

# SUCCESSFUL AGING. BUT, WHY DON'T THE ELDERLY GET MORE DEPRESSED?

Ignacio Montorio Cerrato and María Izal Fernández de Trocóniz  
*Autónoma University of Madrid*

*In accordance with some new perspectives in gerontology, we present an optimistic vision of aging that gives form to what has been called "successful aging". In order to do so we analyse two complementary ways of understanding how people adapt to this stage in their lives: a) the "selective optimisation with compensation" model, which focuses on establishing the limits and possibilities of functioning in old age, and b) "the stress model applied to old age", which emphasises people's capacity for coping with changing or difficult situations that may appear in old age. From the information provided by these two models we make some suggestions for intervention at the level of individuals and of the social system, prioritising preventive strategies that promote successful aging.*

*Se plantea, acorde a las nuevas perspectivas en Gerontología, una visión optimista de la vejez que pretende dar contenido a lo que se ha venido denominando modelos de vejez con éxito. Para ello se analizan dos formas complementarias de entender cómo se produce la adaptación de las personas a esta etapa del ciclo vital a) la perspectiva de la optimización selectiva con compensación que centra la atención en establecer cuáles son los límites & posibilidades del funcionamiento en la edad avanzada & b) el modelo de estrés aplicado a la vejez que pone el énfasis en los recursos que emplean las personas para enfrentarse a las situaciones cambiantes o adversas que pueden marcar la edad avanzada. A partir de la información derivada de los modelos anteriores se ofrecen, sin ánimo de exhaustividad, algunas sugerencias para la intervención centradas tanto en el individuo como en el sistema social en el que está inmerso, bajo la óptica de priorizar las estrategias preventivas para promocionar una vejez con éxito.*

## INTRODUCTION

Gerontology, it is often said, has the practical purpose of *adding life to the years* in the final part of the life cycle. Adding life to the years means helping people to enjoy their life and to obtain satisfaction from it (Havighurst, 1961) –in short, improving the quality of life in old age.

The popular term *quality of life* can, in many ways, be considered as the successor to the more traditional concept of "the good life" (George and Bearon, 1980), the object of philosophical and literary interest throughout history. Despite the fact that the many thinkers that have devoted their attention to this concept have differed with respect to the specific description of the good life, it does not seem unreasonable to affirm their agreement that physical and psychological well-being represent its essence. Quality of life, then, is far from being a new

concern. Indeed, as Cohen (1992) reminds us, the Greek myth of Tithonos reflects perfectly the preoccupation of today's professionals working in the field of aging. "Tithonos, a mere mortal, falls in love with Eos, Goddess of the Dawn. The immortal Eos, wishing to live with her lover forever, begs the almighty Zeus to grant Tithonos the immortality of the gods. Zeus consents, but in doing so, forgets to grant him also the gift of eternal youth. As a result, Tithonos gets older and, as time goes by, becomes frailer and frailer, until he yearns for death". It is certainly remarkable how this story from Greek mythology illustrates one of the major concerns of researchers and professionals working in gerontology today.

Recently, maintaining quality of life in old age has acquired special significance in view of the increase in life expectancy. Social scientists, policy-makers and specialised professionals working in the field of aging have as their objective the improvement of quality of life in the elderly. Having increased life expectancy in the western world, which in principle constitutes a positive achievement, there is an evident need to improve the conditions of life –well-being in its widest sense, taking into account objective and subjective parameters

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Correspondence concerning this article should be addressed to  
Ignacio Montorio Cerrato. Universidad Autónoma de Madrid.  
Facultad de Psicología 28049 Madrid. Spain  
E-mail: ignacio.montorio@uam.es

(Montorio and Izal, 1992). That is, it is attempted to avoid a situation in which the prolongation of life becomes the prolongation of a deficient state of health, characterised by chronic illness and suffering; otherwise, longevity would be achieved at the cost of a decrease in the quality of life (Fries, 1989).

In short, the improvement of the quality of life in the elderly constitutes an unrenounceable objective for gerontology. Of course, what is understood by quality of life, and what kinds of intervention can contribute to its increase in old age, are questions that are currently being debated. In this work we shall approach these matters from the perspective of successful aging, a concept widely employed in current gerontology, and which will be complemented by a more classical perspective from psychology applied to the field of aging, the model of stress.

### **1. Successful aging**

In the early 1960s, research in social gerontology attempted to answer the question: in what does optimum or successful aging consist? These first studies concentrated on the social patterns of aging, and evolved toward the identification of the life conditions under which aging was or was not satisfactory, and of the coping resources and abilities that influenced the aging process. In a way, it can be said that these studies used quality of life measures to describe successful aging and the factors related to certain aging patterns. Nevertheless, the main concern in the sixties and seventies was not so much to investigate why people aged successfully as to describe and form a profile of this age group, which gave rise to a considerable body of basic knowledge in the psychology of aging, aimed primarily at the description of "normal" aging.

Later, in the 1980s, researchers in gerontology agreed that a change was needed in the object of study in aging, proposing the substitution of the concept of "normal" aging by that of "successful" aging.

Whilst the former concentrates on normal or prototypical aging, ignoring the substantial heterogeneity of elderly people and attempting to establish average levels of age-related deterioration in capacities and functioning, the concept of successful aging focuses on the investigation of the limits of functioning in advanced age, and the conditions that permit the maintenance of functional abilities in the elderly (Rowe and Kahn, 1987).

Currently, there is a broad consensus in accepting successful aging as a new framework within gerontology.

