Critical Perspectives on Successful Aging: Does It “Appeal More Than It Illuminates”? 

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“Successful aging” is one of gerontology’s most successful ideas. Applied as a model, a concept, an approach, an experience, and an outcome, it has inspired researchers to create affiliated terms such as “healthy,” “positive,” “active,” “productive,” and “effective” aging. Although embraced as an optimistic approach to measuring life satisfaction and as a challenge to ageist traditions based on decline, successful aging as defined by John Rowe and Robert Kahn has also invited considerable critical responses. This article takes a critical gerontological perspective to explore such responses to the Rowe–Kahn successful aging paradigm by summarizing its empirical and methodological limitations, theoretical assumptions around ideas of individual choice and lifestyle, and inattention to intersecting issues of social inequality, health disparities, and age relations. The latter point is elaborated with an examination of income, gender, racial, ethnic, and age differences in the United States. Conclusions raise questions of social exclusion and the future of successful aging research.

Key Words: Critical theory, Social inequality, Age relations, Gerontological discourse

Successful aging is one of gerontology’s most successful ideas. Although historical traces of it can be found in Renaissance texts (Gilleard, 2013), the modern gerontological idea emerged in the 1950s and was later crystallized in the work of John Rowe and Robert Kahn. Successful aging has been churned into theoretical paradigms, health measurements, retirement lifestyles, policy agendas, and antiaging ideals. Researchers have also generated a discourse of kin terms such as “productive aging,” “positive aging,” “optimal aging,” “effective aging,” “independent aging,” and “healthy aging,” which together promote (a) an industry of books, conferences, journals, funding, and research programs, (b) web sites (e.g., http://healthyandsuccessfulaging.wordpress.com/), and (c) institutional identities. For example, Wayne State University’s Institute of Gerontology’s banner is “Promoting Successful Aging in Detroit and Beyond,” and Florida State University has a new “Institute of Successful Longevity.” Indeed, Carol Ryff’s (1982) comment, now 30 years on, that, “like goodness, truth, and other human ideals, successful aging may appeal more than it illuminates” (p. 209), still holds true. This essay examines the
theoretical development of successful aging and the critical literature that has ensued, with a focus on the disparities of aging and social inequality in the United States today.

Robert Havighurst (1961) provided an early formulation of successful aging. In the first issue of The Gerontologist, he optimistically described successful aging in terms of life satisfaction that emphasized “the greatest good for the greatest number” (p. 8). Havighurst and his associates saw that successful aging was both an adaptable theory and a testable experience. Furthermore, it could apply to both disengagement and activity theories, which were otherwise contending models of retirement living at the time. Later, large-scale studies such as the First Duke Longitudinal Study (Palmore, 1979) multiplied the factors and predictors for successful aging over longer periods of time. Although Havighurst (1961) cautioned that “no segment of a society should get satisfaction at a severe cost to some other segment” (p. 8), the enduring appeal of successful aging was its positive characterization of the aging process (“The Measurement of Life Satisfaction” (Neugarten, Havighurst, & Tobin, 1961) is listed at the top of Ferraro and Schafer’s (2008) “Gerontology’s Greatest Hits” for most frequently cited social science article in the Journals of Gerontology). Successful agers were satisfied, active, independent, self-sufficient, and, above all, defiant of traditional narratives of decline. Thus, for gerontologists, successful aging scholarship combined antiageist advocacy with empirical research. At the same time, the research paralleled the postwar American preoccupation with individual adaptability and adjustment in later life, a relationship that became a mainstay in the successful aging framework developed by John Rowe and Robert Kahn (see Dillaway & Byrnes, 2009).

Rowe and Kahn (1987, 1997, 1998) introduced a more medical framework in which usual aging and successful aging could be differentiated: The former term referred to nonpathologic but higher risk individuals and the latter term referred to lower risk and higher functioning individuals. Although their earlier work equated successful aging with the absence or avoidance of disease, they later widened it to include cognitive and lifestyle factors. What Rowe and Kahn offered was a hypothesis that merged physical, cognitive, and lifestyle factors with measurable indicators of disease and disability. In effect, Rowe and Kahn maintained that the appropriate lifestyle could result in successful aging, which they defined as (a) forestalling disease and disability, (b) maintaining physical and mental function, and (c) social engagement (Rowe and Kahn, 1998, p. 38). According to Rowe, the “new gerontology” recognized that successful aging requires “full engagement in life, including productive activities and interpersonal relations” in addition to health maintenance (Rowe, 1997, p. 367). To their credit, Rowe and Kahn, following their predecessors, evoked a much-needed optimistic narrative of positive aging in their consistent emphasis on self-directed health across the life course; that indeed one’s experiences in later life could be measured in terms of success, rather than dowsed in conventional expectations for failure. At the same time, however, by aligning their “new gerontology” so strongly to the role of individual volition and lifestyle in maintaining, improving, and even reversing disabling problems, Rowe and Kahn moved successful aging further from the social determinants of health. This issue, along with other limitations in the successful aging paradigm, is elaborated subsequently.

