On Being Very, Very Old: An Insider’s Perspective

Elaine M. Brody, MSW, DSc (Hon)

My husband Steve (Stanley J. Brody) encouraged me to go to graduate school while he was in the Navy during World War II. When the war was over, I followed the traditional path most women took in those days, becoming a homemaker and raising our two children. When those children were of school age, I took the only part-time job I could get that was close to my home. It was at the PGC. I was hesitant because I had trained to do psychiatric work with children. Art Waldman, the creative genius of PGC, persuaded me to try it. He said, “If you don’t like it, you can leave and no hard feelings.” I tried it, I liked it, and I never looked back. It was the only place I ever worked, but because the PGC was constantly changing, it always felt new. (Actually, I ended up working with parents and children as I had planned, though the parents were old and the children middle aged.)

On my first day at work, I was given a spacious but windowless office in the basement next door to the morgue. But it was at lunch that I really began to learn about the ailments of the elderly adults. In the small staff dining room, Jerome, the elderly waiter, asked me, “What do you want to order?” “What do you have?” I countered. He replied, “We have diabetic, ulcer, salt free, gall bladder and regular.”

At that time, the agency was a 150-bed home for the aged and, like similar facilities everywhere, was mandated to care for the “well aged.” Such facilities were the descendants of the poor houses of yore. Most of those being admitted were in poor economic circumstances and had few expectations of environmental amenities. Some of the elderly
men assumed that the air conditioning vents were urinals, with expectable unfortunate consequences.

I was assigned to do “intake” of the individuals on the long waiting list for admission. The routine medical screening examinations were finding most applicants to be ineligible because they were not “well.” At the same time, the number of “well” applicants was shrinking.

What was happening was that at that particular time, a process of significant change was under way: A series of developments that began in the 1920s were converging to create dramatic changes for the aging population and therefore for the population as a whole.

First, older adults were not only increasing rapidly, numerically and proportionately, but their health characteristics were also changing. As you know, breakthroughs in prevention and treatment of the great epidemic diseases were allowing more people to grow old and very old. Therefore, they became vulnerable to the chronic ailments that Gruenberg (1977) called “the failures of success.”

Another significant process was a series of socioeconomic developments, such as Social Security, Medicare, Medicaid, and Supplemental Security Income. These programs had been propelled into existence by the Wall Street crash of 1929. I was 7 years old at the time of that crash, and I remember the Great Depression well. Those memories caused an almost visceral reaction to the current economic crisis in those of us who are now 85 years or older and experienced that grim period firsthand. The reports of despairing men jumping out of windows; three-generation families, including those of our friends and relatives, moving in together because they could not afford to live in separate households; two in five Americans jobless. There were bank closings, farm foreclosures, and family migrations across the country to find work. It was a massive disaster.

President Franklin Roosevelt set up a commission, and Congress enacted the Social Security Act in 1935. The Act did not create an income floor at all once, of course. It took many years for it to do what it was intended. As it phased in, fewer and fewer older people lived in poverty, though too many still do.

That impetus given to social policy development is what my husband Steve Brody (1987), in his Kent Award lecture, labeled the “catastrophic approach” as the response of social policy to economic catastrophe. Thus, the Social Security Act responded to the catastrophe of the Great Depression and the need for the government to provide basic subsistence. Before Social Security, more than half of all people aged 65 years and older were totally dependent economically on their adult children, and another 25% were dependent on Public Assistance Programs. Harsh regulations enforced adult children’s financial contributions toward the support of their elderly parents. Social Security gradually took hold (together with private pensions). What a difference it made! By 1980, only 1.5% of the old were totally dependent economically on their children, though poverty was still widespread.

As Steve pointed out in his lecture, 30 years after Social Security, Medicare and Medicaid responded to a “second catastrophe”: the resources of entire families were being depleted because of paying for medical care for older people. Some of you may remember, as I do, the neglect that previously had been suffered by poor older people before Medicare: the six or eight bed wards in hospitals, the humiliating outpatient clinics with 50 or so people waiting to see a doctor, families giving up vacations, and children wearing hand-me-downs and foregoing many amenities.