Nevertheless, there is less agreement with regard to the selection of the indicators of successful aging. Various theorists in this field have suggested a *multicriterial approach* to its definition. In any case, it seems clear that both quantitative and qualitative, objective and subjective criteria should be considered. Thus, Blazer (1990) proposed a definition of successful aging as a combination of *personal vitality, resistance, adaptive flexibility, autonomy and control, integrity* and good *person-environment fit*. Baltes and Baltes (1990) suggest the inclusion of indicators of biological functioning (*longevity and biological health*), psychological functioning (*mental health*) and positive aspects of the human being (*cognitive efficiency, social competence and productivity, personal control and life satisfaction*). Other theories have proposed definitions of successful aging based solely on individual criteria, such as *absence of cognitive deterioration, independence of third persons for daily life functioning or non-use of services* (Roos and Havens, 1991).

In parallel to the search for indicators of successful aging, Baltes and Baltes (1990) propose the usefulness and convenience of considering successful aging as a process of *selective optimisation with compensation*, stressing the role of the individual in the determination of his or her own functioning. Below, we present this perspective on aging, of great relevance in gerontology at the present time.

### **2. Successful aging: Selective optimisation with compensation**

Although, as stated above, the concept of "successful aging" has its origins in the 1960s (Havighurst, 1963), it was subsequently proposed as a field of interest in gerontological research and as a challenge for the design of social policy. The fact that this idea has once again captured the attention of social scientists is due not only to the attractiveness of the term and the importance of aging in the world today, but also to a new optimism that has arisen in gerontology in recent times (Baltes and Baltes, 1980; Baltes, 1987; Birren and Bengtson, 1988; Fernández-Ballesteros, 1985; Skinner and Vaughan, 1986). The question of whether the concept of successful aging will remain within the ambit of gerontology due to its scientific plausibility is, for the time being, a less important matter than the fact that it is currently a dynamic area of great interest to researchers (Baltes and Baltes, 1990).

The impact of two concepts, *interindividual variability*, which accounts for the wide diversity that exists among elderly people, and *interindividual plasticity*, which refers to their learning capacity (Baltes and Baltes, 1990), has been of definitive importance for current thinking on successful aging. Reflections on the implications (both theoretical and for psychological intervention) of these concepts have led to the conclusion that there is "great opportunity" for the continuous optimisation of human development throughout life, including in old age (Lerner, 1984).

Employing both concepts, the successful aging model based on *selective optimisation with compensation* (Baltes and Baltes, 1990) includes and applies a substantial part of the basic assumptions of Psychology of the Life Span to the study of old age, especially in so far as they contribute to defining the process of adaptation. This model postulates that people are immersed in a continuous process of adaptation throughout life, by means of three components that interact with one another: selection, optimisation and compensation.

*Selection* refers to the process of specialisation of behavioural competences that allow the individual to continue his/her development throughout the lifespan. It implies reduction, since it restricts people's lives, limiting the number of competences or areas of functioning. However this limitation in turn implies adaptation, since, on reduction of the demands to which the individual must attend, the competences selected become easier to manage. One example of this specialisation in old age concerns the area of daily life activities (self-care and maintenance of the home). These tasks tend to increase in importance with respect to other activities at this stage of life, given that for many elderly people maintaining their independence in the community is a main objective (Willis, 1991). Another example is the selection elderly people make with regard to their social network. It would appear to be demonstrated that the elderly limit –or select– their source of social support, focusing on the search for social relationships that favour the emotional regulation that preserves their psychological well-being (to the detriment of social relationships that provide information or help to maintain identity) (Carstensen and Frederickson, 1994).

*Optimisation* relates to the idea that individuals regulate themselves in order to function at high, effective and desirable levels of execution. Thus, it is to be expected that people take advantage of environmental

or biological opportunities throughout life to enrich and increase their reserve capacity, so that they can maximise –in quantity and quality– their lifespan. In sum, optimisation means that the individual moves in the direction of obtaining the best possible functioning in a specific number of areas of life. Optimisation is also an attainable objective in old age, since even though the more biologically determined cognitive abilities have begun to decline, there exists substantial residual plasticity for improving the diverse capacities of the human being, including the cognitive ones (Baltes and Linderberger, 1988). The desirability of the promotion of optimisation in individuals is such that it has been demonstrated that when high levels of moderate physical activity are accompanied by healthy lifestyles and relationships with intellectually active people, one's intellectual capacity can be maintained throughout old age (Schaie, 1994).

*Compensation* refers to the process that is activated when a person's abilities deteriorate as consequence of age, or when the demands of the context increase substantially, and it becomes impossible to attain the required standard of execution. In such cases, the use of the strategies normally employed would bring negative results, so that people modify their strategies with the aim of compensating for the deficits. Compensation involves using elements of behaviour (e.g., external memory aids), of cognition (e.g., mnemonic strategies) or derived from technology (e.g. prosthetic aids). Compensation is a natural process that we all make use of in the course of our lives, and which is particularly well-developed in the elderly, given the advantages implied by the accumulation of experience and knowledge in this age group (Dixon, 1995). Thus, for example, it has been shown that typists of advanced age are capable of typing a text as efficiently as younger typists, despite a deterioration of the formers' perceptual-motor skills (Salthouse, 1984). The experience of the older typists allows them to visualise to a greater extent the following text, compensating in this way for their disadvantage in speed of response.

The processes of compensation have been mainly studied in relation to the area of intellectual functioning, but examples can also be found in the field of social behaviour. In this latter area, compensation may operate through the use of *passive control* or *delegated control* (Baltes and Carstensen, 1994). When active or instrumental behaviours are not sufficiently effective to reach stan-

dards of execution, individuals may modify their social environment through passive behaviours or behaviours of delegated control, as Baltes affirms (Baltes et al., 1994). This author and her colleagues maintain that elderly people living in institutions receive more social reinforcement from staff when they display dependent behaviours –i.e., behaviours that are not instrumental or active. From the point of view of self-care this would be understood as a failure. However, bearing in mind that a behaviour in a certain context has multiple consequences, it could also be interpreted as a form of adaptation on the part of residents. Thus, dependent behaviour in self-care creates an environment for ensuring that basic personal necessities are satisfied, at the same time as permitting success in other areas of functioning (that is, greater social contact). In general terms, the use of compensation procedures not only helps people to offset deficits in old age, but has also revealed itself as an important predictor of cognitive efficiency and the capacity of an individual for living independently in the community (Wolinsky, Callahan, Fitzgerald and Johnson, 1992).

