Varda Muhlbauer · Joan C. Chrisler
Florence L. Denmark *Editors*

Women and Aging

An International, Intersectional Power Perspective

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Foreword

It is a privilege to write the foreword to this volume, a volume that is at the intersection of the discourses on women's lives, aging, and power. As a gerontologist, a feminist, and a woman who just turned 50, I, too, am located at this intersection. And what a special time it is to be at this intersection. Today, we know a great deal about women's development over the adult life span, their health and well-being, their roles and relationships, their trials and transitions, and their challenges and triumphs (Whitbourne and Bookwala in press). We have accumulated vast knowledge about how women's aging experiences are unique and distinct from the experiences of men. Women differ from men in how long they live, how they are socialized and the roles they occupy in society, how much and whether they earn, how they maintain and influence their social ties, how much others rely on them, what illnesses are likely to inflict them, what life stressors they tend to encounter and how they cope with them. For these advances, we owe thanks to the field of gerontology and especially to its large number of women scholars who have devoted their careers to advancing knowledge on how women's lives develop over the life course.

As this volume so eloquently points out, however, differences in the aging experience exist not only between women and men; they also exist among women. Women's aging experiences are diverse within and across cultures. At the heart of many of these differences are the same power differentials that emerge from the sociocultural, sociopolitical, and socioeconomic forces that differentiate the lives of women and men. Feminist theory and research has drawn attention repeatedly to the underlying differences in the social constructions of gender roles and how differences in power and privilege produce differences in individual and collective life experiences. Notably, the editors of this book—Varda Muhlbauer, Joan C. Chrisler, and Florence L. Denmark—have underscored the role of power politics in determining the multitude of life options and opportunities available to the powerful relative to the limited ones available to the powerless (e.g., Chrisler 2012; Denmark and Paludi 2008; Muhlbauer and Chrisler 2007). These power differentials also explain the divergence in life trajectories among women. And they are cumulative in their impact, such that women who live in cultures that offer them limited power and opportunities are at risk to experience suboptimal aging.

The field of gerontology also has long underscored the role of cumulative inequalities in explaining diversity in the aging experience, however, the two areas—gerontology and feminist scholarship—have developed more or less independently, with only occasional attempts to bridge them (e.g., Muhlbauer and Chrisler 2007, 2012; Sigal and Denmark 2013). Indeed, feminist explanations of how sociopolitical constructions of group identity and power contextualize women's aging have been largely overlooked in gerontology. Until now, that is. This volume provides perspectives from feminist theory and research to inform and transform our understanding about how and why women experience aging differently not only in comparison with men but also among themselves. It accomplishes this by centering on the critical role of power constructions and power inequities in shaping women's developmental trajectories over the life span. In doing so, this volume inextricably links the gerontological and feminist scholarship by filling a critical need for evaluating the diversity in women's aging experiences and offering insights and strategies for empowering women and making successful aging accessible to women all around the globe.

As I write this foreword, I think back to my life's journey, how I came to be at this intersection of aging, feminism, and power. This volume resonates with me both professionally and personally. I remember being a young graduate student in the mid-1980s. I had just arrived in New York City from Mumbai (then Bombay), India, to pursue a graduate degree in Psychology. When I left India, just barely age 20, it was my first time away from family and friends, from what was familiar and facile. As I embarked on a journey that would alter the course of my life profoundly in terms of experiences and opportunities and accomplishments (read, "power"), I left behind my mother who had recently turned 50. She was a woman of vision and remarkable strength, who infused in me the courage and resolve I would need on my ongoing journey. And yet, her 50 was so different from mine. She lived in a time and place in which women were restricted in their dreams and curtailed in their potential. My mother was curious, articulate, well-informed, and inspirational, but she had no college degree or financial independence. And without these, she had little power to influence the course of her own life, to break free of the tight grip of cultural norms and social expectations.

This volume brings into sharp relief how differences in power define and shape how women age in cultures far and near. It brings into sharp relief the differences between my 50 and my mother's 50. My mother, who died of cancer at 57, gave to life and the world disproportionately more than they had given to her. With every dream I fulfill and every milestone I reach, I am acutely conscious of my mother—and the scores of women like her—who never had the same opportunities to steer their own life journeys, fulfill their own dreams, and age on their own terms. From my first graduate class on the psychology of women with Florence Denmark almost three decades ago to Joan Chrisler's invitation to chair the Society for the Psychology of Women's committee on the Denmark Award for Contributions to Women and Aging 3 years ago, I am reminded of how power can enable and disable the ways that age is gendered and gender is aged. For every woman who is privileged through power, there are countless others for whom power is nonexistent or, at best, illusory.

I am among the privileged women that this volume nods to, who through supportive ties and higher education have been empowered to build a life of meaning and purpose despite early sociocultural obstructions. Florence Denmark's course on the psychology of women was integral to my empowerment. It validated my observations and experiences of growing up in a patriarchal society and contextualized them in terms of the sociopolitical and socioeconomic forces that then prevailed. I became fascinated professionally and personally with development over the adult life span. In particular, I was drawn to a topic that has particular salience in women's lives as they age—their social context. Our close personal relationships are key to defining how we age (Bookwala 2012, forthcoming) and power constructions and differentials are embodied in our relationships with others. Women's relationships evolve in multidirectional ways as they age (Bookwala 2012, forthcoming), and they often have the potential to bring about some measure of power and control. For example, women's spousal relationships are likely to be more equitable in terms of household responsibilities and role allocations in mid and late life relative to earlier in life; women are likely to exert considerable influence on the health behaviors of those they love; women are known to initiate marital dissolution in mid or late life in marriages marked by dissatisfaction; and women are often the party responsible for establishing nontraditional partnered relationships, such as living-apart together.

This volume is a valuable resource for those who want to understand the differences in aging as experienced by women who have power and privilege versus those who lack them. Through their incisive and insightful analysis, the editors of and contributors to this volume inform our understanding of women's aging experiences using classic feminist constructions of power and inequity. I offer that, in planting itself at the juncture at which aging, feminism, and power meet, this volume defines gero-feminism as a field of research that merits continued focus and attention. Indeed, the editors of this volume are three leading gero-feminists of today. Through decades of influential scholarship, leadership, and mentoring, they already have transformed the lives of innumerable young women. Now, they offer a remarkable resource for understanding the integral role played by power differentials in shaping women's developmental trajectories and aging experiences. More significantly, the chapters in this volume point to some select means for empowering women so that they may enhance their capacity to dream, and thereby age, on their own terms. Ultimately, this volume explains eloquently that women must have access to resources that yield power and autonomy—education, income, careers—that are essential to sustaining a lifetime of meaning and fulfillment. The effects of power are cumulative, and, to be a successful older woman, it is essential to have opportunities and resources starting at a young age.

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Jamila Bookwala

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Jessica R. Newton earned her MA in psychology at Connecticut College, where she focused on social psychology and the psychology of gender. Topics of particular interest to her are health disparities, body image, stereotype threat, and applications of psychology to social issues.

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Introduction

Varda Muhlbauer

The psychosocial landscape with regard to the aging process of women over 60 is fast changing. One can hardly fail to take note of the changes that have taken place in the actual lives of older women and, consequently, in their upbeat cultural portrayal. Women in this age group have been engaged in extending the restrictive sociopolitical boundaries of both age and gender. They have often been doing this in ways that signify a fundamental cultural shift in how we tend to think about older women. This fascinating transformation is taking place in defiance of the traditional construction of collective gendered age identity and, also, against social and cultural odds. These changes are easily detected in the way older women position themselves in organizational politics, in the division of power in their families, in the ways they manage multiple identity roles (e.g., job holder, spouse, parent, grandmother, mentor, volunteer) and in the broad life goals they now set for themselves (Muhlbauer and Chrisler 2012). Representations of contemporary older women in popular media are additional indicators of the overall change in the progress in women's lives. Attractive actresses such as Meryl Streep, Diane Keaton, Judy Dench, Susan Sarandon, Helen Mirren, Sally Fields (all of them are over 60), and many others play fictional characters in films or television series who are powerful and highly accomplished, and they tend to enjoy their stylish and often flirtatious appearance (Lemish and Muhlbauer 2012). It is as though aging were reinventing itself as a much more playful development than ever before. In this respect, the popular media are becoming more responsive to sociocultural trends affecting the lives and whims of women in the over 60 age group. All these rather impressive changes have raised serious and intriguing questions: Is this the first generation of powerful older women who have battered the absurd stereotypical portrait and cultural codes of the devalued lifestyles of old age? If it is, what is driving this phenomenon? And more importantly, is this change relevant and accessible to most women in this age group?

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The sociocultural profile of women over 60 is intriguing. In order to justly reflect the caliber and quality of the changes that have taken place in the representation and actual life experiences of older women, it is, perhaps, most helpful to refer to social and feminist theories that explore the dynamics of the construction of collective group identities. These theories tend, directly or implicitly, to connect the unending process of construction of group identities to sociopolitical power relations. Thus, a group's social standing and cultural representation are the outcome of its relative status in power hierarchies (e.g., Fraser 1989; Snow 2000). In this respect, an impressively large group of women over 60 succeeded in improving its relative position in the overall sociopolitical power relations.