Social Security, Medicare, and subsequent legislation benefited not just old people but all generations. These government programs were followed by the invention, development, and funding of facilities and services for the older adults, beginning with the Older Americans Act in 1965. Previously, the help the adult children gave to their elders often resulted in severe deprivation of Generations 2 and 3. When old people need help, the domino effect disadvantages the younger members of the family.

Still another process that occurred was the explosion of professional and scientific interest in aging. In December 1945, the Gerontological Society of America (GSA) was formed with 23 members. By the time I became President of this organization in 1980, membership had increased to 5,581. Practice, as well as research, was developing rapidly. I am glad that we have maintained our strong interdisciplinary approach and our emphasis on the essential partnership between research and practice. Those principles were central to M. Powell Lawton’s creed. Anthropologists, sociologists, social workers, physicians, nurses, psychologists, architects sat around the same table to contribute their insights.

Friedan’s (1963) book, The Feminine Mystique, was published, creating a sea change in women’s lives and triggering their rapid entry into the workforce. Many women (the main family caregivers to
the old) took on the additional role of out-of-home work. Middle-aged women entered the work force at a faster rate than any other age group. This process contributed in turn to the phenomenon of the overburdened and stressed women I called “women in the middle,” who were my main research interest for many years. Ironically, many who responded to Friedan by going to work were forced to quit their jobs to care for an older person in the family (Brody, 1990).

The net result of those developments was a change in the characteristics and needs of older people as viewed through the lens of the PGC’s applicant list: Our applicants were chronically impaired, not “well.” Their ranks were increased by those with Alzheimer’s disease who were being discharged from state hospitals with the benevolent rationale that they were being sent “back to the community.” Some of our applicants were being enabled by Social Security to live in their own homes and avoid institutions. But social, as well as medical, problems often forced applications. Applicants who were childless and widowed had fewer family supports to help them live in the community. Or they had “old” children who were sick or who had died. Those who had no family were exemplified by the elderly man who, when asked why he sought admission, replied simply, “I am an orphan.”

All those developments together—demographic, legislative, scientific, economic, and social—combined at that point in time to cause dramatic changes in the lives and care of older people. At the same time, the pool of physically and/or mentally disabled old people in the community who needed a care facility was growing rapidly.

Convinced that our admission policies at the PGC were outmoded in accepting the “well aged” and rejecting the “impaired aged,” I lobbied Art for change. He gave me permission to follow-up the people who had been rejected to see what had happened to them.

That was my first “research” study. Though I knew little of sophisticated research methodology, I designed a questionnaire so that I would have comparable information about all the old people we rejected in the previous year. After interviewing all of them, I pushed back the furniture at my home; spread out all the data sheets on the floor (this was decades before the advent of personal computers); and did correlations by walking around the room, picking up the appropriate papers, tallying them, placing them back on the floor, and then going on to next variable (Brody, 1966b). I could not do all that bending today.

I found that some of our rejectees had died, some were living in the homes of severely stressed and crowded families, and some were being neglected in “boarding homes.” Art used my report to persuade our Board of Directors to relax our admission criteria gradually—a policy that quickly gained momentum. Ultimately, we not only accepted impaired and disabled old people but also invented and developed special programs and facilities with different levels of care for different groups. Over the years, we grew from the original 150-bed facility to a campus that housed and cared for 1,400 older people in different kinds of facilities (apartment buildings with services, a fully accredited geriatric hospital, a special building for Alzheimer’s patients, assisted living, outpatient diagnostic services, etc.). We served thousands more who lived in the community. (For more complete description of the PGC, see Brody, 2001.)

A year after my follow-up study, Art Waldman lured Powell Lawton to the PGC to create a Research Institute. (Whoever heard of a research unit in a home for the aged?) He was given various documents including my follow-up study in order to orient him to our facility. Walking into my office with my report in hand, he asked, “Where did you send this for publication?” “Nowhere. It was an in-house study,” I replied. Powell said, “Publish it!”, so I did and moved rapidly into research.

