

Literary arts. Literary arts, particularly poetry, have been proposed as a vehicle that can allow older adults to resolve previously unresolved conflicts, prompt life reviews, and provoke thought. These benefits apply to both the writing and reading of poetry (Edwards, 1990). Aadlandsvik (2007) described an elder education project where aging individuals wrote and listened to each other’s poems with professional guidance. Outcomes of the poetry project included establishment of social relationships, improved self-esteem, and a future orientation as participants wrote about their past, present, and perceived future.

Reminiscence and Storytelling

Every individual creates, refines, and shares his or her unique personal story built from experiences as they move through the life stages. According to Randall and Kenyon (2004),
creating stories is how an individual is able to create meaning and is “central to how we learn, how we interact with others, how we experience our gender and culture, . . . and how we grow old” (pp. 333-334). *Reminiscence* is the act of contemplating or telling autobiographical memories and personally significant experiences (Pinquart & Forstmeier, 2012). Pinquart and Forstmeier (2012) outlined three types of reminiscence: (1) *simple reminiscence* is an unstructured form of storytelling with a focus on past events, the goal of which is to communicate and impart information, remember positive events, and foster positive feelings; (2) *life-review* is a more structured form of storytelling that covers the life-span with a focus on evaluating one’s life and integrating both negative and positive experiences and feelings; and (3) *life-review therapy* is conducted with a goal to “reduce bitterness and boredom,” (p. 1) and reframe one’s past into a more positive perspective. Reminiscing and sharing life stories can reduce depressive symptoms through remembering and integrating adaptive, positive memories, and reinterpreting negative, maladaptive memories (Hallford, Mellor, & Cummins, 2013). Reminiscence reflects Erikson’s views (1998) where a central task of older adults is to reflect on one’s life, come to terms with successes and failures, and contemplate opportunities, both taken and missed.

Randall, Baldwin, McKenzie-Mohr, McKim, and Furlong (2015) stated an individual’s self-identity and meaning of life is understood in terms of the narrative they create. Randall et al. (2015) further elaborated on the concept of *narrative foreclosure* where older adults who experience depression or despair due to challenging life circumstances may experience “the conviction that their life story has effectively ended with loss of identity and meaning” (p. 1). Randall et al. (2015) tied individual resilience to reminiscing and reported that individuals with rich, detailed, full, and more complex narratives experienced a higher level of resilience when
faced with challenging and stressful experiences. Randall et al. (2015) suggested that when individuals display lower levels of resilience, as evidenced by despair and depression, they could be helped through some form of “narrative care, whether reminiscence, life review, guided autobiography, psychotherapy, or simply soulful conversation – any activity, that is, in which deep storytelling is elicited through deep story listening” (p. 2). Randall et al. (2015) also suggested the quality of the environment where reminiscences or narratives are told and the effectiveness of the listener has an impact on the storyteller and the depth and quality of the narrative. Pasupathi and Carstensen (2003) found that for older adults, engaging in social reminiscing was an emotionally positive experience and suggested mutual reminiscing could be used as an emotional regulation strategy. Thoughtfully and respectfully listening to another’s story, whether in a professional or social context, can be a “gift of grace” (Moschella, 2011, p. 98) that could possibly provide clarity and feeling understood. Participation with group storytelling, as in a group therapeutic or pastoral context, enables older individuals to recognize similarities and differences with their stories and provides the knowledge they are not alone in their journeys through life (Moschella, 2011).

**Spirituality and Religion**

Leder (1999) argued that, as the body decays, interpersonal losses accumulate, and aging individuals find themselves bereft of their previous roles in life and explore and redefine their concept of self, often searching for greater meaning in life and “coming to a wholeness of soul” (p. 37). Crowther et al. (2002) described spirituality as the *forgotten factor* in Rowe and Kahn’s model of successful aging, and defined a new term, *positive spirituality*, as “a developing and internalized personal relation with the sacred or transcendent that is not bound by race, ethnicity, economics, or class and promotes the wellness and welfare of self and others” (p. 614). This
definition of positive spirituality incorporated the “positive health-related aspects of both religion and spirituality” (Tomás, Sancho, Galiana, & Oliver, 2016, p. 1378). The impact of spirituality on successful aging continues to be demonstrated. Spirituality has been identified as an important factor related to quality of life, well-being, and physical health. Spirituality contributes to resilience, which Manning (2014) defined as “the capacity not only to handle adversities, but also to learn, grow, and be positively transformed by them” (p. 352). Spirituality provides a cognitive framework that helps individuals process painful events, sort out the positive from the negative during times of stress, and provides resources when faced with chronic illness and other significant challenges (Boswell, Kahana, & Dilworth-Anderson, 2006; Crowther et al., 2002; Manning, 2014).