It is important, though, to note that the theories of the sociopolitical construction of group identities do not speak in a single voice (e.g., Bernstein 2005), and it is not our intention to investigate the great variety of social critiques based on these theories. Nonetheless, most theories lean on power relations as the significant context for understanding the construction of group and individual identities, which the editors of this volume think is important for a better understanding of how women aged 60 and above experience aging. It seems plausible to us, therefore, to situate the power construct—in all its manifestations—at the core of our analysis of the present day sociopolitical position of women in the over 60 age group.

Power constructs have featured both in feminist theory and in feminist political movements from a very early stage. As far back as the late 1960s, power was embedded in the slogan "the personal is political." The emphasis, then and now, on gender equality is based on human rights discourse. However, it is the integration of the postmodernist critique of power structures (e.g., Foucault 1973) into contemporary feminist theory that has definitively enhanced its theoretical and practical insights.

Indeed, it is a difficult undertaking to encapsulate the construct of power as it figures in sociopolitical theories. Still, very broadly stated, the extensive and the complex nature of our current understanding of power concepts have broadened and facilitated more productive explanations such as the subtle ways in which power operates to produce and maintain its hierarchies in our society (Yuval-Davis 2011). Following the same theoretical line, Castells (2004) stated that power is mobilized to prioritize the interests, values, and preferences of those of higher status. Thus, a group's position in society (possibly, the group of women over 60) reflects its relative power vis-à-vis other groups. Whenever a group succeeds in improving its relative social positioning, its share in sociopolitical, cultural, and economic eminence is enhanced. In this respect, power is basically a relational phenomenon, that is, one that reveals more about the dynamics and the power relations among people or groups than about the individual characteristics of the people or groups involved (Ritzer and Ryan 2011). Blaikie (1999) also contended that "identity is created, confirmed, maintained, and changed by a person's interaction with other people" (p. 198). As such, power relations contain the potential for both constraint and enablement of the parties involved.

Recently, academic researchers have pointed out the physical and mental health disparities that are related to one's position in the social hierarchy. Langner et al. (2012), for example, reported high rates of depression and emotional repression

among individuals with low social power and low social status. Boksem et al. (2012) argued that power activates a general tendency to action, whereas powerlessness activates a tendency to inaction. Their assumption is that, whereas increased power is associated with a reward-rich environment and freedom, powerlessness or reduced power is associated with an increased threat and greater social constraint. Flaskerud and DeLilly (2012) also related powerlessness to poor health and shorter longevity and raised questions about whether discrimination in and of itself could explain poor health. The findings make it very clear that the outcome of low social status and low social power is a risk factor that might cause difficulties to individuals as well as to groups of all ages.

The debate about power is mesmerizing. It is often the beginning and the end of analytic attempts at theorizing about contemporary society. Our attention, though, is mainly drawn to two dominant characteristics: (a) the fragmentation of power constructs into many, quite subtle, axes; and (b) the institutional nature of its build-up. We assume that both elements are very helpful in understanding the dramatic changes privileged women over 60 have made in advancing their quality of life and in raising their sociopolitical stature and, at the same time, the regrettably greater variability within the same age group that exposes enclaves of lower-income and less-educated women trapped in powerless or poor living conditions. Thus, the large differences between women in the over 60 age group call into question the wide-ranging usefulness of the concept of "double jeopardy," suggested by Dowd and Bengtson (1978) as a point of reference in defining the danger in the interaction of two or more marginalized positions (e.g., age and gender). It seems that, today, a conventional addition of the disadvantages imposed by gender and old age does not provide us with much relevant information regarding the position or quality of life of the women involved. So much so, that the once routine question regarding age is now considered superfluous. What are called for are questions that provide us with more relevant information. Krekula (2007) took the argument one step further and wrote that "the interplay between power relations can signify that these structures (e.g., gender and age) either strengthen or weaken each other, or that they supplement or compete" (p. 167). That is to say that the misery perspective implied in the "added risk approach" is not necessarily the only possible outcome of these intertwining systems of old age and gender. Rather, the outcome of added assets offers another possibility. She argued for a more complex understanding of the intersection of age and gender. We also suggest that the point can clearly be made that we need additional sociopolitical signifiers, such as socioeconomic class, educational level, race, or religion, in order to presume anything about the position or lifestyle options women over 60 might have. To sum up, the gendered power shift has made the question of *whose* aging more relevant than ever before.

Thus, individual and collective gender identities of women are caught at the intersection of several social structures (Cole 2009; Hurtado 2003; Shields 2008). The intersectional perspective strongly indicates that societal power hierarchies are reflected in the structure and salience of various sociopolitical signifiers of a person's or a group's identity (e.g., women of color, college graduates, sexual minorities). It is the specific positioning on different power axes within these societal structures

that ultimately determines the quality of people's general experiences. In other words, one's location in the social structure is indicative of a variety of constraints and possibilities. It is interesting to refer to a heated debate in *The Guardian* (Press Association 2013) on feminism and British working-class women. It was stated that "gender still has a strong independent impact on earnings prospects but class, education and occupational backgrounds are stronger determinants of a woman's progression and earnings prospects." *The Guardian*'s report is an acknowledgement of the overall importance of an assortment of sociopolitical indicators, other than gender, in determining a woman's trajectory.

Our analysis leads us to the conclusion that there is no distinctively consistent collective gender identity of women in the over 60 age group. The privileged women, that is, mainly middle/upper class and well-educated women in liberal democracies have gained—since the late 1960s—impressive social and political influence, which, gradually, has evolved into a greater share in political, academic, social, and economic power. The implications of this sociopolitical change for understanding the subdivisions within today's women in the over 60 age group are very strong: Privileged women tend to share a sense of entitlement for individual and collective rights and to enjoy the benefits that accrue as a result of the accumulation of multiple power resources. Against this, a much grimmer pattern emerges when we focus on older women in gender-conservative societies, as well as poor and marginalized women in westernized nations. Access to power resources is not within reach when gendered age constraints of traditional worldviews or institutionalized intersectional social divisions are left intact. The lives of powerless older women reflect the dire consequences of life under repression. In many cases they are deprived of basic human rights to health, education, work, and control over their own bodies (Chrisler 2012). However, even subtler manifestations of restriction tend to constrict the opportunities of these women, and older women in particular: They are deprived of the right to experience life to its full potential.

Today the aging of women over 60 is, at once, a story of success and failure. Gendered age boundaries have become more permeable for large groups of women; however, they are left intact for many, far too many, others. The range of individual and group identities of women in the over 60 age group indicates that it is the availability and extent of power resources that define women's aging. It is, therefore, the existence of power (or its relative absence) that provides the adequate structure for interpreting and understanding the various representational and experiential perspectives of these women. Because of this shared understanding and because of the personal experience of unease about the growing variability among women in the over 60 age group, we, as feminist researchers and activists, felt the need and the responsibility to emphasize the interconnectedness between gendered age and power resources and the well-being and quality of life of older women through, whenever possible, an international and intersectional perspective. In this respect, this book is politically nuanced as we wish to transform as well as to inform. This view led to an additional editorial decision to elaborate on the following issues of importance to older women: economics and consumerism, leadership, work and career, the impact of multiple roles, aging lesbians, sex and sex appeal, and overall body and health

politics. The questions raised and analyses suggested in each chapter concentrate on meanings and implications attached to concepts of constraint and enablement and the manner in which they affect older women as individuals and as a group.

Older women are generally portrayed more negatively than older men. This is because women's power in youth-oriented cultures depends to a large degree on the body, as attractiveness is a traditional source of power for women. However, as Joan C. Chrisler, Meghan Rossini, and Jessica R. Newton tell us, signs of aging do not carry the same meaning for all women and do not necessarily mark overall loss of power. Older women can reinterpret their body changes in ways that are empowering. The authors suggest that women aged 60 and beyond can make necessary adjustments and learn to use their bodies in ways that can contribute to the continued use of the body as a source of personal and interpersonal power, albeit not in the same way they did when they were younger.

Andrew Schein and Nava Haruvi started by pointing to two major changes that occurred in the twentieth century: the overall rise in life expectancy and a huge increase in the participation of women of all ages in the labor force. These two changes have resulted in many older women with greater economic power than ever before. There is, though, a substantial disparity in economic freedom amongst older women: Not all women have this power because many older women live in or near poverty. Still, they point to a growing subset of older women who might have an impact on various markets and influence the goods that are sold. Thus, older women with financial means could harness their power to impact economies and change cultures.

Liat Kulik reviews the impact of multiple roles on women's well-being in late adulthood. She indicates that the quantity of roles per se cannot explain the effect they might have on older women's well-being; more consideration should be given to qualitative measures such as perceived role centrality, role satisfaction, and perceived meaningfulness of roles. Overall, cultural and socioeconomic background is strongly related to the potential impact of multiple roles on well-being: Empowered women with resources, who belong to a culture that encourages self-expression and self-fulfillment, can afford to take on nonobligatory roles and enjoy a diverse range of activities, whereas women who belong to a culture that restricts them from taking on enjoyable roles and forces them to occupy prescribed roles can weaken them and have a harmful effect on their well-being.

Maureen C. McHugh and Camille Interligi discuss the concerns of older women regarding issues of appearance, sex appeal, and desirability in androcentric cultures. They explain that older women's experiences of their own sexual desire and desirability tend to be more complex and contextual than usually portrayed in oversimplistic and prejudiced cultural stereotypes. They conclude that there is a need to re conceptualize older women's sense of desire and desirability as the present model is flawed by derogatory cultural views that impair women's ability to identify, own, and enjoy their own sexuality.