In summary, the *selective optimisation with compensation* model presupposes that the person, at any age, specialises in different areas of functioning, capacities or abilities depending on his/her life trajectory, on his/her interests, values, habits, health, and on his/her reserve capacity. While necessary at all times of life, in old age this strategy is used even more actively and frequently due to losses (Marsiske, Lang, Baltes and Baltes, 1995). The experience acquired over the lifespan helps elderly people to know how to act optimising, selecting and using strategies that compensate for possible deficits or high environmental demands.

The contributions of this model of successful aging, especially its emphasis on the potential of the individual and on his/her leading role in optimising his/her functioning in carrying out life activities, makes it one of the most fruitful lines of research in gerontology (Marsiske et al., 1995). However, one of the criticisms the model has received is based on its lack of attention to the economic, social, etc. conditions that may influence the achievement of successful aging, and to some of the individual's resources that may favour his or her adaptation (Pearlin and Skaff, 1995). As we shall see below, the perspective of stress applied to old age takes into account the changing or adverse situations elderly people may have to face, as well as the individual resources for coping with them.

### 3. *Adaptation, stress and well-being in old age*

People's adaptational capacity permits them to maintain their well-being in the face of changing or difficult circumstances in the course of life. This adaptation takes place in accordance with a principle of continuity throughout the life span, according to which previous life experiences connect with the experiences of old age, thus marking a life trajectory in terms of the form of adaptation (Pearlin and Skaff, 1995). This trajectory is one of the main sources of differentiation among elderly people. More specifically, independently of the biological changes that characterise old age, differentiation between people at this stage of life is based on two selection routes, via which each individual chooses between different options: the *structural* route and the *behavioural* route (Carstensen, Hanson and Freund, 1995). The first of these refers to those which limit aspects (for example, socio-educational level, gender) or promote opportunities for each individual over the course of life (Daneffer, 1992). The *behavioural* selection route, on the other hand, does not imply any imposition on the individual with regard to available options, but refers rather to the choices made actively and "voluntarily" throughout the lifespan (to increase or reduce the social network, to acquire specialised knowledge, etc.) (Carstensen, Hanson and Freund, 1995). Both forms of selection mark the life trajectory of each individual and, in old age, they delimit both the opportunities available to him/her and the impact of the changes that occur in this stage of life.

In any case, we are not suggesting a kind of determinism as a function of previous stages of life; nor is it possible to simply extrapolate our knowledge of adaptation at previous stages to the conditions and characteristics of old age. In fact, it has been demonstrated that the types of changes or stressful events with which the elderly have to cope, their meaning, the way they are perceived and the response to them are, in certain aspects, significantly different by comparison with other age groups (Castro et al., 1996). The differences between the elderly and other age groups by no means signify that old age should be perceived as a time of stress and desperation (Baltes and Baltes, 1990; Ryff, 1989). These matters will be dealt with below, treating separately the stress factors and the personal resources available for coping with them and achieving adaptation.

### 3.1. *Stressors in old age*

Knowledge of the specific characteristics of stress factors in old age is limited, and certainly less extensive than we would wish. Nevertheless, we know that differences exist with regard to the stressors to which the elderly are exposed and their impact. We shall continue by reviewing these aspects, differentiating between two types of stressor: life events and chronic stressors.

The first type of stressor refers to *life events*, which, as is well known, are specific occurrences that imply important changes in a person's life, demanding of the organism an intense effort of adaptation (e.g., retirement, death of spouse/partner, moving house, etc.) (Holmes and Rahe, 1967). In old age, these stressors do not appear to be a main source of stress (Ensel, 1991), with findings even showing a negative association between old age and life events (Murrell, Norris and Grote, 1988). This result can probably be explained, on the one hand, by methodological bias (basically, that the life-events assessment scales are designed for the conflictive situations of adults, but not for those of the elderly) and, on the other, by the fact that, in general, the lifestyle of the elderly means that they are less exposed to stress-inducing life situations (Pearlin and Skaff, 1995).

There are, however, life events that occur with greater probability in old age. In the first place, there are those related to the loss of roles and status, and which constitute normative transitions in one's life (retirement, "empty nest"). These events can be anticipated, do not necessarily have negative consequences (George, 1980), and may even have positive effects on well-being, as revealed by some of the research on retirement (Aldwin, 1990). Secondly, events related to health, so common in old age, appear to have a more distressing effect than other types of life event (Ensel, 1991). Also, the death of close people—spouse or partner, friends, etc.—is a more frequent event at this time of life, with a negative emotional impact of variable duration and intensity, although it has been found that, in some cases, positive effects also occur: for example, the loss of dear ones, apart from the negative impact produced, may subsequently lead to an increase in social contact, a sense of independence and competence, and an enhanced self-concept (Lopata, 1979; Wortman and Silver, 1992). Furthermore, it would appear that life events related to health and economic situation may be a less important source of stress among the elderly than among younger people (George, 1989).

In general terms, a critical variable that affects adapta-

tion following life events in old age is their condition of normativity, that is, those events that are not related to normative transitions of life and that are less predictable and unable to be anticipated generate greater stress. Thus, a non-normative life event such as the loss of a child is one of the most stressful experiences a human being may suffer (Aldwin, 1990), it being difficult to recover and recuperate one's previous state of well-being, especially if the person who suffers such an experience is widowed (Pearlin and Skaff, 1995).

In contrast to the above, there are stressors that appear, not within a particular time limit, but rather in an insidious and persistent way in everyday life. It has been demonstrated that such *chronic stress situations* cause more stress responses, with more negative effects on people's social, psychological and biological functioning, than other extraordinary situations, such as life events (Pearlin and Schooler, 1978).