That study and Art Waldman’s ensuing actions were valuable lessons to me in the translation of practice into research and back again into policy and practice. In social work school, I had been taught to “listen” to the meanings behind the words communicated by my clients. When I did research studies, I thought of research as “organized listening.” I often used both kinds of listening in research studies to follow, using a qualitative study to precede the quantitative research so as to identify the issues to be included in the survey questionnaire.

Thus, in my past perspective, there was a time when almost nothing existed to benefit older people, but “the curve was in the right direction.” It was an amazing few decades. And I was growing old, though I was not really aware of it.

My Present Perspective

I have spent many years, first becoming young-old, then old-old, and then very very old.
I now live in a condominium building in a world of older people. The building has a pleasant dining room and amenities, such as a swimming pool, lectures, parking valets, transportation to theater, and concerts, but no health services. My neighbors are not representative of all older people nor are they like the older persons with whom I worked professionally. Most are better off financially and are mentally intact and physically able to care for themselves (though some have caregivers). Most are college graduates, many still drive cars, and most are widowed. Though the age requirement is 60+, the average age is about 85, with many people in their 90s and a handful 100 or older.

My “present” is firmly linked to my past because many of the people in my building (the 85+) share my past. They, too, remember the Depression (and often have stories to tell of their experiences during those years). Almost all have benefited, as I have, from the prevention and cure of infectious diseases and now experience the chronic ailments that are the “failures of success.” We saw Social Security, Medicare, and other beneficial programs come into being. The women are the very ones who read Friedan’s book, formed discussion groups to talk about it, and entered the workforce in large numbers. The 85+ group has not forgotten those experiences. They (we) are those very same people grown old.

We are different from the very old of the past. We have had more education and better health care since early childhood. Many more women in our age group have done out-of-home work than did our mothers. Transportation, communication, and technology have exploded in our lifetimes (although some of us do have trouble with the latter). We, the very very old, are a new frontier—for ourselves and for you to know and understand. We are the most rapidly growing elderly age group. By 2050, we are expected to constitute almost 20 million people or about one fourth of all elderly Americans.

We have all been marked by the Great Depression. Many of us, even those not at risk, spend money or rather do not spend money, as we learned to do in the 1930s. A typical example is the man who laughed at himself as he told me he had purchased things at the grocery store that morning that he did not need, just because he had some discount coupons.

Though my personal life is very different from what it had been while I was married and working, I have not been able to get out of the habit of “listening.” Although I no longer listen as a social worker or engage in the organized listening of research, in my old age, I cannot keep from listening to what my friends and peers say—the ups and downs of their lives, their concerns, worries, problems, and joys. As an individual, I will report some of that unorganized listening. As a gerontologist, I can safely leave the organized listening—the research—to you. I will paint their concerns in broad-brush strokes, ignoring the smaller upsets and annoyances, such as a low bridge score or a “bad hair day.”

My present perspective, then, is that of an 86-year-old woman who, I suppose, was prepared for old age intellectually but not emotionally. Even my children are growing into the stages of life I studied. Common experiences of old age, such as illness and losses, were unexpected, even though expectable.

I do not remember becoming old. All of a sudden, I was there. Others perceive me as old. Cars stop to let me cross. People offer to help carry my packages. My grandchildren “check up” on me when my children are out of town and hold my arm when we cross a street. People my age walk more slowly and fatigue more quickly. Our waistlines thicken and our hair thins. Our balance is not great. We develop lots of wrinkles. One of my granddaughters is observant in detecting which of my friends have had what she calls “a little work done” on their faces (though having such “work” is by no means limited to the old). Some have had to give up driving—with the accompanying loss of independence and feelings of competence that entails.

Our perspective on age has changed. One day, three people in succession said to me, “Did you hear about poor Harold? He was too young to die. He was only 83.” A 92-year-old man died suddenly. Until that moment, he had been a regular member of his Neighborhood Security Patrol. As Jerry Seinfeld said, “Who dies at 70 anymore? It’s old-fashioned.” A woman who had recently moved into our building looked closely at three of us who were chatting with her and said, “I can see that I will bring down the average age in this building.” With the three of us glaring at her, I told her, “You just made three good friends.”

What Are Very Very Old People Like?