Lesbians over 60 from the present cohort in North America as well as in other liberal democracies might reasonably expect aging to be a phase of life marked with well-being and empowerment. This trend reflects a shift in cultural values in many

countries toward greater acceptance of lesbians. Suzanna Rose and Michelle Hospital review research on older lesbians to explain this encouraging outcome. As often is the case, no one single factor can clarify the impressive change in lives of older lesbians. However, older lesbians are equipped with sound adaptive responses as a result of a life-long coping with minority stress. This resilience is complemented by the love, friendship, and community relations lesbians enjoy throughout life that tend to benefit them in the transition to old age. However, the aging experiences of lesbians may be complicated by having multiple socially disadvantaged statuses.

Gendered agism was, for a very long time, an impenetrable barrier to fully developed careers and leadership roles for women in general, and particularly for older women. Florence L. Denmark, Hillary Goldstein, Kristin Thies, and Adrian Tworecke inform us that we are currently witnessing noteworthy cracks in the once rigid barriers to influential positions in business, academia, and politics. The viable pathways open to older women's meaningful careers and leadership positions are diverse and extensive: mentorship, coaching, self-employment, volunteering, and encore careers. The opportunities now accessible for women in the 60 and beyond age group are related to the progress already achieved by many in greater gender equality and an enhanced sense of personal power.

Finally, Jennifer O'Brien and Susan Krauss Whitbourne present a model to understand the psychological concerns of older women and offer suggestions for mental health practitioners to follow in providing care and counseling to this population. They expound in the importance of the biopsychosocial model, wherein lifespan development, physical, psychological, and social factors interact to influence the trajectory of an individual's aging process. In their view, it is the stereotypical views of women, particularly in traditional cultures, that build serious barriers to successful or active aging.

The editors of this book set out to provide a broad basis to understand contemporary women in the over 60 age group. From the very beginning it was clear that women's aging process is occurring in a sociopolitical context that tends to stratify older women along status lines and power resources. As a result, today, it seems that the ways women experience aging reveal more about their social positioning and relative power than about their chronological age.

We hope this book will stimulate more thought about women over 60—both from women themselves and from academics and professionals who work with them. Undoubtedly, further research and practical attention should be targeted toward the needs of older women who have not been able to overcome the willful combination of sexist and agist barriers in their lives. Further media and research attention should also be paid to those who are succeeding in ways that women in previous generations could not even imagine.

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Older Women, Power, and the Body

Joan C. Chrisler, Meghan Rossini and Jessica R. Newton

Stereotypes about older people contain both positive (e.g., wise, sage, experienced) and negative (e.g., grumpy, lonely, senile) elements (Kite and Johnson 1988). The positive elements are more likely to be emphasized in collectivist cultures that recognize important roles for older people in society in general and in the family in particular (Calasanti and Slevin 2001). For example, powerful roles for women include grandmother and mother-in-law, and these roles are often especially powerful in cultures where younger women are treated with significantly less respect than men are. Women obtain some of the power associated with these roles through the body or in connection with others' bodies. Bearing children and raising them to adulthood, negotiating a good "match" so that one's children will produce children, reaching menopause, and sharing knowledge about recipes and herbs/medicines/treatments that keep the family healthy are all associated with wise and experienced older women who have proven themselves worthy of others' respect and admiration. Thus, the aging body can empower women.

Negative stereotypes of older people are more common than positive ones in individualistic, industrialized, Western cultures, which tend to be youth oriented. In these cultures, young adults and midlife men tend to occupy more powerful roles than midlife women and older people do. Older adults tend to be marginalized in both popular culture and in society in youth-oriented cultures (Lemish and Muhlbauer 2012; Robinson et al. 2009). Due to the double standard of aging (Zebrowitz and Montepare 2000), older women are generally portrayed more negatively than older men. This is because women's power in youth-oriented cultures depends to a large degree on the body, as attractiveness is a traditional source of power for women. Attractive women gain attention from powerful people, and beauty brings women into the orbit of the powerful (e.g., via relationships with wealthy and/or powerful partners, via well-paid careers that depend, at least in part, on women's self-presentation). The negative stereotypes of aging are often related to changes in the body that render it unattractive (e.g., wrinkled, grey-haired, ugly)

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or incompetent (e.g., weak, feeble, debilitated, disabled, dependent, ill). Thus aging bodies, especially women's bodies, can be disempowering.

Stereotypes of older people are not merely a matter of academic interest. They can have an important impact on older people's physical and mental health and well-being and on their social, physical, and cognitive competence. For example, in social psychology studies where older participants were primed (i.e., exposed to, usually in a surreptitious way) with words associated with either positive or negative stereotypes of elders, the negative priming led to worse handwriting (Levy 2000), stronger cardiovascular response (i.e., evidence of stress) when asked to solve verbal puzzles or do arithmetic (Levy et al. 2000), poorer performance on a math (Abrams et al. 2006) or a memory test (Desrichard and Kopetz 2005; Hess et al. 2003), lower willingness to take a risk, higher scores on a measure of loneliness, lower scores on a measure of perceived health, lower scores on a measure of extraversion, and more frequent requests for help (Coudin and Alexopoulos 2010). Participants who received the positive priming performed significantly better on all of the measures than those who received the negative priming. Thus, it seems that acceptance of the negative stereotypes (or the belief that others accept the stereotypes) that emphasize incompetence can be a self-fulfilling prophecy for older adults who come to embody those stereotypes, both literally and figuratively. The results of the studies suggest that negative stereotypes can actually contribute to dependency, weakness, and inability by disempowering older adults (Coudin and Alexopoulos 2010), and thereby reinforce those negative stereotypes.

In this chapter, we examine the ways that the body can empower and disempower older women. We consider ways that older women can see their bodies as potential sources of empowerment. Finally, given that most of the work on stereotype embodiment has been done in Western countries, we wonder how older women's self-perceptions and self-concepts might be different if they had regular access to positive stereotypes about their age mates.

Empowerment and the Exercise of Social Influence

Social psychologists define power as influence, that is, the ability to persuade other people to do or not do something (e.g., Cartwright 1959). Three types of power have been described: power over, power from, and power to. *Power to* over is the prototypical form; it is the ability to get other people to do what one wants them to do. *Power from* is the ability to resist the influence attempts of others; it includes the ability to say "no." *Power to* is the ability to control one's own thoughts, emotions, and actions in the service of achieving one's own goals (Hollander and Offerman 1990; Yoder and Kahn 1992). Empowerment includes all three types of power, but feminist activists tend to focus on power to—the ability to make change in the service of social justice (i.e., to improve conditions of life for oneself and others). Empowered older women have greater self-confidence, a stronger sense of self-efficacy (i.e., the belief that one can do what one wants to do), and a considerable

amount of social capital (i.e., connections in one's social network) and relationality (i.e., the ability to work with others to get things done) (Denmark and Klara 2007). Disempowered women are lower in self-confidence, self-efficacy, and social capital, and they are able to exercise much less power of all three types. It is important to remember that power only exists in relation to others; it is not a characteristic of individuals. Power is also a dynamic and contextual process; therefore, an older woman may be powerful in some circumstances (e.g., in the family) but not in others (e.g., in the public sphere).

In a classic essay, Bert Raven (1965) described six bases or styles that people can use to exert influence successfully: reward, coercion, referent, legitimate, expert, and informational. Reward power is the ability to offer resources to others in order to persuade them to accept one's influence. Typical resources used by powerful people include money, promotions, awards, and positive publicity. However, other rewards are body-dependent, and do not require wealth or position. Many people can be influenced by a hug or kiss, a warm smile, a pat on the back, or sexual activity, and older women use some of these rewards successfully every day with family and friends. Coercion power is the ability to confer (or threaten to confer) punishment on others in order to persuade them to accept influence. Coercion can include directly delivered punishment (e.g., violence, imprisonment, disinheriting someone) or the withholding of rewards (e.g., no sex, no smiles, no talking until the influence is accepted). Lysistrata showed the power of withholding body-related rewards when she and her followers stopped a war in ancient Greece by refusing to have sex with their husbands until peace was declared. Referent power is based on long-standing or strong relational ties (e.g., "Do it for me," "Parents ought to agree"). Friends, lovers, and kin earn the right to influence each other over time. Older women often have considerable social capital, some of it directly related to the body (through sexuality, birthing, and caregiving), which allows them to influence others they know well.

Legitimate power is the right to influence others based on one's social role or position in a hierarchy (e.g., corporals influence sergeants, religious leaders influence congregations, teachers influence students). Parents have the right to influence their children and their children's children, a form of legitimate power derived from the body. This form of power is what makes grandmothers and mothers-in-law so influential. Beautiful women are also shown in popular culture to be very influential; others want to please them and be seen with them. They have the ability (and "the right") to "turn men's heads" and to draw others' attention away from whatever they were doing. Physically ill, dependent, and weak people also have a legitimate right to influence others to help them or to take care of them. This may not be the most empowering way to deploy the body as an agent of influence, but it usually works, and older women have often successfully used illness and weakness as a claim on others, especially family members.