Thus, for example, as a consequence of certain biological, psychological and social changes that frequently occur in old age, elderly people may find difficulties for interacting with their physical environment, their feeling of insecurity increasing in the face of certain environmental conditions. A clear example of this situation is a change of residence to an unfamiliar place—moving house— or going to live with unfamiliar people—moving into an institution— (Izal and Fernández-Ballesteros, 1990). However, even when the person remains in his/her own home and in the same neighbourhood, interaction with the environment becomes modified over time, since, even though the environmental conditions may remain constant, the person may feel more vulnerable as his/her physical fragility increases. Moreover, the environment in which the elderly person lives is also subject to transformations. The composition and structure of the neighbourhood may change, and the changes may constitute stressors for him/her. Thus, the loss of friends and acquaintances that move out of the neighbourhood or area, or who die, leads to a reduction of the individual's social network, which presumably has a negative impact on the person's life. Equally, over time, changes may occur in the urban environment (shops closing down and new ones opening; changes in public transport; architectural changes; changes in the location, organisation and type of services in the neighbourhood, etc.), and this may have a considerable effect on the sense of security and comfort of elderly people living in the area. Finally, if environmental modifications are

accompanied by changes in the elderly person's own conditions, interaction will become even more difficult. For example, having to walk further because a certain service (a shop, a health centre, etc.) has changed its location may constitute an excessive effort for a person suffering a progressive loss of mobility, besides affecting his or her feeling of personal security.

Another form of chronic tension results from the difficulties that may arise in connection with the *relationships and activities* associated with the fulfilment of social roles in old age. According to Pearlin and Skaff (1995), the main stressors in this sense originate from interaction with relatives, and concern the failure of one's children to fulfil expectations, the absence of support and assistance from children, or support and assistance from children that reduces the elderly person's autonomy and self-esteem, and favours the appearance of "excessive incapacity". Lastly, one of the stressors derived from the fulfilment of roles that may generate most tension concerns care of a family member (Izal and Montorio, 1994). Thus, the role of principal caregiver (for example, the wife responsible for caring for a husband with Alzheimer's Disease) involves a series of (primary) stressors directly derived from the caring, such as helping with daily life activities or coping with difficult behaviours (hallucinations, agitated behaviour, wandering, etc.), as well as other (secondary) stressors generated by the primary ones, such as conflict with other relatives, reduction of social network, health problems, etc. (Izal, Montorio and Diaz-Veiga, 1998; Montgomery and Borgatta, 1989; Montorio, Izal and Diaz-Veiga, 1995).

Finally, the micro-environment in which elderly people live is the scene of stressful *everyday situations*, specifically related to organisational and logistical problems which must be coped with as part of daily life (e.g., climbing stairs, self-care activities, administrative matters, remembering names, etc.). Such situations, trivial for most adults, may, for the elderly, become obstacles they have to overcome each day, and which constitute an important aspect of their everyday life (Barer, 1993; Fernández-Ballesteros, Diaz, Izal and Hernández, 1988). To define or list these situations is a difficult task, since a situation will become conflictive depending on the physical, psychological and socio-environmental conditions of a person's life.

In summary, stressful situations old people face differ from those faced by younger people in terms of type and

impact, daily life situations being particularly stress-inducing. Nevertheless, a life event or stressful situation may have very different consequences in the life of a person depending on the subjective importance of the area of life in which it takes place (Krause, 1994), and the extent to which its occurrence is predictable at a particular stage of life (Pearlin and Skaff, 1995). Thus, for example, early retirement at age 55 will presumably have different consequences from retirement at age 63, while the loss of loved-ones in one's thirties will have different effects from their loss at the age of 85.

### 3.2. Resources for coping with stressors in old age

As already stated, most elderly people have to cope daily with situations of chronic stress, and also with specific or extraordinary life events that presumably reduce their well-being. Nevertheless, and also as pointed out earlier, the majority of them manage to adapt, maintaining an acceptable level of well-being and satisfaction (Baltes and Baltes, 1990; Knight, 1986). This is possible thanks to the resources that everyone, including the elderly, use for coping with stressful situations in life. In the face of the demands that arise in the course of old age, individuals respond by developing or employing resources for cushioning the harmful effects that difficult life circumstances may produce (Cohen and Edwards, 1989). In general terms, these resources are common across age groups, and can be grouped in three categories: economic, social and personal, though in old age we also find specific aspects of these resources.

*Economic resources* constitute one of the best "shock absorbers" in the face of adverse or changing conditions. Good availability of economic resources increases the range of selection possibilities for elderly people in the different circumstances –normative or non-normative, expected or unexpected– that may occur to compensate for possible losses that are frequent in old age. For example, having good economic resources has been associated with quicker adaptation to retirement, given the possibility of carrying out various activities thanks to the direct and indirect benefits of such resources (Carstensen and Freund, 1994).

*Social resources* are probably the most important type of resources for cushioning the adverse effects of stressors in old age (Hanson and Carpenter, 1994). The prime importance of social support is especially noted when adverse situations have been unable to be resolved by means of other strategies or resources for coping

(Hanson and Carpenter, 1994). Many studies have demonstrated the effectiveness of social support, even as a predictor of longevity (Berkman and Syme, 1979), though the conditions under which its effectiveness is maximised are not known with any precision (Antonucci, 1990). Recently, research has been carried out on the idea that the effectiveness of social support depends on an appropriate combination of *who provides the support* and *type of support given* (Pearlin and Skaff, 1995). Thus, for example, in the case of caregivers (including elderly caregivers) of elderly people, types of help that are especially useful are the *instrumental help* given by professionals to prevent the sensation of burden and deal with specific problems of care, and the “emotional help” provided by “veteran caregivers” for preventing emotional disorders (Montorio, Díaz-Veiga and Izal, 1995).

*Personal resources*, or competences that the individual him/herself possesses for adapting to his/her environment, are diverse, those most studied being *coping strategies* and, especially among the elderly, the *perception of control*.