Spirituality should not be confused with religion, although the two are often intimately intertwined. Koenig referred to religion as “an organized system of beliefs, practices, rituals and symbols (as cited in Tomás et al., 2016). Participation in religious practices has beneficial effects on aging individuals by increasing longevity, social support, psychological resources, and a sense of coherence or meaning (Crowther et al., 2002; George et al., 2002; Principi, Schippers, Naegele, Di Rosa, & Lamura, 2016). Together, spirituality and religion are linked to hope, peace of mind, comfort, a sense of community and belonging, reduced loneliness and isolation, a sense of comfort, and reduced depressive symptoms (Bonelli, Dew, Koenig, Rosmarin, & Vasegh, 2012; Malone & Dadswell, 2018).

**Individual Psychology**

Alfred Adler was the founder of Individual Psychology (Ansbacher & Ansbacher, 1956). Adler postulated that children, and later adults, must be understood within the context in which they are raised and currently inhabit. Adlerian therapists attempt to understand context,
especially opportunities as the child perceives them, how these opportunities affect or guide the child’s engagement in life, and the continued effect on adult life (Mosak & Maniacci, 1999; Oberst & Stewart, 2012). Understanding an individual’s lifestyle fosters understanding necessary to address the therapeutic needs of aging adults. Adler’s term *lifestyle* refers to the individual’s core personality developed in early childhood through interactions and responses to unique experiences and unique and creative ways of responding to those experiences (Oberst & Stewart, 2012). Several fundamental tenets could be used to guide Adlerian therapy with the aged.

**Holism, Creative Power, and Fictional Goals**

*Holism* encompasses a new way of understanding an individual and distinguishes Adler’s theory from Freud’s theory (Mosak & Maniacci, 1999). Holism refers to viewing the whole individual (i.e., the entire person) rather than focusing on various components of the person (e.g., Freud’s id, ego, or superego) or interpreting the individual based on different stages of development (i.e., infant, adolescent, or adult; Mosak & Maniacci, 1999). A holistic view includes an understanding of the social and cultural environment of the individual, the family constellation, other potential stressors, and the impact of those stressors.

**Creative Self and Soft Determinism**

Concomitant to holism is the notion of the *creative self*. According to Mosak and Maniacci (1999) and Oberst and Stewart (2012), Adler argued that children were born with a creative force that enabled them to evaluate opportunities within their environment, and react to, and *act upon*, their environment or individual circumstances. Acting on their environment gives children the opportunity to create their circumstances and create themselves. Ansbacher and Ansbacher (as cited in Oberst & Stewart, 2012) coined the term *soft determinism* to describe the
fact that while genetics and environmental factors (e.g., family constellation, education, and economic status) can influence the formation of personal fictions, these factors cannot cause the fictions. For example, children born into the same family are uniquely influenced by the family system, are faced with distinct choices and opportunities, and create distinct fictional goals (Oberst & Stewart, 2012).

**Movement and the Fictional Goal**

Adler argued that individuals continuously move toward a goal, and they move from a felt minus to a felt plus, but Adler argued that this goal is a fictional goal (Oberst & Stewart, 2012). Oberst and Stewart (2012) described Adler’s individual fictions as “conscious and non-conscious ideas that have not necessarily a correspondence with reality, but that serve the purpose to guide us to cope better with reality” (p. 13). The fictions created by the self guide an individual’s thoughts, feelings, and behaviors by providing a way of understanding and seeing the self, the environment, and other individuals. Adler understood that fictions are constantly revised, but by early childhood, a final fictional goal is established that influences and guides all subsequent behavior and movement that represents the individual’s lifestyle. Fictional goals can be adaptive or maladaptive, and the most common final fictional goal is to belong (Mosak & Maniacci, 1999; Oberst & Stewart, 2012). According to Oberst and Stewart (2012), Adler believed that mentally healthy individuals are able to recognize and give up non-adaptive fictional goals and create new, adaptive fictional goals. For instance, the belief that one needs to achieve perfection in order to be loved and belong is an example of a concretized, non-adaptive fictional goal, and Adler advocated for the courage to be imperfect. Adler believed that emotional problems arose when individuals concretized their maladaptive fictional goals;
however, he believed the fictional goals were necessary in order to successfully complete the three tasks of life (as cited in Oberst & Stewart, 2012).