Expert power is the ability to persuade others to accept one's influence because of the special expertise one has. For example, most people willingly accept influence from doctors, plumbers, stockbrokers, and mechanics because they have specialized training most of us do not have. Informational power is the ability to persuade

others based on a solid argument that is convincing or because the persuader has access to information (e.g., through gossip) that is not generally available. Older women can have considerable expertise based on their profession, specialized education, or practical experience gained over a lifetime. They may also be good at explaining patiently to others why a particular course of action is the right one, and their wisdom and experience can back up their advice. Their social networks, which are often more extensive than men's, provide them with the opportunity to "hear things" or learn from others' experiences that can add to their arguments. However, these power bases have less to do with the body than others do, so we will not say much more about them here.

Aging Bodies and Power

There are three main ways that changes in the body that are related to aging can empower or disempower women. Those ways are changes in (1) beauty or physical attractiveness; (2) physical fitness; and (3) physical health and ability.

Physical Attractiveness

Both women and men are rewarded when they engage in activities related to gender roles and gendered expectations (Burgess and Borgida 1999; Rudman and Phelan 2008). Sports and leadership are expected of men, and men with talents in those areas have high social status and ability to influence others. Physical attractiveness is a primary way that women gain social status and earn rewards (e.g., "You're beautiful," "You look so young for your age"). For example, there are many studies in social psychology that demonstrate a halo effect for attractive people of both genders (e.g., greater likelihood of being hired, promoted, accepted into college, rented a desirable apartment, and lesser likelihood of serving jail time for a criminal infraction; see Fikkan and Rothblum 2012, or Saltzberg and Chrisler 1995, for a review). The rewards of attractiveness are even more obvious for women than for men, as studies show that men rate "attractiveness" a more important quality in a romantic partner than women do (Miller et al. 2007), and some well-paying female-dominated jobs are actually advertised with the qualification "must have front-office appeal" or FOA (in other words, must be attractive to clients and customers). The pursuit of beauty has become a key component of what is perceived as feminine behavior, and most women spend a lot of time, money, and energy to look as attractive as they can (Saltzberg and Chrisler 1995). Those who do not wish to engage in these pursuits are considered to be unfeminine and/or to have "let themselves go."

The current beauty ideal in Western cultures includes a youthful, thin body, with medium to large breasts, small hips and waist, toned muscles, and European hair and facial features (Brown and Jasper 1993; Smith 2008). Most Western women

do not measure up to this ideal (Saucier 2004), and this realization has led to what some call "a normative discontent" (Rodin et al. 1984, p. 267) with the body; however attractive women are, they are never attractive enough. One result of globalization is that images of these ideal women are seen around the world with such high frequency that it can be difficult for women to avoid them, and this means that the body dissatisfaction so common in the West is spreading to other cultures that previously had different beauty ideals. For example, in some cultures, fat women have been considered more beautiful than thin ones (especially where weight is a proxy for health), and in others, dropping breasts, facial scarring, and deformed feet have been greatly admired (Saltzberg and Chrisler 1995; Smith 2008). We know that Western media have changed others' beauty ideals because studies conducted in Eastern Europe (e.g., Forbes et al. 2004) after the fall of the Iron Curtain and in the South Pacific after the arrival of satellite television (Becker 2004) clearly show a rise in eating disorders as women have attempted to change their bodies to look more like the Western models and actresses they now admire.

The Western beauty ideal has become progressively more youthful in recent decades (Seid 1989), and many of the models who appear regularly in beauty magazines and fashion shows are adolescents. The slim, lean lines of "ideal" bodies are child-like, as is the smooth skin unblemished by any sign of lines or winkles, age spots, cellulite, or stretch marks. In addition to changes in the skin that signal aging, women tend to gain weight with each reproductive milestone (e.g., menarche, pregnancies, menopause); therefore, older women, on average, weigh more than younger women do (Rodin et al. 1984). Thus, no matter how near or far from the beauty ideal they started, women move farther away from it with age (Chrisler 2011). Because attractiveness (especially facial attractiveness) is an important component of social capital and interpersonal power (Hatfield and Sprecher 1986), bodily changes that move women farther away from the beauty ideal are disempowering, especially for women who were considered beautiful in their youth.

Although studies show that both female and male faces perceived as old are judged as less attractive than both female and male faces perceived as young (e.g., Kissler and Bäumi 2000; Wernick and Manaster 1984), older women are judged more harshly than older men (e.g., Foos and Clark 2011; Furnham et al. 2004; Harris 1994). In a particularly interesting study (Harris 1994) of 268 adult women and men (ages 18–80), women were significantly more likely than men to report that they use (or plan to use) products that conceal signs of aging (e.g., hair dye, antiwrinkle cream). The participants also read scenarios about midlife characters, who either did or did not use age concealment techniques. Even when the participants themselves favored age concealment, they judged the female characters who attempted to look younger more harshly than they did those who were content to look their age. That is, they described the age-concealing characters as foolish, vain, conceited, and pathetic. Thus, midlife and older women are damned if they do try to conceal their age, and they are damned if they do not.

The studies discussed above illustrate the double standard of aging (Sontag 1979). In the USA, men whose hair is beginning to grey are thought to look "distinguished," whereas women whose hair is beginning to grey look "old." Men with

lines on their faces are thought to look wise and experienced, but women, again, merely look "old." The virtual disappearance of midlife and older actresses from American films and television, whereas male actors continue to work much longer, sometimes playing romantic lead roles well into their 70s, is an expression of the double standard (see Bazzini et al. 1997; Lauzen and Dozier 2005a, b). Although in recent years, there have been several high-profile films starring older actresses (e.g., *Calendar Girls, Something's Gotta Give, The Mother, The Queen*), the positive roles those women played were white, higher-income, and attractive characters (Lemish and Muhlbauer 2012), who can hardly be said to represent the majority of older women. The typical older woman in film and television (rare as she is) is marginal to the plot and exhibits negative stereotypes of older people (e.g., lonely, irritable, senile; Robinson et al. 2009).

Although some studies have documented considerable body dissatisfaction among midlife and older women (e.g., McFarland 1999; McLaren and Kuh 2004; Platte et al. 2000; Wilcox 1996), others have found that older women seem to have a neutral, or even a positive, body image (e.g., Donaldson 1994; Deeks and McCabe 2001). The difference between these two groups of women might be how beautiful they were in their youth and/or whether they have internalized the Western beauty ideal as their standard. Older women who have internalized a youthful beauty ideal are at risk for body dissatisfaction, appearance anxiety, and lowered self-esteem as they are reminded of their aging bodies every time they look at a mirror (Hurd 2000; Saucier 2004). In interviews, older women have complained about grey hair, wrinkles, double chins, facial hair, loose skin on their arms and necks, sagging breasts, and weight gain (Clarke et al. 2009; Foerster 2001; McFarland 1999). Some women, who had previously felt empowered by their ability to turn heads, now feel sad that no one seems to notice them anymore, no matter how well-groomed and nicely attired they are (Chrisler 2007). Thus, women who were closer to the beauty ideal are likely to be disempowered by physical signs of aging, as they are no longer as easily able to exercise power over others and to use the legitimate and reward power bases. However, women who were farther away from the ideal may be empowered by signs of aging. They may be able to exercise power from—the ability to refuse to continue the pursuit of beauty, given that stereotypes of older women as frumpy and ugly are available. Some beautiful women may also feel a relief that could be seen as empowering, as they are freed from some constraints now that their aging bodies are no longer sexualized and objectified by others, and they may be glad to have the opportunity to feel more authentic. Women in cultures that value older women come into power as they embody the wisdom and experience of elders. Thus, signs of aging do not carry the same meaning for all women.

Rather than relaxing into old age by giving up the pursuit of beauty, some women turn to age concealment techniques and attempt to "pass" as younger than they are (Ostenson 2008). Women can do this through the strategic use of fashion accessories (e.g. scarves to hide their necks) and clothing choices (e.g., longer sleeves, looser blouses), through diet and exercise, through the use of cosmetics (including hair dye) and cosmeceuticals (i.e., cosmetic products with biologically active ingredients, which are purported to have medical benefits), and, for those who can afford

it, through cosmetic surgery (e.g., face lift, breast lift) and other medical procedures (e.g., Botox, dermabrasion) (Clarke and Griffin 2007, 2008; Clarke et al. 2009; Clarke and Korotchenko 2010). In interviews, women often express ambivalence about age concealment products and techniques and recognize them as inauthentic, ageist, sexist, and risky, yet many still choose to use them to enhance their self-esteem, relieve body dissatisfaction and anxiety about aging, reduce the risk of age discrimination at work, or because of perceived sociocultural pressures (Clarke et al. 2007; Muise and Desmarais 2010). Indeed, "antiaging" products and cosmetic surgeries are advertised so frequently in the media that their use has become normalized, almost mandated (Brooks 2010; Clarke and Griffin 2007), in the sense that those who can afford to use these techniques are expected to do so.

Recent studies in Australia (Slevic and Tiggemann 2010), Canada (Muise and Desmarais 2010), and the USA (Chrisler et al. 2012) show high interest among midlife women in cosmetic procedures and cosmeceuticals. One third of 57 American women surveyed by Chrisler et al. (2012) had had at least one cosmetic procedure, and 81 % said they would like to have one or more procedures if they could afford them. Although it is certainly true that cosmetic procedures skillfully done can permit women to pass as younger than they are, thus, re-empowering them and shoring up their self-confidence, these gains can be fleeting, as age catches up with the women in other ways or the need to repeat the procedures begins to feel oppressive (Dingman et al. 2012). We have seen women whose smooth faces do not match the loose skin on their arms or necks and women whose face-lifts left their skin so tight that they appear to be wearing plastic masks. These examples of age concealment gone wrong could be among the reasons that Harris' (1994) participants described women who try to pass as "pathetic," "vain," and "foolish"; failed age-concealment techniques certainly do not help women to feel empowered.