The *coping strategies* employed, or the efforts made by a person to avoid the harmful effects of a stressful situation (Lazarus and Folkman, 1984), have been classified in various ways. Here, following the classification by Pearlin and Schooler (1978), we shall distinguish three forms of coping: direct action on the situation, modification of the meaning of the situation and attempts to manage the effects of the situation. Among the elderly less frequent use of the first type of strategy has been found; that is, the probability that they will respond by directing their efforts to controlling the situation through direct action is lower. Consequently, they more frequently employ the other two types of strategy, modification of the meaning of adverse situations and controlling the manifestations of stress, that is, coping strategies *focused on emotion* (as opposed to those *focused on action*) (Castro et al., 1995; Chiriboga, 1992). In this sense, in spite of the popular belief that the elderly adopt a passive attitude in the face of adversity and difficult life circumstances, developing a more or less acceptable “capacity for resignation” as the only possible response to *conditions of fragility* and *irreversible physical deterioration*, the verification that they tend to use coping strategies that shape or re-define the meaning and importance of difficult circumstances shows that they do not

necessarily resign themselves, passively, to these irreversible changes, but that, on the contrary, they respond effectively, modifying preferences and priorities (Pearlin and Mullan, 1992).

The predilection of elderly people for one type of coping strategy or another may be explained by a previous process. Thus, the person considers whether it is possible to maintain former objectives and standards of execution, once personal changes due to age or other social changes have begun to prevent him or her from reaching them. In the case that the objectives are perceived as attainable, the person will use instrumental behaviours that he/she considers effective for counteracting undesirable changes, as long as this effort does not exceed his or her resources and capacities (Brandstädter, 1984). If, on the other hand, it is deemed impossible to maintain the previous objectives and standards, because they exceed the *manageable level of difficulty* (Brim, 1992), the individual will react by modifying preferences and priorities, which is what most frequently occurs in old age. In some cases, elderly people probably tend to use strategies of this latter type to consider as unattainable or irreversible situations that are not actually so, either due to lack of the appropriate knowledge or because the environment is not favourable for carrying out instrumental behaviours (Brandstädter, 1984).

Concluding, the different coping strategies are not universally effective for all age groups and all conditions, but rather a selective use of them will be more effective, depending on the time of life in which the individual finds him/herself (Kahana, 1992) and the extent to which the situation can be resolved through direct or instrumental action (Brandstädter, 1984). The well-known maxim that states that we should have the serenity to accept that which cannot be changed, the courage to change that which can, and the wisdom to differentiate between the two –at all times of life, we would add–, is eminently applicable with regard to the selective use of strategies.

The *perception of control*, or the capacity people feel they have for exercising control over important circumstances of their life (a concept close to that of Bandura’s [1977] self-efficacy), has a crucial influence on how losses are perceived and subsequently compensated for. An appropriate perception of control is positively related to adaptation to negative events, whilst loss of control is related to feelings of helplessness that may have a negative impact on psychological functioning (Fry, 1989). With regard to the elderly, in spite of the widely-held

opinion that fragility and deterioration at this time of life would result in the individual feeling a reduction in his/her perception of competence, it can be stated that many elderly people maintain the perception of control as an important resource for keeping their well-being (Rodin, 1986). There is, moreover, sufficient empirical evidence to establish that the perception of control is particularly important among elderly people (Izal, 1985). A considerable number of studies in residential centres support this statement, since, although entering a residence may involve a reduction in well-being (Baltes and Wahl, 1987), these effects would be amply offset by the level of perceived control. In one of the studies most widely quoted in the gerontological literature, in which, in a residence, a programme was developed for increasing the personal responsibility of the residents in relation to their immediate environment (basically, by means of small, everyday responsibilities and possibilities for choice in daily life), it was concluded that favouring a sensation of control not only influences well-being, but also health and longevity (Rodin and Langer, 1977). Similar results were found in later experimental research (Banzinger, 1987), while a recent longitudinal study showed that low perceived control is a predictor of mortality, even after controlling the effects of old age, health, depression and other psychological problems (Carstensen and Pasupathi, in press).

In any case, the perception of control should coincide as far as possible with real capacity for control. Sometimes, an excessive level of perceived control has dysfunctional consequences, either because irreversible changes have taken place (e.g., due to chronic illness) or because the environment restricts the individual's capacity for control (e.g., in an institutional environment). In these cases, an inappropriately high sense of control would lead not to adaptation or success, but to frustration and despair (Janoff-Bulman and Brickman, 1982).

The reasons why the perception of control is such an important factor in adaptation in old age are still not sufficiently clear. A possible explanation is that the sense of control is in itself useful, in that it reduces the feeling of threat associated with difficult or stressful situations: the more control the individual feels he/she has over adverse situations, the less helpless he/she will feel, whilst a perceived lack of control will lead him/her to feel like a "victim" of these difficult circumstances, and impotent in the face of them (Pearlin and Skaff, 1995). For example, a high perception of control in people caring for

Alzheimer's Disease patients protects the caregivers from the tensions deriving from daily care (Skaff, 1991). A second explanation for the effectiveness of perceived control is based on its capacity to predispose people to act and mobilise social support for their own benefit (Brandstädter and Baltes-Götz, 1990).

In summary, adaptation to old age should be seen as a dynamic process through which the person deals with challenges not in a passive way, but actively, using the various resources at his/her disposal. Even when possibly insoluble situations have to be confronted, their impact can be reduced through the restructuring of their meaning, the availability of appropriate social support and the maintenance of a sense of control over other aspects important for the individual him/herself.

