Finding Peace in Successful Aging

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If one is able to exercise personal control over even just a few of the variables of aging, then one may be able to add years with success, grace, and peace.

Many of us grow and age with grace and success. We pray for the peace that is beyond all understanding and embrace the 1955 motto of the American Gerontological Society, “of adding life to years, not just more years to life.” We may wonder at times if we are getting any closer to our goals. It is projected that 40 million people aged 85 and older will be living in the United States in 2040, and even now, more than 40 percent of the population over age 85 remains fully functional. We are living longer and healthier. In fact, over the last century the years spent in active, healthy retirement have increased ten-fold (Valliant and Mukamel 2001).

Aging, however, is often viewed through a lens synonymous with failing or declining rather than one of success or peace. Evidence suggests that our senses begin a slow decline at age twenty, and we know, for example, that most of us at age 70 will only be able to identify 50 percent of the smells we could recognize at 40. More than half of us at 70 will not drive at night, and that by age 90 fewer than 50 percent of us will use public transportation (U.S. Bureau of the Census 2000). Change happens: our hair turns white, our small bodies might become somewhat larger, and our once wrinkle-free face now has crow’s feet. But experience increases as well and, for some, so do wisdom and faith. It is important to note that most mental deterioration before age 80 reflects disease and not the normal aging process (Schale 1990).

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Aging will include change and development and much of it will be good. Often as we age we become more patient, more tolerant, and more accepting of ourselves and others. We will become more likely to tolerate paradox and appreciate relativity, and to understand that every present has a past and a future (Cartensen 1992 and Baltes 1990). Despite a generally accepted myth, there does not seem to be an increase in depression among the elderly. In fact, on the contrary, notable in the literature are significant findings that point to the stability of happiness and satisfaction with life over the last half of the lifespan. A steady decrease in death anxiety and an increase in a belief in the afterlife begin after age 40 (Baltes 1999).

This is not to say that there are not some undesired or even negative changes that limit us as we age, but rather to contrast those changes to other information. For example, in the two best-known longitudinal studies, the Berlin Aging Study and the MacArthur Study, while the majority of the elderly took an average of three to eight medications daily and were perceived by the doctors as chronically ill, they did not regard themselves as sick. Two out of three individuals perceived themselves as having superior health to their peers (Baltes 1999).

**Insights from Research on Aging**

The two studies shattered many of the widely held myths about aging including that greater longevity typically results in less, not more years of disability. Before age 95, for example, less than 10 percent manifested dementia; nine out of ten still retained life goals. Among octogenarians, 76 percent still had sexual partners with 17 percent engaging in sexual intercourse at least once a week. Only one quarter of waking life past age 85 was spent resting. Our subjective well-being often rises far above what may appear to be to some a lack of objective happiness and health.

When the Berlin Study assessed for a global definition of successful aging at age 75, 80 percent of the study group were considered to be in “good health, that is, cognitively fit, active and involved in life, or average health (relatively healthy, still independent and satisfied with life).” At age 90, this level of health was still maintained by 30 percent of the subjects (and it is thought that number would be even higher if those in terminal decline—those who would die within three years—had been excluded). The study points to a decline in vital capacity and the efficiency of oxygen utilization (which begins at age twenty) as the most inevitable consequences of aging.

It is important to note that both studies identified the two most important psychosocial predictors of aging to be the level of education (probably pointing to traits of self-care and planfulness) and to presence of an extended family or social network. Poor aging (which was defined as dependence, dissatisfaction with living, and being bedridden) bore a high correlation with trouble walking, poor
vision, depression, and dementia. An awareness of our ability to control our weight, exercise regimen, education, and use of tobacco and alcohol, along with working on our relationships and our coping styles seem to be the seven protective factors for aging well (Valliant and Mukamel 2001).

A third supportive study which also focused on studying subjects as they age instead of only the aged is the Adult Development Study done at Harvard University. The study defined well-being in old age as measured along six domains on a continuum between the happy-well and the sad-sick. The domains were physician-assessed objective physical health and the absence of irreversible physical disability; second, subjective physical health; third, length of active life (the number of years an individual survived without either objective or subjective disability). The fourth, objective mental health, reflected objective evidence of competence in four areas: work, relationships, play, and the absence of need for psychiatric care or medication. The fifth domain was subjective life satisfaction, meaning that over the past twenty years, the person had reported subjective satisfaction in multiple facets of his or her life (e.g., marriage, job, children, and friendship). The sixth domain was social supports: objective evidence of friends and mutual satisfaction with spouse and children.