**Tasks of Life**

According to Individual Psychology, a person can only be understood within the context of his or her involvement with society (Oberst & Stewart, 2012). Oberst and Stewart (2012) stated Adler believed throughout a lifetime, individuals are challenged by three responsibilities or *tasks of life*, and it is the success, or lack thereof, in meeting these challenges that influences emotional well-being. The three tasks of life are *work* (i.e., one’s profession or occupation), *love* (i.e., a long-term, intimate partner relationship), and *community* (i.e., contributing to the welfare of others). According to Oberst and Stewart (2012), “Adler maintained that people face the dual challenge in life of approaching and fulfilling these tasks while also seeking completion” (p. 202). The style of life is developed in order to meet this dual challenge. Failure to meet the challenges posed by the tasks of life can lead to decreased emotional well-being, including a decreased sense of competence, significance, and self-esteem (Oberst & Stewart, 2012). Mosak and Dreikurs (1967/2000) added two more tasks of life they believed were part of Adler’s philosophy; however, the tasks had not been specifically spelled out. These additional tasks are (a) getting along with the *self* (i.e., self-acceptance), and (b) *spirituality* (i.e., values, the search for meaning, life goals, and the relationship with the cosmos).

**Early Recollections**

In Individual Psychology, *early recollections* are considered a window into an individual’s past and present (Mosak & Maniaci, 1999). Early recollections provide a means of understanding the lifestyle developed by an individual. Adler recommended gathering recollections prior to age 8 or 9, because he believed early recollections before this age reflected
the issues and fictions that contributed to the development of the individual’s lifestyle (as cited in Mosak & Maniacci, 1999). Early recollections are not necessarily factual or accurate. The recollection is viewed and interpreted through an individual’s present lens and is a reflection of the individual’s past and current beliefs and perceptions of the self. Mosak and Maniacci (1999) stated succinctly: “What we remember from our early childhood is reflective of what we believe now” (p. 137).

Social Interest

Oberst and Stewart (2012) suggested Adler believed people could only be understood in terms of a global society and within the context of the society into which they were born, raised, and lived. A cornerstone of Individual Psychology is understanding how a person interacts with others. The original term for social interest was *gemeinschaftsgefühl*, which has no direct translation into English but has been referred to as either *community service* or *social interest* (social interest is the term predominantly used in the United States.) Oberst and Stewart (2012) defined social interest as the ability of a person to participate, to contribute, to share; to feel accepted, appreciated, and loved, as well as to accept, appreciate and love other people . . . being able to cope with the obstacles and misfortunes of life in a socially adaptive way; not by seeking one’s self-interest and personal advancement but by pursuing, at the same time, the benefit of – theoretically – the whole of humankind. (p. 17)

From a subjective, individual viewpoint, social interest refers to a person’s feelings of belonging in a family and community, rather than feeling like an outsider, and the individual’s concern for, and involvement in, the society he or she inhabits. A person’s level of social interest corresponds with the person’s emotional well-being (Oberst & Stewart, 2012).
The Adlerian Perspective on Aging

Adler did not write much about the aged individual and focused predominantly on children and young adults. Adler’s beliefs are reflected by Ansbacher and Ansbacher (1956):

Not much is done for old people in our culture…Many persons seem to be changed when they are older, and this is mainly due to the fact that they feel futile and useless. Then they try to improve their worth and value again in the same way as adolescents do. They interfere and want to show in many ways that they are not old and will not be overlooked, or else they become disappointed and depressed. (p. 443)

In old age, a person has entered Erikson’s eighth stage (i.e., integrity vs. despair), or ninth stage (i.e., elder status; Erikson, 1998). Either the individual is focused outward, or he or she is focused inward. An outward focus is commensurate with the concept of social interest. An aged person has often resolved the three tasks of life, retired from a job, raised a family and saw them leave home, and potentially, suffered the loss of a spouse and friends. At one time, these conditions were perceived as positive aspects of aging, as the aged were now free to do as they pleased; however, physical and cognitive decline could contribute to a growing lack of subjective well-being (Ansbacher, 1992). The solution for declining well-being was not active social interest, but “the spiritual self-transcendence of community feeling,” a reflection of a person’s place in the world and place in the cosmos (Ansbacher, 1992, p. 408). These concepts are evoked in Mosak and Dreikurs’ (1967/2000) fifth life task, spirituality, and are in accordance with more recent literature on the importance of spirituality for subjective well-being and positive aging (Boswell et al., 2006; Crowther et al., 2002; Manning, 2014).