#### **4. Implications for intervention**

As is clear from what has been said up to now, successful aging depends on the result of the process of adaptation to the changes associated with old age and to the challenging situations of life, all of this modulated by a set of economic, social and personal "shock absorbers". We can now respond to the question that gives the title to this article, and which originates from an expert clinical psychologist and researcher in the field of aging, Knight (1986), who surprised himself by coming up with the question in his consulting room. In general terms, elderly people, throughout their life span, have developed potent and effective ways of coping with adverse situations. Baltes and Baltes' (1990) successful aging model explains this adaptation by means of the process of *selective optimisation with compensation*, whilst the *stress model*, complementary to it, argues that the use of appropriate strategies in each case, together with social and economic resources, constitutes the key to such adaptation (Pearlin and Skaff, 1995).

However, whilst many elderly people manage to successfully adapt to the multiple challenges presented by old age, such successful adaptation is not always the case. The consequences of failure to adapt are diverse, and include psychological and behavioural disorders, as well as the worsening of health and functional and physical deterioration.

As regards possible forms of intervention for facilitating successful adaptation in old age, we find that, throughout the history of gerontology, researchers have shown a preference for analysing the problems derived from poor adaptation in terms of results (e.g., low level

of satisfaction with life, depression, etc.), to the detriment of research about the way elderly people adapt. Thus, interventions have been oriented more towards remedy or rehabilitation than towards prevention. Nevertheless, there currently exists a general consensus in considering that preventive intervention strategies should be prioritised, especially if we are concerned with the promotion of successful aging (Gram and Albee, 1995). From the preventive perspective, on which we shall concentrate, we can distinguish between *person-centred* intervention strategies and *system-centred* ones (Cowen, 1986). In turn, within the first type of strategies, it is possible to differentiate, on the one hand, those that focus on the anticipation of negative consequences that may derive from adverse life situations and, on the other, strategies that seek to develop competences and abilities in people without serious problems, with the aim of reinforcing the competences and skills that permit them to cope successfully with future adverse situations.

Thus, bearing in mind the different types of intervention strategy that can be developed, and basing ourselves on the theoretical models we have described (successful aging model based on selective optimisation with compensation and stress model) from an essentially optimistic perspective on old age, we shall continue by outlining some general patterns of intervention for ensuring that, in our society, old age is a successful stage of life. In any case, what follows should be considered as a kind of general orientation, since in no way do we pretend to be exhaustive with respect to the possible interventions, but rather to suggest some ideas that may serve as guidance.

#### 4.1. *Intervention strategies centred on the individual*

Given the considerable differences that exist between individuals in the way we age, it is important to discard simplistic solutions for improving the life conditions of the elderly or fomenting the flexibility of the individual and society with regard to their perception of old age and attitudes towards the elderly.

Taking into account the above, it may be useful to distinguish, within person-centred interventions, the two types previously mentioned. Thus, in the first place, we can consider forms of intervention aimed at preventing the negative consequences of certain difficult or stressful situations in those people who, having been exposed to such situations, may consider themselves at more risk of developing disorders. This is the idea underlying the

development and implementation of some possible interventions. Without listing all of the possibilities, intervention may be directed at the following groups: people about to move into a residence for the elderly and people recently widowed, or at the following situations or problems: people with chronic pain, those in the follow-up period after hospitalisation or surgery, people with insomnia or depression, worriers, etc. Secondly, interventions may be developed to favour abilities and competences in elderly people who are not in a situation "of risk", with the sole objective of increasing their capacity to cope successfully with potentially adverse future situations and, in general, to promote optimally competent and healthy functioning. This second type of intervention has been developed less than the first, though some specific examples would be: environmental education and accommodation for the home and the community, protection of personal security, development of intellectual and physical skills, promotion of social competence, prevention of falls, encouraging the elderly to do voluntary work, etc. Basically, whatever the types of intervention, these will be oriented towards promoting competence in the use of capacities and abilities that permit adaptation to the particular situations of each individual (Dixon, 1995).

In general, adaptation being a process in which the person deals in an active way with challenges through the use of the diverse resources available to him/her (personal, social and economic), it becomes necessary to carry out interventions that promote such resources, bearing in mind, moreover, that they are especially necessary for managing stressful situations which have to be faced every day. Especially important in the elderly are interventions to promote interaction and social contact, one of the most potent ways of facilitating adaptation. When the rest of the resources fail, the availability of appropriate *social support* is particularly useful. Furthermore, however, we should emphasise the fact that the availability of support is understood in a double sense: the elderly person as recipient of support and as the person providing it to others, thereby feeling useful and avoiding isolation (within the family, with friends, as a volunteer, etc.). Interventions can also be developed that help elderly people to use appropriate *coping strategies*, that is, which promote facing up actively or instrumentally to unattainable objectives or restructuring the meaning of adverse situations. Lastly, of fundamental importance are interventions that promote the feeling of *per-*

*sonal control*, through the identification of strategies for increasing the perception of control and self-efficacy in those people who, for diverse reasons (health problems, moving into a residence, etc.), are in danger of losing their sense of autonomy. In this sense, we should take into account the enormous influence of certain messages coming from the context (Langer and Rodin, 1976) (from the immediate social network to society in general), in order, through their correct use, to promote self-confidence and feelings of worth in people.

The optimisation of personal functioning is not only a question of sound individual competences, but to a large extent depends on the context that surrounds the individual. Thus, to compensate for possible deterioration and limitations due to age, it is necessary to *adapt the physical and social environment* in which one operates by means of prosthetic elements, special facilities in public places and the creation of "friendly" environments (elimination of architectural barriers, adapted traffic systems, orientational aids, adapted public transport and, in general, any measures that tend towards the optimising of functioning in the elderly) (Lawton, 1990). However, in addition to compensating for possible limitations, the environment may favour the individual's competence through characteristics that serve to stimulate and even involve a degree of challenge (proactive environment): new social contacts, new activities, a prosthetic and secure physical environment only to the extent necessary, etc. (Izal, 1995).

In short, the essence of preventive intervention centred on the elderly individual would be that, wherever possible, it should provide him or her with opportunities to develop his/her abilities, to demonstrate more competence, to attain better harmony with him/herself and others and, in consequence, to experience a feeling of success (Gram and Albee, 1995).