Responses, Limitations, and Exclusions

Although the successful aging literature has grown vast, for purposes of brevity here we divide the main responses to the Rowe–Kahn paradigm into the following categories: (a) Empirical and methodological limitations, (b) theoretical assumptions around ideas of choice and lifestyles, and (c) lack of attention to intersecting social inequalities and age relations.

Successful Aging: Limitations and Modifications From Within

One of the greatest challenges faced by those working within the successful aging framework is the inconsistency across studies in terms of conceptualization and measures, so much so that the meaning of successful aging is often more implied than delineated (Knight & Ricciardelli, 2003; Phelan, Anderson, LaCroix, & Larson, 2004; Pruchno, Wilson-Genderson, Rose, & Cartwright, 2010). In fact, in their review of quantitative studies, Depp and Jeste (2006) identified 29 definitions in the 28 studies they examined, with most (but not all) including a measure of disability or physical function. This variability alone presents limitations to research on successful aging.

Researchers concerned with the empirical and methodological limitations of successful aging have responded by extending or adapting successful aging criteria in alternative ways. The most
prominent example is the work of Baltes and Baltes (1990) and their model of “selective optimization with compensation” in which aging individuals compensate for losses and limitations by adjusting their expectations and goals to focus on those with the highest priorities. Curb and coworkers (1990) propose the notion of “effective aging” to encompass both successful agers and those in the “middle ground” who face physiologic losses and disease (p. 828). Martin and Gillen develop a “spectrum model of aging” to broaden successful aging research at the level of individual development over the life course with the aim of improving care and quality of life (Martin & Gillen, 2013).

These innovative exercises often respond to a perceived methodological shortcoming of the Rowe–Kahn paradigm: Its neglect of what aging, successful or otherwise, means to older people, a situation addressed through qualitative discovery and self-reporting studies (Bowling, 2006; Fagerström & Aarsten, 2013; Rossen, Knafl, & Flood, 2008; Strawbridge, Wallhagen, & Cohen, 2002; Strawbridge & Wallhagen, 2003; Torres & Hammarström, 2009). Although life is lived as a subjective process in time through a diversity of contexts and relationships, “the successful aging paradigm seems to define success as an outcome … a game which can be won or lost on the basis of whether or not individuals are diagnosed as successful or usual” (Dillaway & Byrnes, 2009, p. 706). When the voices of older individuals are included, we learn that disability and disease are not necessarily experienced in terms of unsuccessful aging nor is successful aging a precondition of aging well, and this has led some scholars to modify the model to incorporate coping and other strategies (Phelan et al., 2004; Van Wagenen, Driskell, & Bradford, 2013). And the repeatedly demonstrated discrepancy between the objective criteria (variously measured) and older individuals’ experiences and definitions (Montross et al., 2006) of successful aging has resulted in researchers’ calls to alter the notion of successful aging by combining subjective and objective dimensions. For instance, Pruchno and coworkers (2010) argue for the utility of exploring both dimensions simultaneously, rendering a typology “of successful aging, whereby some people are successful according to both definitions, others are successful according to neither, and still others are successful according to one, but not the other definition” (p. 822).

Our discussion of these limitations, debates over measurements and appropriate criteria, and modifications is not undertaken in order to adjudicate these, but to elucidate them so that we might comment upon their ramifications for gerontology, a topic to which we turn in the final section of this article. Here, we note that regardless of how these debates are decided, their resolution does not move them away from the successful aging framework itself but instead serves to further its prominence and use.