Keller and Hughtson (1981) described a modified version of Dreikurs’ four unproductive goals of behavior that could be targeted during therapy: (a) attention seeking, (b) bossiness, (c)
countering or reacting by hurting others, and (d) disabling attempts at creative intervention strategies. Keller and Hughston (1981) listed generic and specific strategies for use in counteracting the unproductive goals, including promoting social interest, encouragement, reminiscence exercises, participating in group activities, promoting self-esteem, and involvement with family; Shulman and Berman (1988) identified the loss of belonging as a major cause for a decrease in self-esteem and meaning. Shulman and Berman (1988) also adapted Dreikurs’ goals of misbehavior to the elderly and cited three goals: excessively demanding love, attention, and service; displaying power in order to keep an existing status; and taking revenge or getting even for perceived wrongs. Shulman and Berman (1988) suggested restructuring the child-parent relationship to provide greater enjoyment of life; Brink (1979) addressed major depression, anxiety, delusional disorders, and organic brain syndromes. Brink believed self-esteem and social interest could be fostered in the most discouraged and dysfunctional individuals through the use of individual and group approaches; Sweeney and Myers (1986) encouraged the use of early recollections as a means to resolve previous conflicts, achieve resolution, integration, and life satisfaction.

Linden (2007) applied Adler’s law of movement to the aging population and reinforced the concept that individuals engage in continuous development and striving regardless of age. As cited in Linden (2007), Adler stated “to live means to develop,” which means “continuous active adaptation to the external world [and] this coercion to carry out a better adaptation can never end” (p. 31). Linden (2007) perceived aging individuals as better able to contribute to society when they exhibited social interest, and the tasks of life could be reframed within the context of social interest.
Discussion

The subject of aging and the factors promoting successful aging have gained increasing interest as evidenced by the evolution of numerous theories and the search for interventions to promote healthy aging. Research on aging is relevant as a large segment of the population is reaching the later stages of life (Krajci et al., 2019; Thomas et al., 2016). Aging well has been considered a paradox (Jeste & Oswald, 2014; Wettstein et al., 2016) as objective standards for well-being often contradict subjective perceptions of well-being. Responses to Rowe and Kahn’s theory (1997, 2004), which emphasized objective measures of successful aging, demonstrated the need to understand this paradox. Successful aging is an individual, subjective evaluation; therefore, it is amenable to change.

Implications for Practice

It is well understood that a healthy physical and cognitive state are ideal for aging well (Rowe & Kahn, 1997). Mental health practitioners should not disregard these concerns when addressing the health of their clients; however, in older adults, the ability for the mental health practitioner to affect these factors can be limited. Instead, mental health practitioners can have an impact on a client’s subjective well-being by understanding the underlying mechanisms affecting client self-perceptions and assisting with continued development. Depression, loneliness, and isolation are common mental health issues in older adults (Cornwell & Waite, 2009; Stewart et al., 2013; Wettstein et al., 2016), and depression has a greater impact on subjective well-being than chronic physical conditions (Stewart et al., 2013; Wettstein et al., 2016).

In the theory of psychosocial developmental theory, Erikson proposed that an individual’s perceptions of life could change even in the eighth and ninth stages (Erikson, 1998).
Adler’s Individual Psychology (Ansbacher & Ansbacher, 1956) includes a focus similar to Erikson’s theory. Understanding and reframing mistaken beliefs maintained and concretized throughout the life cycle is also an important factor in promoting emotional well-being, even during the later stages of life. Substantial losses faced by older adults compound previous mental health issues acquired during the life cycle and exacerbate current life situations.

Factors contributing to subjective well-being and aging well are often interrelated. Major factors identified include maintenance of good health (Rowe & Kahn, 1997); an individual’s perceived control over changing and challenging life situations, and the ability to shift from primary control to secondary control strategies (Heckhausen & Schulz, 1995; Stewart et al., 2013; Swift & Chipperfield, 2013); the level of social engagement, social support, and social interest (Ansbacher & Ansbacher, 1956; Cohen, 2004; George, 2010; Infurna & Okun, 2015); and the strategic use of social and psychological resources (Baltes & Carstensen, 2003). Mental health practitioners can assist older adults’ access or enhance well-being through the use of selection, optimization, and compensation (Baltes & Carstensen, 2003); the appropriate use of downward social comparisons (Stewart et al., 2013); reappraisal and avoidance of self-blame (Barlow et al., 2015); psychological adjustment and acceptance (Swift & Chipperfield, 2013); goal disengagement or shifting goal priorities (Dunne et al., 2011; Infurna & Okun, 2015), social comparisons, positive reappraisal, and distancing (Heckhausen & Schulz, 1995; Stewart et al., 2013); and rewriting the life narrative (Randall et al., 2015).