#### 4.2. *Intervention in social systems for the optimisation of health and well-being*

The majority of psychosocial and health interventions focus on the individual, and their objective is constituted by the emotional, cognitive, behavioural and/or physiological reactions or responses (Levi, 1992) we have referred to above. However, as we have seen, the physical and social environment that surrounds the individual may contain a series of potent stressors, such as lack of person-environment fit, conflict between competing roles (for example, being the main caregiver for a dependent family

member and dedicating time to other members of the family) or loss of roles. Therefore, it appears clearly necessary to intervene not only with regard to the elderly themselves, but also with respect to external factors that may be endangering their well-being (understood in its widest physical, social and psychological sense).

Interventions aimed at the identification and improvement of the social system are especially important for the elderly, given the various forms of vulnerability frequently associated with this age group. Thus, for example, the greater prevalence of health problems in old age implies, in many cases, a real loss of autonomy; moreover, though, the beliefs maintained by the people in the immediate environment (family, residence staff, etc.) about the elderly person's incapacity and the consequent over-protective behaviour affect him/her, causing this actual loss of autonomy to increase (Little, 1988). Ultimately, this situation may give rise to a vicious circle in which there is progressive reinforcement of the pathological process. Similarly, loss of personal control, common among the elderly, is influenced not only by the loss of the individual's own personal resources (health, memory, etc.), but also by external factors that affect the perception of personal control, such as, in certain circumstances, moving into a residence, agist attitudes, scarce economic resources, and so on.

In spite of the undeniable interaction between individual and contextual variables throughout the lifespan, including old age, psychosocial interventions directed towards factors that are contextual or external to the individual, that is, towards change in social systems, have received scant attention. Quite possibly, one of the main reasons for this lack of attention is the complexity inherent in interventions focusing on the social system (Levi, 1992). Thus, it is a generalised fact that state policies in all countries aimed at solving social or health problems target only a single problem, or part of it, at one time, and, moreover, adopt a remedial approach that focuses on critical situations (for example, a specific health problem, such as an epidemic of gastrointestinal infection, is easily attacked, whilst malnutrition due to poverty is ignored). In the elderly, an illustration of this type of situation is provided by the problem of Alzheimer's Disease. Around this illness, in addition to the progressive cognitive and physical deterioration suffered by the direct victims, there grows a series of problems that greatly affect the sufferer's family (the "hidden victims" of the illness). Political decisions that pro-

pose tackling the problem by concentrating exclusively on the physical aspects of this up to now incurable disorder, that is, the provision of nursing facilities and care, of medication, etc., when the illness is already at a fairly advanced stage, represent a good example of the prototypical intervention to which we refer –intervention focused on a partial aspect of a complex problem, remedial in nature and targeting critical situations. Such intervention, while absolutely necessary, should be complemented by other measures acting on the social system that contribute to alleviating the burden on families involved in caring for sufferers, and to reducing the stress they experience (support services for relatives, respite services to combat care fatigue, programmes for caregivers, family advice services, etc.). Moreover, these measures should form part of an approach that widens purely remedial objectives, which begin with the earliest possible detection of the illness, making possible the design of a plan for appropriate treatment (given that the disease is incurable, but not untreatable) for the sufferer and his/her family. Neither should we forget the importance of measures with regard to the training of professional caregivers, who, in the future, due to increasing difficulties of families to take responsibility for dependent elderly with problems, and also to demographic changes, will foreseeably be of key importance in geriatric care (Rodríguez and Sancho, 1995). In addition, measures could be taken to design appropriate environments (home or institutional) or modify existing ones, to train residence staff to deal with problem behaviour characteristic of old people, and even to introduce regulations guaranteeing the rights of those affected by this disorder, which could be included in future legislation to protect the elderly.

In short, the person-environment system involves a multitude of factors that interact with one another, so that approaching environmental, behavioural, health, etc., problems by considering only a part of this complex system does not augur well for the success of preventive, therapeutic or research activities (Levi, 1992).

Apart from the complexity of interventions at the level of the social system, another of the factors that may explain their scarcity is that, in so far as they imply social and political change, they may be difficult for professionals to accept, given that their implementation is necessarily interdisciplinary, and that they may have controversial results. As a specific example, the recommendation that elderly women should acquire more

social competence as a form of improving their well-being has been questioned (Wine, 1981). The main argument behind this objection is based on the notion that a greater assertiveness on the part of these women may give rise to conflictive relations with other members of the family, who expect more submissive behaviour, in accordance with the traditional status of women.

The process of intervention at the level of the system is well illustrated through the use of a metaphor (Levi, 1992). Let us imagine that the road representing the human lifespan crosses a bridge over a river. This bridge has various defects (holes in the floor, no protective rails at the side, etc.) that create the risk of falling into the water, as there is no completely safe route. In consequence, a large number of people fall into the river. Many of them do not know how to swim. In order to prevent drowning, lifeguards (qualified in first aid) dive into the river, get the people to the bank and try to revive them. If the lifeguards do not manage to save those in the river, these people are swept downriver by the current as far as a waterfall, which plunges them into the depths. Divers then have to make great efforts to bring them back to the surface, and from there to the bank, where sophisticated and costly attempts at resuscitation have to be made.

The conclusion is that the life-saving personnel are, of course, necessary, as are the institutions and resources they represent. However, resources are also necessary for: a) repairing the bridge when it is in a poor state, b) equipping the bridge with a safe lane and warning signs, c) informing people of the dangers of the deep water in case they cannot swim, and d) teaching people to swim and to save other people who cannot swim, and need help (Levi, 1985). In other words, there is a need for different types of intervention directed towards fomenting health and well-being in the elderly –successful aging–, that go beyond initiatives centred exclusively on the individual. Thus, interventions aimed at the wider social system within which people live their lives should, on the one hand, create the most favourable environmental conditions possible (healthy contexts, elimination of negative stereotypes about the elderly, opportunities for social participation, etc.) and, on the other, provide people with the means to acquire personal resources (healthy lifestyles, personal control over their lives, education for health, social competence, cognitive competence, etc.) for preserving their well-being and health, and for preventing

possible problems in the future, as well for contributing themselves to the attainment of these same goals by others.