**Individual Choice and Lifestyles**

The successful aging paradigm has drawn criticism for its assumptions around concepts of individual choice, agency, and lifestyle (Katz, 2013). Individualist culture shapes Rowe and Kahn’s formulation about successful aging, which not only emphasizes successes and failures, but also individual responsibility for same. In their book (Rowe and Kahn, 1998), they wrote: “Our main message is that we can have a dramatic impact on our own success or failure in aging. Far more than is usually assumed, successful aging is in our own hands.” (p. 18, emphasis ours). And “To succeed … means having desired it, planned it, worked for it. All these factors are critical to our view of aging which … we regard as largely under the control of the individual. In short, successful aging is dependent upon individual choices and behaviors. It can be attained through individual choice and effort” (p. 37). However the problems of individual choice go back to the lifestyle ideas of sociologists Georg Simmel and Max Weber. Simmel thought that urban modernity created “a tendency towards extreme subjectivism,” a kind of coerced individualism (Simmel in Frisby, 1992, p. 76) that was also constructive of new characters at the edge of cosmopolitan life (e.g., the stranger, the modern prostitute, the adventurer). Max Weber’s critique of lifestyles was part of his analysis of status and class division. Weber claimed that, while people may have pretensions to certain status-bound lifestyles, “the possibility of maintaining the life-style of a status group is usually conditioned on economics” (Weber in Runciman, 1978, p. 52).

For both Simmel and Weber, lifestyle choices and individual volition are always constrained by the material conditions that accumulate lifelong advantages and disadvantages. In this vein, Pierre Bourdieu (1984) modernized the critique of lifestyle practices to include cultural capital, whereby individual choices are disclosed as the products of privilege; hence, those with the most access to health benefits and services also frame their health behaviors within positive lifestyle outcomes. Like
Bourdieu, Anthony Giddens (1991, 1999) forefronts lifestyle in his theories of reflexive and posttraditional individualism, arguing that the structuring of life chances limit individual lifestyle options. The critical traditions of Simmel, Weber, Bourdieu, and Giddens can be seen in the work of contemporary sociologists of aging, such as Hendricks and Hatch (2009), who aver that “lifestyles and social resources deriving from social arrangements work in tandem to structure the life course, yielding cumulative advantages or disadvantages leading to one or another experience in older age” (p. 440).

These and related critiques make it clear that aging research has to theorize lifestyle, choice, health, and successful aging beyond personal choice because lifestyles are configured by differential opportunities and relations of social inequality (Calasanti and King, 2011; Dannefer, 2003, 2006). However, these critical perspectives on lifestyle are lost in the successful aging research because individual choice is reduced to decontextualized health-relevant choices, such as smoking, diet, or exercise (Franklin & Tate, 2009). For example, policy recommendations such as A Survey in Europe on Nutrition and the Elderly: A Concerted Action (2003) conclude that “the identification of people with unhealthy lifestyle habits, and finding ways to improve lifestyle habits of specific target groups is the challenge of future prevention programmes in young and elderly subjects” (Haveman-Nies, de Groot, & van Staveren, 2003, p. 432).

Where successful aging research conceives of health advantages and disadvantages as the results of individual responsibility, buoyed by media narratives of aging winners and losers (Rozanova, 2010), it thus fails to acknowledge social relations of power, environmental determinants of health, and the biopolitics of health inequalities. Indeed, lifestyle and individual volition fit a contemporary consumerist, neoliberal, and entrepreneurial style of thought that dominates health and retirement politics. Where this style of thought intersects with person-centered explanations of health, such as those pronounced in successful aging discourse, the result can be a powerful opposition to state welfare entitlements that “defeat[s] the political lobbying for more social support and resources” (Dillaway & Byrnes, 2009, p. 708).

**Intersecting Social Inequalities and Age Relations**

The most contentious critiques of the successful aging paradigm target those whom it excludes. For example, scholars have questioned what successful aging means for groups who live with dependency and disabilities (Minkler & Fadem, 2002). If they are considered unsuccessful agers in theory, then such labeling deeply affects their treatment by health care regimes in practice. Further, if populations are homogenized as either successful or unsuccessful agers, then the diversity of the aging experience is flattened, especially the consequences of social inequalities as they intersect with age relations. These should figure in theories of successful aging more fully than they do, given all that researchers of intersecting inequities have discovered about patterns in spending power and access to health care, which remain two critical pathways to successful aging as defined by Rowe and Kahn. The advantages and disadvantages that accrue across the life course become more salient in later life. The time in which people are to be “successful agers” is one in which those aged 65 and older are faced with ageism. To this they bring varying material and social resources (based on the intersections of gender, race, ethnicity, class, and sexuality) with which to resist being subjected to this form of inequality. A brief examination of financial and health resources can demonstrate how social inequalities shape opportunities for and constraints upon successful aging in the United States (similar patterns accrue in many other countries in the global North).