From an Individual Psychology perspective, strategies that can promote aging well include the use of early recollections as a mean to reframe the life’s narrative and create a starting point for understanding and resolving mistaken beliefs (Ansbacher & Ansbacher, 1956; Oberst & Stewart, 2012). Creative expression has the potential to increase social interest,
purpose, and a sense of belonging. When people age, the tasks of life may be redefined, and it is still possible to pursue the completion of life tasks with increased satisfaction. The implications for promoting aging well in therapeutic practice are numerous. With respect to perceived control, mental health professionals can help aging individuals relinquish primary control strategies and engage secondary control strategies by evaluating current circumstances, identifying and disengaging from unattainable goals, and identifying new attainable goals (Stewart et al., 2013).

Aging individuals can be encouraged to participate in artistic endeavors as a means to increase social engagement and develop increased self-mastery and self-confidence. According to Fisher (1999), visual arts (e.g., painting, drawing, collages, and sculpture) foster continued development through the use of problem-solving skills, decision-making, facing challenges, innovation, and flexibility. According to Bolwerk et al. (2014), visual arts also increase resilience and promote a decrease in depression symptoms. Music and performance arts have been successful in helping aging individuals overcome adversity and age well through community contribution, social engagement, decreased isolation, and decreased depression. Music can be used to increase understanding of the past and narrate the life story as older adults revisit music that has been important to them in the past. Songs elicit emotions about past and current events, which opens the door for creating a narrative timeline of joy and sadness, pride and shame, and an integration of past experiences (Duffey et al., 2007). Reminiscing and sharing life stories can reduce depressive symptoms through remembering and integrating adaptive, positive memories and reinterpreting negative, maladaptive memories (Hallford et al., 2013).
Randall et al. (2015) suggested older adults could be helped through some form of narrative care. Pasupathi and Carstensen (2003) recommended social reminiscing as an emotional regulation strategy. Moschella (2011) recommended group storytelling used in a group therapeutic or pastoral context as a means of recognizing older adults are not alone in their journeys through life. Assisting older adults to read and write poetry enables the resolution of unresolved conflicts, prompts life reviews, and provokes thought (Edwards, 1990).

In addition to artistic endeavors, volunteering reduces depression and enhances subjective well-being by strengthening networks, increasing self-efficacy and self-esteem, strengthening emotional supports, creating new life goals and roles, and providing opportunities for continued development (Chen, 2016a, 2016b). Also, encouraging older individuals to explore the spiritual aspect of their lives will help with successful aging. Spirituality can foster resilience, enable the processing of painful events, and can be used as a resource when faced with chronic disease and significant challenges (Boswell et al. 2006; Crowther et al., 2002, Manning, 2014). Assisting older adults with opportunities to continue to develop and grow, to reconnect or strengthen relationships, and to foster or strengthen self-esteem and meaning, creates the foundation for increasing subjective well-being in older adults and increases the possibility of successful aging.

As the population continues to age and longevity increases, mental health practitioners will be faced with a new challenge: helping a previously underserved population acquire and benefit from mental health services. A significant challenge will be to understand the complex interaction of the factors that impact older adults. Mental health practitioners will be challenged to develop and implement interventions that can address myriad issues simultaneously from acceptance or adjustment to functional disability and helping individuals develop a new sense of
purpose and meaning. The overarching goal will be to help older adults achieve subjective well-being and age successfully.

**Recommendations for Future Research**

Research on aging has progressed from the perception that older adults complacently accept their situation, to identifying the factors and possible interventions to help older adults with successful aging. Spirituality continues to be a component of aging that deserves additional research. Adults with religious backgrounds, as well as adults with no religious affiliations, increasingly seek purpose and meaning that transcends their previous understanding of life. The application of new technology and its impact on the aging population also deserves additional research. Research could focus on understanding and providing methods to assist older adults with continued development. As part of aging research, greater understanding is necessary regarding the application of Adlerian concepts of aging and the effectiveness of early recollections and potential opportunities to foster social interest.

**Conclusion**

As the population continues to age, mental health professionals may be faced with an increasing number of older adults seeking help with mental health issues. Some of these issues will appear to be similar to those found in younger populations; however, the complexity of the underlying causes and interactions of the issues, such as substantial losses of functional ability, bereavement, social losses, and loss of purpose and meaning, will require that mental health professionals have a significant understanding of gerontological therapeutic issues. A need exists for further education that incorporates the advancing research on aging. When mental health practitioners increase awareness of gerontological issues and concerns, they can provide
ethical, timely, and appropriate care and are better equipped to assist older adults in reaching greater life satisfaction and subjective well-being through the perception and sense of aging well.
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