Gerontologist Bernice Neugarten found that “as one grows older, one grows more like oneself.” The
difficult thing is to sort out the concerns of the people I know that are due to each one’s unique and continuing personality and life situation from those that are related specifically to our advanced age.

My favorite example of continuity of personality is my own mother. She was a dedicated world-class worrier all her life. A bad back hospitalized her when she was well into her 80s. My son visited her and asked if the doctor had prescribed any medicine. “Oh, yes,” she replied, “he prescribed Valium, but I do not take it.” “Why not?” my son asked. “Well,” said my mother, “if I take Valium, I can’t worry.”

In addition to the economy, health is an omnipresent concern. I do not know anyone my age who has no ailments. You know so much about that subject that I will not dwell on it. I will say, however, that it is impossible to keep track of the multiple ailments of each of our friends, so there are a number of subterfuges we adopt. On meeting a friend, it is safe to ask, “Tell me, how is your condition?” Or “What did your doctor say?” When I asked a friend who had been ill but was now recovered how she was feeling, she answered, “I’m bored.” Then, she hastened to add, “but boring is good.”

I realized one day that most of the animals that are the older people’s pets are also advanced in age and have chronic health problems. One dog has arthritis, another has a bad heart, a third has breathing problems, a cat named Libby has high blood pressure, and so on. Animals, too, have increased in life expectancy. Pet pharmaceuticals have become a major industry.

Certainly, our reactions to our ailments show continuity of personality. But now, we have more ailments to be continuous about. We are all on a slippery slope, and we know it. We feel ourselves sliding. Most do what we hope will slow the process—exercise, swimming, yoga, walking, and golf. In the main, what we try to do continues our past lives and is as diverse. The change is in the speed and the amount of those activities. We have trouble accepting the fatigue and other limitations that arrive more quickly.

The specter of Alzheimer’s disease hovers over all of us. My friend Ann arranged a meeting of three friends to discuss the fact that a fourth had become very forgetful. The latter had no family. So, what to do? But Ann, who had convened the meeting, forgot when it was to take place.

Despite gallant efforts at activity and humor, inevitably people become ill or disabled. And we often have to make new “best friends” because old friends, to say nothing of family members, die. “I keep losing pieces of myself,” one man said. The question, “Hi, how are you?” is too often answered by a glum, “Well, I’m here” Or “I woke up this morning.”

What is impressive, and in keeping with the theme of this conference, is the resilience of some of my peers. The very oldest are greatly admired, and many function very well. A 90-year-old woman had a hysterectomy, and during her convalescence, she continued to plan her own birthday bash. Another birthday party was given by 98-year-old Betty, a former judge, who chose a gourmet menu preceded by cocktails and hors d’oeuvres; arranged the seating with due attention to her guests’ friendships; and then worked the room, visiting each table and chatting with each of the 100-odd guests. She wore an elegant suit made for her in Switzerland when on recent travel with a somewhat younger “boyfriend.”

Also on the positive side, most of the very old still have a capacity for enjoyment. We love socialization and recreational activities. All—men and women—enjoy dressing up (in current fashions, of course) and going to a party—particularly if there is music, dancing, hors d’oeuvres, and an open bar. And we go to the theater, reading groups, movies, and so on. Bridge is big.

Women outnumber men, of course, as in the total older population. But it is touching to see couples who have been married many decades dancing smoothly together, relaxed, and holding each other gently. There have also been marriages of couples who met and fell in love in our building. And... some liaisons.

Most of my peers are also resilient in adapting to their new environment. One woman told me she is an artist and had always painted life-size lions and tigers. When she moved to our building, however, she no longer had enough room for such large productions. Moreover, the canvases and frames had become too heavy for her to lift. So she adapted, albeit in her own fashion. Now, on smaller canvases, she paints only the heads of those animals.

Some of us are adept with computers and cell phones. Some of us are not. A cartoon in the “New Yorker” captured the dilemma some of us feel. Titled “How Grandma Sees the Remote,” the cartoon showed Grandma looking bewildered. Her large remote had buttons labeled: “TV explodes,” “Launch rocket ship,” “Tidal wave starter,” “House blows up,” “Drop the big one,” and so on.