The individuals who did well in all six areas until age 80 were classified as happy-well, those who were both psychosocially unhappy and physically disabled were classified as sad-sick, and those who fell in-between were classified as intermediate.

Unlike other studies, this study seemed to be reasonably able to predict successful aging by assessing a number of independent predictor variables: smoking, alcohol misuse, body-mass index, years of education, regular exercise, a stable primary relationship, the maturity of adaptive defenses, depression (the presence of major depressive disorder), parental social class, warmth of childhood, ancestral longevity, stable childhood temperament, and an objective disability.

The absence of smoking, alcohol misuse, a high body-mass index and depression, combined with higher levels of education, exercise, and a stable relationship correlated to more successful aging and a classification as happy-well, than did parental social class, warmth of childhood, and ancestral longevity, which seemed only marginally significant. The happy-well used mature defenses, especially humor, while the sad-sick used immature defenses, especially projection and dissociation (Valliant and Mukamel 2001).
Noteworthy here is the effect that some predictors that correlate to aging as a sad-sick individual have on each other. For example, depression, smoking, and alcohol misuse, which seem to affect one’s liver, heart, and immune system, also factor into problems in significant relationships and can affect job performance.

A similar study not only suggests that the presence of significant others is associated with both cognitive ability and satisfaction with life in old age, but that it may well be that loneliness is the one feature most associated with cognitive and physical decline and dissatisfaction with life. Only fifty percent of those at age 90 felt they had a confidant. Remedying our loneliness and that of others may be the most effective route to improving the quality of life in our journey of successful and peace-filled aging (Gow, Pattie, Whiteman, Whalley, and Deary 2007). An important research finding was that good social support in old age, correlating to aging as a happy-well individual, was a direct result as the same importance on social supports and self-physical health care at age 50. Further, the variables that play the largest role in aging as a happy-well person can be self-controlled. This should appeal to both our desire for autonomy over our destiny and for healthier longevity.

**Spirituality and Serenity**

It is important to know for ourselves and to guide our ministry to others that with increasing age, according to the Berlin Study, our levels of both spirituality and serenity (that is faith, acceptance, and allowing another to help) increase. Also, the coping strategies of humor and comparison of oneself with others more severely afflicted did not change between ages 70 and 90. When this research is paired with Martin Seligman’s work, *Positive Psychology* (one’s choosing to focus on a pleasant life, an engaging life, and a meaningful life [Moyer 2007]), we seem to have a strong case for building intergenerational communities that would allow for social support and successful aging. This is important because while there may be no simple key to happiness, it is necessary to have good relationships with those around us before happiness is possible (Gow, Pattie, Whiteman, Whalley, and Deary 2007). We need not have a primary significant other or romantic attachment (although some research does suggest having one enhances our happy-well aging), but it does seem essential that as we grow older, even if we identify ourselves as living alone, we do not feel alone. Living alone has been identified as a risk factor for cognitive decline, poorer age IQ (possibly dementia), and lower life-satisfaction. It is possible that living alone may lack the cognitive stimulation that would come from other individuals and lead to depression. However, living alone may be quite different from being alone (Berkman 2000). It is feeling alone that seems to have the strongest association with cognitive decline, that is, indi-
individuals who showed the highest cognitive decline across the lifespan were those who also report the highest feelings of loneliness. Further research indicates that in addition to feeling lonely, it is the actual lack of social support, contact with others, or integration in a social network that drives the decline toward unhappy-sick aging.

While it is possible that loneliness promotes cognitive decline, it is also possible that those who are experiencing a decline are less able to gauge how lonely they are, or that they have chosen to remove themselves from social situations, or have been left socially isolated because of the decline (Berkman 2000). Loneliness is the only feature of social support related to later life ability, and life satisfaction in old age is much more strongly related to aspects of social support, with loneliness accounting for the highest proportion of variance. This seems to fit well with other findings that postulate that from our organismic perspective people are viewed as having inherent psychological needs to connect with others and with the community, needs that are important for people of every age (Sheldon and Kasser 2001). How we can remedy our own loneliness and that of others is critically important.