Women who want to resist sociocultural pressures to try to erase signs of aging can try to reinterpret their bodies' changes in ways that are empowering. Stretch marks, sagging breasts, and extra pounds are evidence of having birthed and nursed children. Grey hair and lines on the face are marks of experience and suggest wisdom well earned. If grey hair and lines are distinguished in men, why not in women, too? Many people think that photographs of the writer Susan Sontag, with her streak of grey hair, and the artist Georgia O'Keefe, with her deep wrinkles from years of painting outdoors under the desert sun, are beautiful and show Sontag's and O'Keefe's strong character and individualism. Sexiness derives as much from self-confidence and experience as it does from attractiveness, and sexiness is a way to exercise power over, as well as reward, coercion, and legitimate power. Age-peered romantic and sexual partners know that their own bodies are not what they were, and they do not expect the ideal from each other. Women who are concerned about men's reactions to their aging bodies might be comforted by the results of two recent studies. In a study of attractiveness ratings of women's faces (Foos and Clark 2011), it was younger men and women and older women who rated the older faces harshly. Older men rated both younger and older women's faces as attractive. In a study of midlife married couples (Markey et al. 2004), wives thought that their husbands were dissatisfied with their bodies, but the husbands reported that they

found their wives attractive. Women might feel more comfortable with their aging bodies if they watched fewer films from Hollywood and more from other cultures where older women are still seen as sexy or are portrayed as playing powerful roles in society.

Physical Fitness

The process of aging invariably involves changes in the body that can leave older women less physically fit than they once were, and this transition can be disempowering. During the aging process, cardiovascular and respiratory capacities tend to decrease, and muscle fiber count and bone density also diminish (Hamberg-van Reenen et al. 2009). Aging is associated with a decrease in skeletal muscle mass, which accelerates after menopause (Janssen et al. 2000). By age 65, a woman's muscle strength is, on average, 75–80% of her lifetime maximum muscle strength (Hamberg-van Reenen et al. 2009); how serious a problem this is depends, of course, on how much muscular strength she developed in her youth and maintained through midlife (e.g., through manual labor or athletics). A decrease in the elasticity of muscles and tendons can limit a woman's range of motion, and the natural changes in collagen tissue that come with aging leave many older women with decreased flexibility (Jorgic et al. 2013). In part due to these changes in flexibility, range of motion, and other changes in the musculoskeletal and sensory system, the ability to maintain balance significantly decreases over a woman's lifespan (Isles et al. 2004; Jorgic et al. 2013). These factors lead to an increased risk of falling, which is one of the most common, serious, and potentially incapacitating dangers for older adults (Zhang et al. 2006).

A number of negative stereotypes of aging (e.g., ineffective, dependent, less physically active, weak; Robinson et al. 2009) are related to physical ability and fitness. Although the age-related changes described above mean that older people slow down their physical activity with advanced age, there is considerable variability in how much energy, stamina, balance, and cardiovascular and muscular fitness people have at every age. Men's levels of physical activity tend to be greater than women's throughout the lifespan, but the gap is wider in older cohorts (Bassey 2000; Chen et al. 2012). In some cultures, girls and women are discouraged (or even forbidden) to engage in sports and exercise routines that take them out of the house, involve revealing or form-fitting clothing, or require them to compete with or against boys and men. In some cultures, women who live in rural areas may not engage in sports, but develop strength and fitness through manual labor, including long walks to markets or wells, heavy lifting, and aerobic activities (e.g., sweeping, hoeing). In the USA, where a "fitness boom" began in the 1970s, the women who are most involved in fitness activities are circumscribed by class, culture, and cohort (Chrisler and Lamont 2002). Demographic predictors of a sedentary lifestyle in US adults include being older, female, and African American and having less

education, more body weight, and a lower level of physical activity in childhood (Blair et al. 1993).

It is important to consider women's lower levels of activity from a power perspective. It is easier to control women and to keep them in "their proper sphere" if they are less physically fit and more aware of their lesser physical strength and underdeveloped physical abilities (Chrisler and Lamont 2002). Many older women were raised to believe that sports and exercise may be fine for children, but are not appropriate for adult women. The beliefs that it is unfeminine to develop muscles or to sweat are common among older women, as well as among some class and cultural groups, even in developed nations (Hayes 1999; Nelson 1998). Many girls have been discouraged from participating in team sports and told that individual sports that emphasize gracefulness (e.g., figure skating, gymnastics) or involve the use of "light" objects (e.g., racquets) are more feminine than those that require physical force or the use of "heavy" objects (e.g., weights, boats; Hall 2008). In the USA, prior to the enactment of Title IX in 1979, it was difficult for girls to find opportunities to participate in team sports, even if they wanted to do so, which means that older cohorts of women have less experience with physical activity as "fun" and a greater sense of it as an unpleasant "duty" that their physicians have recommended. Barriers to exercise among older cohorts of women include social anxiety (e.g., people will laugh at her because she is unfit or does not know how to use the machines in the gym), lack of free time (e.g., family, work, and volunteer roles keep her too busy to exercise), unsafe public spaces (e.g., too dangerous to walk in the streets or nearby parks), concern about physical appearance (e.g., if she sweats, she will ruin her hairdo), body shame (e.g., she is too fat or too old or too clumsy), gender role constraints (e.g., exercise is a masculine activity; if she takes time to exercise, people may see her as selfish, ambitious, or competitive), and fear of falling and breaking a bone (Chrisler and Lamont 2002; Marcus et al. 1995; Nelson 1998; Vertinsky 1998; Zhang et al. 2006).

Those barriers make it difficult to encourage older women to exercise. However, physical fitness is widely seen as crucial for healthy aging; the American College of Sports Medicine recommends that older adults engage in regular aerobic and strength training exercises (Lemos et al. 2009). Even minimal physical activity can have significant effects on the health and well-being of older adults. One study (Sundquist et al. 2004) showed that those who participated in occasional physical activity had a 28 % lower mortality rate than those who were physically inactive; those who were physically active at least once a week had a 40 % lower mortality rate. Older adults who were physically active in midlife, as well as in later life, tend to live longer and suffer from fewer disabilities than their sedentary peers (von Bonsdorff et al. 2011). Women in developed countries who perform blue-collar jobs that require manual labor do not have lower mortality rates than women who perform white-collar jobs, but they do have higher rates of disability, perhaps due to the combination of the increased physical and mental strain (e.g., sexual and gender harassment) and the decreased resources that blue-collar workers face (von Bonsdorff et al. 2011).

Physical activity can increase independence and functional capabilities, and it can reduce the risk of falling (Lemos et al. 2009). The ability to navigate through one's community independently is critical to maintaining a sense of independence and autonomy; thus, mobility can help women maintain a sense of empowerment over their own lives and a sense of self-efficacy. However, female sex and older age are both associated with decreased community mobility (O'Brien and Tan 2002). Moreover, older women are less likely than older men to exercise, and they tend to have poorer physical status than men their age (Chen et al. 2012), which results in more older women than older men with lower mobility and greater dependence on others. Although dependence provides older women with a way to exert the legitimate power associated with helplessness (e.g., she deserves help), it is a form of power that can breed resentment in helpers, and it can weaken self-confidence and self-efficacy in the long run. However, some women with disabilities find it empowering to voice their needs and name what they want from others (Julie Williams, personal communication). It is also empowering to focus on interdependence with others, rather than dependence on others, which is a way to gain or maintain connectedness (e.g., "You help me to walk or dress, and I help you to entertain the children or by giving advice"). Some women, who have worked hard all their lives and now are frail or disabled, may find "surrender" liberating; it may even feel good to "allow" others to help them (Williams, personal communication).

Physical activity has also been linked to a number of other psychological benefits for older women. Among frail older adults, exercise programs have been shown to improve global quality of life, including improved social and family relationships (Langlois et al. 2013). Other researchers have found similar results that suggest a causal relationship between physical activity and psychological well-being. A meta-analysis (Netz et al. 2005) of 36 experimental studies showed that physical activity leads to a decrease in anxiety and depression and an increase in self-efficacy and positive view of the self (e.g., self-worth, self-esteem, self-concept, body image, perceived physical fitness, sense of mastery, locus of control). Research indicates that these results hold constant regardless of the country in which the study took place or the nationality of the participants. For example, a study of Brazilian elders (Antunes et al. 2005) showed that, after a 6-month exercise regimen, participants in the experimental group demonstrated significantly lower scores on anxiety and depression and reported significantly better quality of life than did participants in the control group. A similar study of elders in Taiwan (Wang et al. 2011) showed that those who participated in a regular exercise program reported lower levels of depression than did those who exercised irregularly.

The positive psychological effects that exercise has on older women may be just as important as the physical effects in helping them to remain empowered. Both anxiety and depression are associated with decreased social interactions and reduced independence (Antunes et al. 2005), which is of special concern for women, given estimates that one in five women experience depression during their life (Mayo Clinic 2013). Risk factors for depression include stressful life events (e.g., bereavement), chronic medical conditions, lack of social support, and isolation—all of which occur at higher rates among older people (Fulbright 2010). Depression

can be a debilitating illness among all age groups as it leads to impaired functioning; however, in older adults it can be particularly dangerous as it is associated with functional decline, cognitive impairments, frailty, and increased dependency and disability (Antunes et al. 2005; Duckworth 2009). Further, depression is the most significant risk factor for suicide among older adults (Duckworth 2009).