Beginning with income, we note that gender-based differences in earnings persist despite women’s increased employment rates (DeNavas-Walt, Proctor, & Smith, 2013, p. 11, Figure 2). Individual choice cannot explain these discrepancies, which prevail despite educational levels and occupational incumbency. For instance, gender comparisons at various occupational levels find that women’s absolute earnings are highest when they have obtained a professional degree; yet the gap between their income and that of men’s with a similar degree (72%) is also greater than at any other educational level (AAUW, 2013, p. 10, Figure 6). Such differences are further shaped by their intersections with race and ethnicity such that White women out-earn racial and ethnic minority women at each educational level (AAUW, 2013, p. 14, Figure 7). Similarly, although women’s occupations pay less overall than do men’s, women who work in traditionally male jobs still earn less than their male peers; and even in female-dominated occupations, such as registered nursing, women’s earnings are only 91% of men’s (AAUW, 2013).
Similar racial and ethnic patterns of economic inequalities persist. In 2012, the ratio of Black to non-Hispanic White median income was 0.58, not significantly changed from 1972, whereas the ratio of Hispanic to non-Hispanic White median income actually declined from 0.74 to 0.68 (DeNavas-Walt et al., 2013, p. 8). Poverty rates also reflect these disparities; only 9.7% of non-Hispanic Whites were poor in 2012 compared with 11.7%, 25.6%, and 27.2% of Asians, Hispanics, and Blacks, respectively (DeNavas-Walt et al., 2013, pp. 14–15). Such systemic differences in earnings become magnified in a time of recession where impacts of economic downturns are not evenly dispersed. Racial and ethnic groups with the lowest incomes (Blacks and Hispanics) saw the largest percentage decreases in the 2008 recession (DeNavas-Walt et al., 2009, p. 7), while class-based income inequality increased (DeNavas-Walt et al., 2013). Older workers also face increasing odds of losing their jobs and difficulty finding comparable employment in later life (Johnson, 2009; Roscigno, 2010). Once unemployed, Black and Hispanic older workers are less likely than non-Hispanic Whites to find new jobs and thus face long-term joblessness or leave the labor force altogether; Hispanic women are particularly disadvantaged (Flippen & Tienda, 2000) and all such workers lose income for their Social Security and/or other pensions. Ending up in jobs that pay much less than previous occupations further their financial woes. Taken together, these factors mean they also will have lower incomes in retirement (Johnson, 2009, p. 29).

The results of these employment and income patterns include differences in health and health care, which affect the ability to realize ideals of successful aging. For example, those who have unstable or low-paid work have fewer benefits and lower access to health care, which in turn influences their ability to work and receive higher wages. Racial and ethnic minority members of the working class are more likely to occupy lower skilled jobs that are exposed to toxic working conditions or are physically demanding, thus increasing their health risks. Yet such workers are also less likely to have health insurance coverage of any kind (Brown, 2009; DeNavas-Walt et al., 2013; Williams, 2004) and tend to receive care in less optimal settings without the benefits of a continuity of care (Williams, 2004). Taken together, racial and ethnic minority groups are more likely to enter old age in poor physical health. Adding to these outcomes, gender relations also influence the ways in which people define and maintain health. For example, scholars have faulted the performance of masculinity for leading men to engage in risky behaviors or to neglect health protective behaviors (Courtenay, 2000). Yet men do attend to their bodies in contexts where good health and functional capacity are connected to masculine ideals and expectations (O’Brien, Hunt, & Hart, 2005).

If different groups enter their later years with varying financial resources, then these deeply affect how they govern their ability to engage in the activities related to successful aging as defined by Rowe and Kahn. Indeed, older men and women have significantly disparate median incomes and average monthly Social Security benefits (Administration on Aging, 2013; Social Security Administration, 2013), but given that men’s median income is almost twice as high as women’s, it is obvious that men also have more sources of income. Reliance on Social Security for a large portion of one’s income certainly bodes poorly for financial security in old age; among those who are poor or near poor (below 200% of the federal poverty line), three fourths of their income comes from Social Security (Issa & Zedlewski, 2011). And gender, race, ethnicity, and class all shape the likelihood that one will rely predominantly on Social Security and experience financial strain. Given these financial realities, it follows that many people aged 65 and older—and women more than men, as well as minority group members and poor or working-class people—are constrained in their lifestyle or health choices. This is so despite the availability of Medicare because, while the entitlement enhances older groups’ access to health care, their copayments and deductibles remain problematic to those with low levels of disposable income. In 2012, nine percent of those aged 65 and older are considered poor under the official poverty threshold ($11,011 for an individual 65+). However, this number jumps to 15% when the supplemental poverty measure, which takes such health expenditures into account, is used (Short, 2013).