**Developmental Stages**

These findings integrate well with both the Eriksonian stages of psychosocial development and Fowler’s stages of faith development. Erikson formulated a developmental stage and task process theory in which healthy growth or movement is always forward and upward: in a sense, humans are like other organisms, even sunflowers, always seeking to grow upward toward the light and health. It seems there is an inherent propensity for growth found in all human beings (Rogers 1961). Erikson organized life into eight stages from birth to death based in part on his belief that the course of development is determined by the interaction of the body (genetic, biological programming), the mind (the psychological), and cultural influences (Sheldon and Kasser 2001). His final two stages of life—middle adulthood, which may range from ages 35 to 65, and late adulthood from ages 55 or 65 to death—emphasize first, in the seventh stage, our mastery of production and care abilities as we struggle between “Generativity and Stagnation.” In middle adulthood, Erikson teaches that our task is to perpetuate culture through the family and working to establish a stable environment. Strength comes from caring for others and the production of something that contributes to the betterment of society, which he called generativity. When we are at this stage of life we typically fear inactivity and meaninglessness. If we do not get through this stage successfully, we can become self-absorbed and stagnate.

While in the eighth stage, we find our basic strength to be wisdom and our ego development will emerge from resolving the tension between “Integrity versus Despair.” In the final stage of life in Erikson’s framework we may look back at
our life as filled with perceived failures and fearing death; struggling all the while to make meaning and find our purpose before the end. If we cannot or do not find it, we will likely despair. But, if we are able instead, to reflect back on a life well-lived with happiness and contentment, feeling fulfilled with a deep sense that our life has had meaning and that we have made a contribution to life, then we will have a sense of integrity (Harder 2002). Our strength comes from a wisdom that is able to see the world and all of existence as very large. This strength comes at a time when we have a healthy, but detached, concern for the whole of life and may accept death as the completion of our individual life. Research has illustrated that thriving in the final stage of life is associated with psychosocial maturity and personal integration (Deci and Ryan 1991).

James Fowler used a similar developmental paradigm to show how faith grows, if nurtured, to a mature coexistence in and with God. How closely Erik Erikson seems to conclude his final theoretical stage is consonant with Fowler’s stages. Living in these stages, even though they describe the final years of life, seem to nonetheless respectfully bow to the words of Ireneaus, that “the glory of God is the human person fully alive.”

So, while old age has historically been seen as a time of decline and degeneration, the current research is much more positive and emphasizes the remarkable resilience of the human personality. Specifically, the older, happy-well person clearly knows what values are most important in life and pursues such objectives with a more mature sense of purpose and ownership than younger people do. Seeking the fountain of youth may be at times attractive, but people may be drawn even more to moving forward to greater meaning and satisfaction later in life. There is cause for great optimism as we age, mature, and grow ever closer to God.

**Insights for Ministry with the Aging**

These findings offer guidance to us for our ministry to the aging whether we find our selves in parishes, pastoral care offices, classrooms for the adult learner, skilled nursing facilities, hospitals, or hospices. We must work hard to integrate the insights and research from developmental theories of both human growth and faith across the lifespan with strategies for health, maturity, and aging. As ministers, we are called to create an environment where God’s human family can grow and we are to nurture that growth, helping people to actualize more of who they are.

This work can be pursued by committing ourselves to six key aspects of human growth: self–acceptance, positive relationships with others, autonomy, environmental mastery, purpose in life, and personal growth (Ryff 1990). Teaching others of all ages to develop and enhance a positive view of themselves as having multiple parts and dimensions, who are children of the living God and who are loved, is the
first step. Promoting the importance of the community to provide a context for initiating and nurturing warm, satisfying relationships with people whom we grow to care for and about and for whom we share our concerns about their welfare is next. It is the place where we practice empathy, affection, and intimacy and reinforce the concept of reciprocity in relationships. Third, we can encourage independence and autonomy—even if it is limited—enhancing self-confidence so that people are not pressured to think or behave negatively. Fourth, we can assure people that they are at a place in their lives where they can effectively use the resources and opportunities available to them in their environment, even empowering them, if needed, to know that they are not in any way “less than” because they are aging. Fifth, we can remind people that they are always co-creating their lives with God as meaningful and purposeful, with goals and a sense of direction, and that their present and past have meaning. Lastly, we can share that there is always room for personal improvement, a need to be open to new experiences and teaching that growth in self-knowledge and personal effectiveness never truly stops (King 2007).

So it is still seemingly so (as John McNeil told us) that good theology is good psychology and good psychology is good theology. We are called to love one another and not to be afraid, to companion well, building and maintaining a support network and building up the Body of Christ, to live life mindfully, with gratitude and hope, as we spiral forward and upward making meaning of our life as we co-create it, even in our final years, with God. We can cultivate spending time with those we love and learning something new every day, living and praying all the way for the peace that is beyond all understanding (Valliant 2003). Now that is successful aging.

References


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