The Gerontologist
When I was having trouble with my computer one day, and my son was attempting to help me via the telephone, he finally said, “Mother, go outside and wait until a 6-year-old boy comes along. Ask him to look at your computer, and he’ll fix it in five minutes.”

In addition to the economy and our health problems, the very old worry about family matters, mainly children and grandchildren. The sudden awareness that our children are getting old, or are old, comes as a shock. “My son (daughter) is retiring. I can’t believe it.”

When I talk about some of the worries my peers have about their aging children, you will ask, “Didn’t they worry about their children when they were younger?” The answer, of course, is yes. There is no magic age that is worry free. But the seeds of concerns often present in earlier life now stand out in bold relief, and our worries rise in importance and urgency. And the content is different. No longer worried about their children’s school grades or measles and mumps, for example, but about their heart attacks and the ailments and disabilities associated with middle age and young-old age. Almost every one of my friends has a “child” who is having some health problem: the need for a hip replacement, breast cancer, heart problems, and so on. No longer worried about how their children did on college entrance but about their failing businesses and divorces. Some have a grandchild with a serious ailment or disability. Most bitter of all, how to recover from the death of a “child”?

And, in the context of the current economic crisis, many are seriously worried about the financial prospects for our near-retirement-age children as well as their own dwindling assets, which they have no way of replacing.

Then, there are those who are sadly concerned about middle-aged or young-old children who may be retarded, physically disabled, or mentally ill. Such people live longer nowadays, and who will take care of them when the elderly parent dies?

When the old person has economic resources, the worry is often about how to allocate those resources among his or her children in the will. Should assets be divided equally or equitably? Should a rich “child” be left less than one who is poor? Should stepchildren or step-grandchildren share equally in whatever estate will be available? Should those who have a disabled child leave more money to that one than to the other(s)? For widows, the weight of making such decisions alone is heavy.

An almost universal experience is the shift in the balance of dependence/independence between elderly parent(s) and adult child(ren). When the older person begins to need some help, the issue for him or her is the fear of losing autonomy—control over one’s own life—and no longer having the essential sense of mastery. The beginning dependency of the elderly parent may initiate a struggle (mild or severe) that is reminiscent of the struggle between a parent and an adolescent. The adult child tries to “take over” and to make decisions, and the parent resists. The shift in independence/dependence is a central issue and reactivates unresolved conflicts about dependency in both generations. The siblings may become involved in the problems that ensue. In some families, the issue is resolved in a relatively orderly manner; in others, it may become an acute crisis. The struggle for control between the elderly parent and middle-aged child is similar to the adolescent struggle. Yet, despite adolescence being generally foreseen as inevitable and expectable, it still daunts us. A parent’s dependency is different in that it presages more dependence rather than independence as with the adolescent.

When a group of my friends were discussing dependence/independence problems, one said plaintively, “When did we become afraid of our children?” That question was greeted with a burst of understanding laughter.

Some older people experience a nagging fear that their “old” children will not have the capacity to care for very old parents. Almost 50 years ago, I wrote about the increasing number of families that contained two generations of older people (Brody, 1966a). Nowadays, many daughters aged 65 years and older are primary caregivers of disabled old people. And more than one third of people aged 60–74 years have a surviving parent.

When very old, one is likely to have grandchildren and great-grandchildren, thus increasing the number of descendants about whom to be concerned. My father, a reflective man, wrote an essay published in The Gerontologist called “Even Unto the Fourth Generation” (Breslow, 1980). He wrote that events—negative and positive—in the lives of his grandchildren affected him doubly because he cared so much about members of both younger generations. He also wrote that he was sometimes critical of the way in which his children were bringing up their children but that his gentle criticism was often politely ignored.

My mother was less restrained, often remonstrating with my children about how they were bringing...
up their children (her great-grandchildren). When my children asked me to talk to her and get her to stop, and I did, my mother looked at me in amaze-
ment. “Why should I stop?” she asked. “Because it’s interfering and intrusive,” I replied. My mother thought about that for 3 seconds, then said, “But I do not mind being interfering or intrusive.”