Walking difficulty is associated with reduced activity, and thus, a decline in physical and social functioning (VanSwearingen et al. 2011). Low-impact exercises, such as walking or stair climbing, have been a prominent feature in recent interventions aimed at encouraging exercise among older adults (e.g., MacMillan et al. 2011; O'Brien and Tan 2002). VanSwearingen et al. (2011) evaluated a program aimed at increasing the efficiency of their gait among those with walking difficulty. Results indicated that elders who participated in "motor sequence learning" improved in gait speed, physical activity, and total physical functioning. Interventions that improve mobility could enable older adults to remain independent and active for longer; however, studies (e.g., Orsega-Smith et al. 2008) have shown that long-term adherence tends to be quite low. To resolve this problem, some researchers have suggested that sport leagues, which provide social support, competition, and recreation, might be a better strategy. Some research (e.g., Orsega-Smith et al. 2008) supports this hypothesis, as does a more casual observation of the growing number of older adult sport leagues in Western countries. Although these leagues might be of greater interest to men than to women, and of greater interest to the "young old" than to the "old" and "old old," given the cohort effects addressed earlier, we are inspired by the South African grandmothers who formed their own soccer league after having been told that it is undignified for them to wear shorts or run around. Those women have a newfound sense of physical and personal empowerment, and they have discovered the joy of sport (Dixon 2010).

VanSwearingen et al.'s (2011) study suggests that effective exercise programs can be created to meet needs of older women of various physical ability levels, yet many are nonetheless hesitant to participate; one of the main deterrents is a fear of falling. This creates an unfortunate paradox as physical inactivity is significantly associated with the likelihood of falling and regular physical activity can help to prevent falls (Lim and Sung 2012; Zhang et al. 2006). Although much literature on physical activity among older adults is focused on aerobic training, a growing body of research demonstrates the benefits of Tai Chi (Roppolo et al. 2012). Tai Chi, which was originally developed as a martial arts form in China, has been used for centuries as a form of exercise for older adults because of its low velocity, low impact, and focus on strength and balance (Zhang et al. 2006). Tai Chi techniques can easily be modified so that women of different fitness and physical activity levels can participate and benefit. A study of 74,941 middle-aged and older Chinese individuals (Birdee et al. 2012) showed that 28% of the women practiced Tai Chi as a form of exercise; those who did tended to be older and to suffer from chronic medical conditions. Studies have shown that Tai Chi improves flexibility, balance, and strength and decreases both the likelihood of falling and the fear of falling (Song et al. 2010; Roppolo et al. 2012; Zhang et al. 2006). Decreasing this fear is of critical importance in building older women's confidence in performing

various physical activities, including leaving home to attend social and cultural events, which in turn helps to keep women independent, mobile, physically functional (Zhang et al. 2006), and in touch with their social network. Yoga, swimming, and certain forms of dance are other examples of low-impact physical activity that might be appealing to older women.

There is a scant research on the physical fitness levels of aging populations in developing countries. For the first time in human history, those who survive childhood can expect to live past 50 in every country on earth (Ramashala 2001), but older adults who live in countries with widespread poverty face many more challenges than older adults who live in wealthier nations. In settings with limited healthcare resources (Ramashala 2001), older adults might be less likely to be able to maintain a level of physical fitness that renders them physically empowered and independent. On the other hand, a lifetime of physical labor might result in stronger bones and muscles in older age than are typically seen in developed nations with more modern conveniences and sedentary jobs. However, insufficient data exist to address this question. As the proportion of older adults increases across the globe, the physical fitness and empowerment of older women in developing nations should become an increasingly important area of research.

In the meantime, older women can be encouraged to engage in regular physical activity of whatever kind interests them and at whatever level they can manage. Older adults do not necessarily like to exercise with a mixed-age group (Beauchamp et al. 2007), thus organized groups of older people (e.g., walking clubs, Tai Chi, yoga, "senior swim time") would be more attractive to many. The sociability of group activities for older adults is another benefit. Those with disabilities that prevent most forms of physical activity should be encouraged to see a physical therapist and to procure mobility aids (e.g., walker, wheel chair, scooter, cane) in order to maintain greater independence, better ability to navigate their communities, and social ties. Reframing physical activity as a way to promote longevity and extend the time a woman can perform her family roles may be helpful in working with older women who see exercise as a masculine or selfish activity or one that interferes with the time she spends with her family (Cantu and Fleuriet 2008). Enhanced physical fitness will give women the energy, strength, and stamina necessary to exercise power over, power from, and power to; it will also improve women's quality of life and provide opportunities to exercise reward, coercion, referent, and other power bases that come from work or community roles (e.g., expert, informational, legitimate).

Physical Health and Ability

Women live longer than men in most nations: 11 years longer, on average, in Eastern Europe, 5 years longer in Northern Europe, 3 years longer in East Asia and North America, and 1 year longer in Sub-Saharan Africa (Lee 2010). Although people often assume that the gender difference in longevity has biological origins, many studies indicate that it can be accounted for in most cases by health-related

behaviors (e.g., social support, health habits, risk taking) that are influenced by sociocultural expectations about how women and men should behave (i.e., gender role-related behaviors; Lee 2010). Women usually report better health habits (e.g., smoke and drink less than men, see a physician more regularly), have larger and more reliable social support networks (i.e., friends and family they can count on for advice and assistance), and take fewer risks (e.g., wear seatbelts, wash hands more frequently) (Lee 2010; Taylor 2011). Learning about health and caring for ill people is also a part of the feminine gender role (Chrisler 2012); thus caring about health and knowing how to keep others healthy could also contribute to women's greater longevity.

Chronic illnesses are conditions that cannot be cured (e.g., hypertension, diabetes, osteoporosis) and whose symptoms require active management (i.e., self-care) by patients as well as medical professionals. Chronic illness is a highly variable category. For example, it includes cancer, autoimmune disorders, and heart disease, each of which is a high variable category itself. Some illnesses (e.g., hypertension, arthritis) can manifest as mild or severe, and others (e.g., multiple sclerosis, rheumatoid arthritis, heart disease) have forms that are progressively debilitating. Although the average age of diagnosis varies by illness, many are associated with older ages. The longer people live, the more likely they are to be diagnosed with chronic illness. Because women live longer than men, they are more likely to face their older years with one or more chronic illness (Taylor 2011). Furthermore, due to benevolent sexism (i.e., chivalry, solicitude; stereotypes of "sainted mothers" and "long-suffering wives"), including the belief that older women are too weak to withstand aggressive medical interventions, physicians may prefer to take a "wait and see" stance rather than "subject" older women to heart surgery or aggressive chemotherapy that they are more likely to order for men of the same age (Travis et al. 2012).

Although older women are hardly likely to be surprised to receive a diagnosis of a chronic illness (given that most older people they know have at least one), a diagnosis requires a series of adjustments. For example, it might be perceived as a sign that one is now officially "old." Regardless of age at diagnosis, chronic illness requires changes in identity (e.g., "I am diabetic," "I am ill"), body image (e.g., energy level, physical capabilities, physical comfort), future plans, and life goals (Carel 2008; Goodheart and Lansing 1997). It also requires a change in the way people think of being "ill." As Gordon (1966) described it, people with a chronic illness or disability must abandon "the sick role" and adopt the "impaired role." The sick role refers to appropriate behavior for people with an infectious disease: rest, obey "doctor's orders," get well. It may be appropriate to acknowledge weakness and dependence upon medical personnel when one is sick; however, because people with chronic illness will never "get well," they need to maintain normal roles and behaviors to the extent possible given their condition. Their role is not to recover, but to learn as much as they can about themselves and their illness and to discover what they can and cannot do under which circumstances. The sick role is a disempowering orientation for people whose conditions will not improve. However, the impaired role can be empowering; it results in the development of expertise, which

can be used as a power base in interactions with medical personnel and with family (especially in regard to power from).

Not all chronic illnesses are necessarily debilitating, but many can become so if they are not well managed. Patients must work with medical personnel as a team in order to manage symptoms and prevent deterioration of their condition. This is a new idea to those who have been healthy for most of their lives or have suffered only from short-term disease or injuries for which they relied on medical personnel to cure them. This teamwork might require patients to learn some medical techniques (e.g., test blood sugar, give self injections). The teamwork also requires keen observation (e.g., How do I feel today? What was I doing right before I noticed this symptom?) and self-discipline (e.g., exercise daily, take medications on time). Some chronic illnesses (e.g., diabetes) have complex treatment regimens that require a great deal of self-knowledge and self-discipline from patients. Physicians and health psychologists typically refer to the patient's role on the medical team as adherence (or compliance) with a treatment regimen. Nurses typically refer to the patient's role as self-care, which may be a more appropriate term to use with older women, who sometimes need "permission" to take care of themselves and put their own needs ahead of those of others. Self-care can be empowering in a number of ways, including power over (e.g., I can control my symptoms or keep them from getting worse), power from (e.g., This is "me time"; I have to take care of myself, so I cannot do what you want), and power to (e.g., If I care for myself, I will be able to care for others; If I work when I feel well, I can rest when I feel ill).