Again, the intersections between race, ethnicity, gender, and age are salient. Racial ethnic minority group members do not receive equivalent treatment for dementia despite their receipt of Medicare, even when socioeconomic status, health care access and utilization, and comorbidities are considered (Zuckerman et al., 2008). Black Medicare beneficiaries also receive fewer medical procedures and lower quality medical care than do Whites, even under similar conditions of
income, insurance, disease, and medical facility (Williams, 2004). Furthermore, because Medicare is more geared toward acute than chronic illnesses, this means that women who have higher rates of chronic disabilities (Quadagno, 2014) pay more out-of-pocket expenses than do men, despite their lower financial means. Such do not appear to be the result of lifestyle decisions or other personal choices but are configured by relations of power. And to the extent that power relations themselves are not dismantled, the inequalities that constrain individual choice will persist, and the call to age successfully will continue to demarcate winners and losers and will itself serve as another marker of group-based differences.

Critical Conclusions

A key contribution of critical gerontology is its reflexive attitude toward the major concepts by which problems of aging are addressed. Successful aging is certainly one such concept. It has animated a controversial space in which almost every branch of gerontology has participated in some way, including the protagonists themselves. In an exchange between Matilda White Riley and Robert Kahn, Riley accused Rowe and Kahn of not taking into account the fact that “changes in lives and changes in social structures are fundamentally interdependent” and thus neglecting “the dependence of successful aging upon structural opportunities” (Kahn, 1998, p. 151). Kahn replied that an obstacle to demonstrating “the effects of major structural interventions is the expense and difficulty of mounting such interventions” (p. 151). For Riley, the sociologist, understanding aging requires a vision of group activities and social structures. For Kahn, the scientist, society is a human population laboratory into which social improvement is based on rational intervention. In response to a different criticism concerning the lack of self-reporting in successful aging research (Strawbridge et al., 2002), Kahn says that, despite his and Rowe’s best intentions to invite researchers “to investigate the heterogeneity among older people” and to “encourage people to make lifestyle choices that would maximize their own likelihood of aging well,” he shares the concerns of his critics “that the term successful aging may itself have the unintended effect of defining the majority of the elderly population as unsuccessful and therefore failing. I believe that this problem, to the extent that it exists, reflects a characteristic of contemporary American culture rather than something intrinsic to the concept” (Kahn, 2002, p. 726). However, Rowe and Kahn’s well-taken point concerning the importance of exploring heterogeneity again refers to individual differences; this is quite different from group-based differences resulting from social inequalities.

Rowe and Kahn’s work (1998) sought to combat myths of aging, particularly those that rely upon and promulgate narratives of decline. However, the hypothesis that successful aging is a minimization of declines in physical and cognitive health, or in social connections—rather than as a social location different from (and in conflict with) middle age—shows too little of both the social forces that affect success and the groups’ definitions of it. Both access to the means to succeed, however defined, and the very definition of success itself are matters of social inequality. Ultimately, the power relations that underlie ageism are not challenged (Calasanti, 2003). In part, these power relations derive from a culture in which ageism is so embedded that we may not realize that middle age serves as its implicit standard (Calasanti, 2003). Thus, gerontologists might consider demonstrating the value of diverse, inclusive, less ageist, and less ethnocentric experiences of aging, for example, the Eastern spiritual context of “harmonious aging” (Liang & Luo, 2012). Again, other studies that have modified the successful aging framework by focusing on subjective assessments provide starting points from which to build alternative conceptions that value old age as qualitatively different from middle and other age categories, rather than a time of life defined by loss or lack of success. In Knight and Ricciardelli’s (2003) study, older participants wisely understood the purpose of their aging lives because “it was a time to take things as they came” (p. 237).

As for the future, in both of his responses above, Kahn suggests that greater interdisciplinarity is needed between scientists and social scientists in order to actively improve the lives of older individuals. To this end, we, as sociologists, hope our review of the critiques of successful aging—in concept, theory, and practice—makes a contribution. We also expect that, in the spirit of critical gerontology, the successful aging paradigm in all of its manifestations will continue to inspire passionate debate between the disciplines, to question why certain models fill theoretical voids in gerontology, to be wary of the popular appeal of positive discourses in aging research, to think historically
about the concepts we promote and their exclusionary consequences for the people we care about, and to see clearly which interests are served and knowledges mobilized by the ideas we espouse.

References