There is a happy and gratifying side to family relationships, of course. For those whose number of descendants increases, there are the gatherings that surround births, christenings, bar mitzvas, graduations, weddings, and so on. Our children and grandchildren provide us with the gifts of babies and young children.

And we keep trying to take care of our children! Even when we are very very old, the help still often goes downward through the generations. I have seen people older than 85 years travel across the continent to help an adult child who is having sur-
gery or is suffering from cancer or who had a heart attack. Many old people help their children finan-
cially if they can. And we avoid spending money on ourselves so that we can leave it to the next generation.

Most adult children are reliable, dependable, show affection, and support. Their behavior bears out the huge amount of research on the subject of intergenerational relationships. They mobilize to help the old person move and get settled (not an easy job). They arrive (sometimes from other con-
tinents or across the United States) when the par-
et is ill. They keep in touch. They gather and make birthday parties. And they give the elderly parent what is wanted the most—the sense of con-
nection, of having someone who cares. The “back-
up system” is also extremely visible and active. Grandchildren, stepchildren, nieces, and nephews fill in when children are not there. (Part of my backup system is here with me today.)

Despite the well-documented increase in family help to the older people, some are now again ac-
cusing adult children of “putting more of the bur-
den onto government.” Schultz and Binstock (2007), in their recent book, pointed out that peo-
ple they call “Merchants of Doom” keep pitting the generations against each other. Long ago,
Shanas and colleagues (1968) called such attitudes a myth like a Hydra-headed monster. Again the monster has grown a new head.

“On balance, is it good or not so good to live to be very very old?” Most who have done so say that it is good and not so good. “IT DEPENDS.” Advanced old age dictates neither pessimism nor Pol-
lyanna optimism. Recently, a man of 104 years old—a former movie mogul—was given a special award at the Academy Awards ceremony. He held his arms out to the applauding audience and said, “This is the good part of getting old. I don’t rec-
ommend the other.” However, we should not glamorize getting very very old because most who do are not able to attend Academy Awards and/or to express themselves in that way.

**Getting Very Very Old Has a Price!** — A large survey received enormous publicity when it reported findings to the effect that happiness increases as one grows older, so that the oldest Americans are the happiest (Yang, 2008). Of course, that is counterintuitive when one is acutely aware of the myri-
ad of health problems and interpersonal losses that occur so frequently in old age. But the survey find-
ings were tempered by the facts that the people who were found to be happier had more income, were married or had a confidant, were in good or excellent health, were not in nursing homes, and had survived selectively. IT DEPENDS.

And, of course, it also depends on one’s “expectations.” I am reminded of a scene in a movie when an about-to-be-married but ambivalent son asks his father, “Are you happy?” When the father re-
plied in the affirmative, his son asked, “What is it that makes you happy?” The father replied, “A nice pot roast, a good chicken . . . .” Expectations. IT DEPENDS.

Recently, while chatting late at night with one of my granddaughters, she asked me, “Are you happy, Grandma?” When she saw that I was strug-
gling for a response to that existential question,

she said, “I’ll ask the question this way: Are you glad to be alive today?” I was able to answer that question at once. YES! I call it the Karpman Kues-
tion, naming it after my perceptive granddaughter, Hannah Karpman.

**Future Perspectives: Professional and Personal**

My future perspective is informed by my past and present perspectives and is, of course, my per-
sonal viewpoint. I do not presume to make any predictions.

For much of my life, the curve was going in the right direction for older people. The result is that today’s older Americans are markedly different from previous generations. They are more prosperous, better educated, healthier, and live longer. The Census Bureau projects that those differences
will accelerate as the first boomers hit retirement. And disability will be postponed to one’s later years. All of that, of course, is good even though we had not gone the whole way.

But in many ways, that curve changed its direction and has been moving in a downward trajectory. I will not spell out the current economic crisis, as you know it all too well.

Though that is disheartening, because I am very old, I can look back to a past that was much worse. Before 1929 and the “crash,” we had no Social Security, no Medicare, no Older Americans Act, no facilities or services for the aged, and so on. When the curve began to move upwards, all those came into being. Since 1945, we—the members of the GSA—have accumulated much knowledge and practice expertise that has been applied to help older people. Interest in aging has soared.