Chronic illness reflects several negative stereotypes of older people (e.g., weak, unhealthy, disabled), and it can be disempowering if it means that older women must give up favored activities due to fatigue, joint and muscle stiffness, difficulty breathing, or other signs and symptoms of chronic illness. Although many chronic illnesses can be improved by regular exercise, symptoms (e.g., stiffness, fatigue) and related concerns (e.g., fear of falling and breaking a bone) may lead patients to become more sedentary, thus making their conditions worse and contributing to the problems we discussed above related to physical fitness. Of course, chronic illness does allow for the use of the legitimate power base through the patient's weakness or helplessness, but, as Gordon (1966) pointed out, the sick/helpless role is not a good strategy for the long haul, and the helpers may begin to withdraw from the ill person's influence after months or years.

Although it seems counterintuitive, self-care and the impaired role can be empowering. As older women learn more about their illness, adjust their behavior accordingly, and become better at managing their symptoms, they gain self-confidence and self-efficacy, they feel that they have some control of their bodies and their lives (Leach and Schoenberg 2008), and they become able to exercise expertise and informational power in relation to their condition. Recent studies of older women with chronic illness illustrate a variety of ways that women can be empowered as they engage in self-care, despite the frailty they might experience.

Rather than giving up favored activities, women may modify the way they carry out those activities in order to continue them (Roberto et al. 2005). Pain and lower stamina or energy level can be accommodated by slowing down the pace of the

activity. Occupational therapists may be able to assist women in finding new ways to perform tasks that have become difficult (e.g., use of an assistive device to open tight jars). In her illness narrative, Carel (2008) spoke of learning to manage her poor lung capacity by learning new routes (so as to avoid walking up steep grades), allowing more time than she had needed before her illness to do most things, and changing her habits (e.g., limiting how many times she walked upstairs at home, carrying her phone everywhere). The use of assistive devices (e.g., canes, scooters, hearing aids) can also help ill or disabled individuals to maintain their activities, and these devices can become incorporated into the individuals' body image (e.g., "My cane is part of me"). Although some older women resist devices (or handicapped parking tags) because of embarrassment or concern about looking "old" and infirm, the devices, along with the other suggested modifications, can allow women to maintain independence and autonomy.

Older women often report spirituality as a source of strength and empowerment, especially in relation to living with chronic illness (Gallant et al. 2010; Harvey 2008; Leach and Schoenberg 2008; Shawler and Logsdon 2008). Praying for strength and courage to face illness is a favored approach. Meditation, communing with nature, or losing oneself in music or other art forms helps relieve stress associated with illness and can provide hope and a sense of being part of something larger than oneself. The belief that one is not suffering alone (e.g., that God, a guardian angel, a saint, an ancestor, a spirit, or a totem is always there) can contribute to self-efficacy and empowerment.

Emotion-focused coping techniques can help older women to maintain emotional equilibrium and avoid the depression that chronic illness may bring (Lonborg and Travis 2010). Use of positive self-talk (e.g., "I can do it!") and refusal to dwell on the negative aspects of one's situation are helpful (Shawler and Logsdon 2008). Relabeling emotions is another strategy that can be used to stay positive and empowered (e.g., "It's not anger, it's annoyance"; "I'm not depressed, I'm disappointed"). When anger or frustration occurs, it can be channeled into positive action (e.g., "Don't tell me I can't go out on my own, I have my scooter!"; "If at first, I don't succeed, I'll just try, try again"). Normalizing is another useful emotion-focused approach (Carel 2008; Leach and Schoenberg 2008); it refers to gently reminding oneself at frustrating times that this is the "new normal": One's body has changed, and accommodation must be made. Recollection of past competencies and accomplishments (both physical and professional) have provided comfort to some women (Shawler and Logsdon 2008), but others might find those memories distressing if they focus on their reduced capacity compared to the past.

Social comparison refers to the process of identifying others as standards against which to compare oneself. As we have discussed earlier, older women who compare themselves to a youthful beauty ideal are going to be disappointed. Similarly, disabled or chronically ill individuals who compare themselves to able-bodied or healthy individuals are also likely to be disappointed. Part of normalizing involves selecting a new comparison group. For example, we have heard older women say, "I'm doing fine for my age" or "I get around pretty well for someone my age." Upward social comparisons (i.e., to unreachable standards) are likely to be

disempowering, whereas downward social comparisons (i.e., to people in worse condition than the self) can be empowering. Some older women have reported that they maintain their self-confidence and positive feelings by helping others who are worse off than themselves (e.g., doing volunteer work in a nursing home) or thinking about others who are worse off (e.g., "At least I don't have dementia like poor Lucy") (Leach and Schoenberg 2008; Roberto et al. 2005).

Older women often rely on their social support networks to manage their chronic illness. Having a shoulder to cry on, a person who provides comfort and reassurance, someone who can help with practical matters (e.g., walk the dog, drive to appointments), someone who gives good advice, someone with the same chronic illness, and someone who has needed information (e.g., knows a good doctor or physical therapist) in one's social network is very helpful. When people know whom to call for what they need, and can feel fairly sure that they will get a good response, they feel more confident and in control of their circumstances. Social support has many well-documented positive effects, but sometimes it can have negative effects as well (Taylor 2011). For example, older women sometimes report that they get too much help, which is disempowering, or that they get the wrong help, or that their social network depends too much on them, which takes all of their available energy (Roberto et al. 2005). Some older women may hesitate to use referent power to call upon their social network for assistance for fear of "bothering" their friends and family or because they do not want to upset the power balance in their friendships. They may worry that the usual "give and take" in friendships will become "all give" on one side and "all take" on the other. However, that power balance can be preserved when tangible support is received from the healthy friend and emotional support is given by the ill friend. In collectivist cultures, and cultures where families often live in multigenerational homes, older women in need of help may not need to worry about exhausting their helpers. Their years of caring for and giving to others activate the reciprocity norm: Younger family members expect to give back, see elder care as their duty, and may even appreciate the opportunity to show their affection through providing social support to their elders. However, in developing nations young people are increasingly likely to leave their home towns and villages to move to cities where there are greater economic opportunities. Elders who are left behind might find themselves without the support and care they had expected to receive from their children and grandchildren, and their situations may resemble those of older people in developed nations—but without government-funded agencies that can deliver needed services.

Finally, problem-focused coping is very helpful in managing chronic illness and/or disability. It refers to active attempts to manage a situation by gathering information, making plans, trying different strategies, and assertively asking for help needed from medical personnel or others in one's social support network (Lonborg and Travis 2010; Taylor 2011). The support groups (either in-person or online) can be good sources of tips and strategies for managing symptoms. Learning to solve problems related to one's condition is empowering and builds confidence and self-efficacy.

Thus, even when chronic conditions limit older women's ability and hence can be disempowering, they also provide the opportunity to learn to think about, and to use, the body differently in ways that can re-empower patients in the impaired role to get the most out of their lives. The quality of life of older women with chronic illness or disability can be much better than young, healthy people imagine it to be. Obviously, women with more resources and better health care options at their disposal will be able to manage their illnesses better than those with fewer and worse options, but many of the coping strategies discussed above can be used by anyone, anywhere.

Conclusion

Attractiveness, physical fitness, and health are common ways that bodies empower women, providing influence and ability to achieve plans and goals. In old age, those ways may be less available and cause women to feel disempowered. However, changing one's standard for social comparison, taking good care of the body, learning to manage chronic illness, and learning to use the body in different ways can all contribute to the continued use of the body as a source of personal and interpersonal power. Some women may turn to cosmetic procedures to erase signs of aging writ on the body; others may do better by remembering that sexiness has more to do with knowledge, skill, and confidence than with beauty. Most people's energy and stamina can be improved through self-care (e.g., adequate rest, good nutrition, regular exercise). Assistive devices and community services (e.g., van service for those who can no longer drive or walk easily) can empower older women by helping to maintain their mobility and independence, as can a focus on interdependence rather than dependence.

It is also helpful to remember that there are many sources of power outside the body for people of any age. Older women can often empower themselves and their social networks by sharing their wisdom and experience as mentors, volunteers, and activists (Denmark and Williams 2012; McHugh 2012; Wray 2003) or by sharing family stories with, and caring for, their grandchildren (Kulik 2007; Wray 2003). Although aging invariably leads to changes related to the body, the process of aging does not inevitably mean a decrease in empowerment; it might just mean a change in how and from where power is derived.

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Older Women, Economic Power, and Consumerism

Andrew J. Schein and Nava Haruvi

One of the major advances in the world in the last 100 years has been the huge increase in longevity. It has been estimated that, in England, between the years 1540 and 1800, life expectancy at birth averaged 37 years, and this was comparatively high for the period (Clark 2007). One reason for this low figure was the high rates of infant and child mortality, but even if one survived one's early years, most people did not reach the age of 60. In England, from 1580 to 1800, 31 % of newborns did not make it to age 15, and those who did had a life expectancy of 52.

In 1800 the global average of life expectancy was 28.5 years, and this increased to 32 years in 1900 (Riley 2005). By 1960, the average jumped to 52.5 years, and it continued to climb, reaching 67 years in 2000 and 70 years in 2011 (www.worldbank.org). In the higher income countries, life expectancy was even higher: 68.5 years in 1960, 77.5 years in 2000, and 80 years in 2011.