Various conditions need to be met for the above to take place. Firstly, there must be close collaboration between social planners, who define the political objectives, and professionals and researchers, who test and evaluate these ideas, as well as providing additional knowledge on which to base decisions. Secondly, and related to the first point, it is necessary to have sufficient information, and to this end the ideal way forward is through applied research on intervention targeting the elderly, with special emphasis on how people reach old age with most vitality and in the best conditions of health and well-being (following the metaphor of the bridge and the river, those that cross the bridge successfully).

## CONCLUSIONS

One of the best strategies for achieving successful aging is to understand that the stage of old age is the continuation of the life that has gone before. In this sense, we can learn a great deal from those individuals who today are elderly but healthy. Those that have known best how to age successfully are those that are in a position to transmit important knowledge. The progressive development of competences throughout life, widening their repertoire of abilities, allows them to select from among an extensive range of possibilities when losses that occur in old age deprive them of certain options. We must be aware of the strengths of elderly people and of the environments that allow them to confront the challenges of old age. We can learn from these people to promote effective and supportive contexts or environments, so that other elderly people can benefit from such knowledge. Following the recommendation of Kahana (1992), we must begin to ask the elderly of today about their problems and how they cope with them. Attaining this objective requires a new perspective of analysis, far-removed from the vision of the elderly as deficient, and which accepts that the parameters of success at each stage of life are not necessarily the same.

To facilitate this perspective, we should bear in mind that public policy towards the elderly should essentially be no different from that towards other age groups. Policy should provide citizens with comfort and health, reducing threats to their well-being. For other age groups, such policies have been clear and explicit; the protection of minors and access to culture and education

for children and young people are clear examples of policies benefiting the youngest groups. Let us consider, to take a more specific example, the enormous investment made recently in Spain to reform pre-university education. As far as adults are concerned, there is a clear policy, independent of results, to improve life conditions. For example, the recent, novel and encouraging plan to improve working conditions in our country through the *Ley de Salud Laboral* (Health and Safety at Work Act). While it is true that all generalisations are subject to error and omission, we feel that, in the case of the elderly, policies do not appear to be so clearly directed towards the "development" of this age group and the promotion of successful aging. Rather, and reflecting an attitude shared by society at large, policies are directed mainly at covering the basic, primary needs of this group. Though such attention clearly remains absolutely necessary, other, new and complementary routes must also be opened. In this sense, we believe the use of scientific knowledge with regard to this age group to be pertinent as a preliminary step to the introduction of services. It is necessary for programmes to be designed, chiefly preventive ones, which correspond to global policies and focus both on the social system and on the individual, employing qualified professionals at the different levels of development, administration and implementation. Policies aimed at the promotion of health and well-being may find expression in some of the following programs, though this is by no means an exhaustive list: education for health, optimisation of the functioning of institutional residents through continued training and motivation of staff, promotion of autonomy and independence of elderly people, with special emphasis on the prevention or elimination of excessive incapacity, thorough attention to Alzheimer's Disease patients and their families, plan of action for caregivers of the dependent elderly, development of intellectual abilities, promotion of social competence, training of paraprofessionals, promotion of participation of the elderly in voluntary work, etc. Obviously, some of these lines of intervention are under way at present. In such cases, it is necessary to foment them and extend their reach. For example, a physical activity programme in a Day Centre could be extended, converting it into a global programme that includes a promotion campaign in the target community (change of attitudes, education for health, the benefits of physical exercise, etc.) involving specially trained professionals (with knowledge of the limi-

tations of exercise for elderly people, of useful motivation techniques for the age group, etc.) and specially developed technical and audiovisual material.

A crucial aspect in drawing up appropriate policies for the elderly is the transfer of the knowledge derived from research to policy, services and programmes. Knowledge about this age group, their potential, their deficiencies and their forms of adaptation is extensive, but far too much of this knowledge fails to reach much beyond the limits of the academic environment and research institutions. There is a need for organisms to take responsibility both for fomenting research and for transferring scientific achievements to the practical sphere. In some countries, the response to this need has been the creation of specialised public institutions dedicated to matters of the elderly, which is undoubtedly an appropriate measure.

Of course, the planning of routes of intervention with regard to the elderly should not only take into account scientific-technical knowledge, but should, as a priority, ensure that this age group does not become marginalized. Elderly people should become the chief managers of their own lives, and for this it is necessary to promote their participation at all levels at which decisions about them are made, to favour their involvement in the societies of production and leisure, and to foment in society and among professionals the idea that it is they who make the decisions about their own daily life. As Rodríguez and Sancho (1995) affirm, only in this way will we be able to achieve the improvement of the quality of life of the elderly, whose right to choose and to make decisions is unrenounceable.

To conclude, we should like to stress that the way "successful aging" is put into practice will depend on each individual, depending on one's personal characteristics and the culture in which one lives. Successful aging will thus take a different form for each person, according to his or her peculiarities and own way of adapting to this stage of life. There are no standards for successful aging; each individual shapes his or her own way of achieving it. However, this should in no way be understood as exempting society from its responsibility to contribute to satisfactory adaptation in old age. On the contrary, social policies should ensure that current and future generations of senior citizens have the energy and interest to continue being productive and maintain competences and skills through extensive practice; they should also encourage the search for new ways of overcoming deterioration and loss of functions

and abilities. Undoubtedly, the form, ambit and reach of policies, services and programmes related to the elderly will change as new cohorts appear with different personal, social and educational resources from those of today's elderly, and quite probably with new demands for programmes and services.

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