It is my hope (not a prediction) that our recent and continuing economic downturn will, like Steve Brody’s economic catastrophes, cause reversal of the downward curve in social policy and once again enable improved policy measures to help older people and their families. As Steve wrote, “Developing favorable public policy depends on our values. It is not a question of our ability but on our willingness to do so (Brody, 1987).” IT DEPENDS. When I met Rob Hudson (Editor of GSA’s Public Policy and Aging Report) here the other day, he warmed my heart by spontaneously remembering and mentioning Steve and that lecture.

My personal, if unsatisfactory, answer to the question “Is it good to be very, very old?” is IT DEPENDS. And it depends on our expectations.

Earlier in this talk, I described my friend Betty’s 98th birthday party. She said in her one-line welcoming speech, “I’m glad you are all here, and I’m glad I’m here, too.” Remember: she is “exceptional, not typical.” She has enough money, has a very pleasant living style, is essentially in good health, has good functional capacity, has a boyfriend, and has plenty of beautiful clothes. (That last variable does not appear on any morale scale.) Her lifestyle meets her expectations. IT DEPENDS.

True, not all the elements of a “good” old age are within our control. But some are. Though we cannot do it all, we have shown in the past that we can remedy some of the conditions that impede “happiness.” We, as a nation, can see to it that there is an adequate income floor. We can see to it that good health care is affordable and available. We can see to it, although we have not always done so, that nursing homes are places for care, not neglect. (More than 20% of people my age or older are in nursing homes.) We can see to it that a range of support services and living arrangements exist and are accessible when needed. We can see to it that funds are available for further research to identify what is needed for the well being of older people. Instead of piously invoking the need for adult children’s “filial maturity,” we can as a society meet our collective filial responsibility (Brody, 1985b). As someone said before me, “Yes we can!”

**Future Perspective About Gerontology**

In the past, gerontology was an exciting enterprise and, in my view, will continue to be that way in the future. There is always change and the emergence of new ideas to be explored. Older people’s characteristics change constantly in response to trends in health care, ethnicity, education, environment, new ideas, and broad social trends, for example. Nothing remains static, and no findings are written in stone.

In the GSA, contact with gerontologists with different skills and professional orientations is a source of enrichment. It seems to me, however, that nowadays there is less communication of relevant findings to policymakers. I would hope that we can return to the days when our research-based recommendations were sought by the appropriate Congressional committees.

The stimulation provided by gerontology also lies in the fact that the findings of each research study raise new questions to be explored—a never-ceasing source of renewal. Even as I was writing this article, for example, I wanted to know more and more about what my listening to my age peers was yielding. I am a great believer in listening and translating what I hear into organized listening (research). Being very very old—85+—is an example. There are now many of us with many more to come. What do we really know about us? Gerontologists can explore our concerns and thoughts. My friends were unknowingly providing us with clues, some of which are sprinkled throughout this article.

Many years ago, in a study of older people’s day-to-day health concerns, we debriefed the interviewers and asked them, “What is the main piece of advice you can give health professionals?” The interviewers, over and over again, said, “Listen to what older people are really saying . . . not only to the words but to cries, whispers and silences. Really listen so that they know their
concerns and feelings are being recognized” (Brody, 1985a).

Titmuss (1970), in his foreword to Helping the Aged, wrote of the value of listening and asked “who is listening in society for the sounds and symptoms of the need for help?”

A Personal Future Perspective

My personal future perspective is expanding. My four 20-something granddaughters are in the family formation stage of life, bringing some new members into the family. And in addition to the children and grandchildren who are my future, I was expecting a great-grandchild while this was being written. Jonah has now arrived!

The GSA and its members and staff have been an extremely important part of my life. I thank you very much for this opportunity to talk with you once again—my “Last Hurrah”—particularly because this lecture was commissioned by the Polisher Research Institute in memory of the extraordinary M. Powell Lawton, my long-time colleague and friend. Yes! I am glad to be alive today.

References

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