Another differential in life expectancy is between women and men. Of the 193 countries/territories for which the World Bank (www.worldbank.org) reported life expectancy in 2011, there were only five countries (Botswana, Lesotho, Qatar, Swaziland, and Zimbabwe) where men had a longer life expectancy than women. It has been argued (see *The Economist* 2013a*)* that this gap in favor of women's life expectancy is falling in the wealthier countries, and, for some countries, such as the USA, the difference narrowed from 6.5 years in 1960 to 4.8 years in 2011. However, there were other wealthy countries (e.g., Denmark, Japan, and Sweden) where the gap increased from 1960 to 2011. For the entire world, on average, the difference between the sexes increased from 1960 to 2011; amongst countries where women had longer expected life spans, the difference was 3.9 years in 1960, and it increased to 4.7 years in 2011. Accordingly, it is not clear if, in the future, women's and men's life expectancies will be equal.

The overall increase in life expectancy has incurred in three stages. In the first stage, 1850–1950, the increases were due mostly to reductions in maternal and child mortality, which increased the average life expectancy, but did not significantly

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increase the life expectancy of a 50–year-old person. The second stage was in the middle of the twentieth century when there began to be improvements in the life expectancy of people aged 50 and older. Eggleston and Fuchs (2012, p. 138) described this development as a "longevity transition." In the third stage, toward the end of the twentieth century and the beginning of the twenty-first century, there have begun to be increases in the life expectancy of people over 80.

Due to these changes, many people are now living more than 60 years, though the rate of this increase still depends on the economic development of the country. According to the UN (www.unpopulation.org), in 2012, in the more developed regions of the world, 22% of the population was over 60 years old; in the less developed regions, 9% of the population was over 60 years old; and in the least developed regions, only 5% of the population was over 60 years old. These figures are expected to increase in coming years. The UN has forecast that, in 2050, in the more developed regions of the world, 32% of the population will be more than 60 years old; in the less developed regions, 20% of the population will be more than 60 years old; and, in the least developed countries, 11% of the population will be more than 60 years old.

The progress in health care that has increased life expectancy has also led to improvements in functioning for older people, such that the effects of aging have been less debilitating than in the past. Christensen et al. (2009, p. 1204) noted:

> Most evidence for people aged younger than 85 years suggests postponement of limitations and disabilities, despite an increase in chronic diseases and conditions. This apparent contradiction is at least partly accounted for by early diagnosis, improved treatment, and amelioration of prevalent diseases so that they are less disabling.

With these improvements, the rate of aging has slowed. Maestas and Zissimopoulos (2010, p. 150) noted "that evidence is mounting that, at least on some dimensions of health, age 60 is the new 50."

Independent of this increase in longevity, in the twentieth century, there was also a huge increase in the participation of women of all ages in the labor force, and these two changes have resulted in older women with potentially greater economic power than ever before. Yet, are older women actualizing this power? For example, in the market of consumer goods, are goods being designed for the needs of older women when the good is being sold both to younger and older women?

In this chapter we attempt to answer these questions. In order to do so, we review the participation of women of all ages, and especially older women, in the labor force, as well as women's earnings in order to assess older women's potential economic power. We also discuss consumerism and older women, and examine various markets to determine how much economic power older women actually have in the market. We focus primarily on women in the USA and other developed economies that have had the largest changes both in life expectancy and women's participation in the labor force. In addition, these are the countries for which there are a relatively large amount of available data due to the US Labor Bureau of Statistics (BLS) and the Organization for Economic Co-operation and Development (OECD).

Women in the Labor Force

In 1890, in the USA, only 15% of women aged 25–44 were part of the labor force (either working or looking for a job), and only 12% of women aged 45–64 were part of the labor force (Goldin 1998, 2006). These numbers rose to 75 and 59% by 1990, and, in 2012, the rates were 74 and 67%, respectively (www.bls.gov). This growth is particularly striking in contrast to men's participation in the workforce, which, although greater than women's, has declined during the same period. In the USA, in 1890, the labor participation rate of men aged 25–44 was 96%, and it was 92% for men aged 45–64. In 2012, these rates had declined to 90 and 79%. This reversal could be due to a loss of manufacturing jobs in the USA, which are traditionally male-dominated, or, perhaps, some men are content to work less now that their wives or partners are working more.

In addition to the increase in the number of women working, there has also been a change in the type of work that women do. Goldin (2006) pointed out that, from the late 1970s to the present, a quiet revolution has transpired with regard to women in the workforce. Until that period, the main qualification for women, even college graduates, was their typing ability, and job interviews would generally begin with the question "How well do you type?" However, after 1970s, women began to enter the professions. In 1960, 5% of law students were women, whereas, in 2000, women comprised 50% of the law students in the USA. Goldin explained that, due to this expansion in their job opportunities and earnings, many women began to view their employment as careers rather than as jobs.

The experience of the USA is not unique. In Britain, in 1931, 32% of women aged 20–64 were in the labor force, and most of these workers were single women (Joshi et al. 1985). Groves (1993, p. 45) noted that "many women were required to leave their jobs upon marriage. Better paid occupations typically operated marriage bars, which affected women who were well qualified by the standards of the day, such as school teachers or civil servants." After WWII, marriage bars were abolished, and women's participation in the labor force increased such that, in 2011, 73% of women in the UK aged 25–64 were in the labor force (www.oecd.org). Riboud (1985) reported a similar pattern for French women. In 2011, for the 34 countries in the OECD and Russia and South Africa, the average labor participation rate of women aged 25–64 was 70%; a few countries had relatively low rates, such as Turkey at 33%, Mexico at 51%, Italy at 56%, and South Africa at 59% (www.oecd.org).

Older Women in the Labor Force

An additional recent change in the labor market in the beginning of the twenty-first century is that older men and women are remaining longer in the labor force, reversing a trend to retire at younger ages that had developed in the twentieth century. When people lived shorter lives, they worked up to the time of their death or until

they were physically unable to work. For example, in the USA, in the late 1880s, the labor participation rate of men over 65 was 75% (Maestas and Zissimopoulos 2010). Similarly, in Britain in 1881, it has been estimated that 73% of the male population over the age of 65 was still in the workforce (Phillipson 1990).

This idea of working until one died changed in the twentieth century as people began to have a period of retirement before they died. The ability to retire began before the longevity transition. In Britain, toward the end of the nineteenth century some private companies and some branches of the civil service began to offer pensions to various categories of workers (Phillipson 1990). Gradually pensions were offered to more and more workers, and then the reason for retirement changed from physical disability to the age of eligibility for pension benefits.

The particular age when a person becomes eligible for pension benefits differs throughout the world, and, in 2012, it ranged from 50 to 67 years old for women (www.unpopulation.org). In 61 countries, the retirement age for women was 60 years; in 36 countries, it was 55 years; and, in 23 countries, it was 65 years. Generally, but not always, in the more economically developed countries, the retirement age is older. For example, it is age 66 in the USA, and age 65 in Canada, whereas it is 50 in Sri Lanka and Nigeria. This difference might be due to the greater longevity in the more developed countries, to cultural factors in each particular country, or to the relative amount of manual labor performed in the particular country.

The ability to retire led to declines in the labor force participation rates of older men. In the USA, in 1950, the labor force participation rate for men 65 and over had declined to 45.8%, and, by 2000, it had declined further to 17.5% (Toossi 2002). Similarly, the labor participation rate for men aged 55–64 was 86.9% in 1950, and, by 2000, it had declined to 67.3%. Likewise, in the UK in 2013, 87% of the men aged 65 and up were retired (based on data from www.statistics.gov.uk).

The retirement effect impacted older women differently than older men because older women were also influenced by the increase in labor force participation by women of all ages. It appears that, for older women in the USA, the stronger effect was the increase in employment by women of all ages. From 1948 through 1976, the labor force participation rate of women aged 55–64 increased from 24 to 41% (www.bls.org). Starting with data from 1976, the BLS provides a breakdown of women's labor force participation rates for the age groups 60–64, 65–69, and 70 and over. From 1976 to 2000, labor force participation rates for these three age groups increased from 33, 14.8, and 4.5% in 1976 to 40.2, 19.5, and 5.8%, respectively, in 2000.

Even with a reduced retirement effect, older women are still enjoying many years of retirement. Leonesio et al. (2012, p. 59) noted that, in the beginning of the twenty-first century, the median age for women to leave the labor force in the USA was 60.5 years. At that same time, the life expectancy for women at age 65 was 19 more years, which means that, in the beginning of the twenty-first century, on average, women in the USA could expect to live as retirees for 23.5 years. Of course, just because women are retired does not mean that they are not working, rather, as pointed out by Sugar (2007, p. 164), "much of the unpaid work that women do continues after they exit from the paid labor force." Thus, many older women continue

to cook, clean house, manage their household, care for older and younger relatives, and do volunteer work in their communities.

In the beginning of the twenty-first century, the retirement effect began to be postponed for men in the USA as older men began to work more after a century of declining labor participation rates. From 2000 to 2012, the labor force participation rate for men aged 55–64 increased from 59.2 to 60.9%, and, for men 65 and above, the rate increased from 12.8 to 14.8%.

Correspondingly, from 2000 to 2012, the labor force participation rate for US women aged 60 and over continued its increases from the end of the twentieth century and at a faster pace. In 2012, the three age groups' (i.e., 60–64, 65–69, and 70 and above) labor force participation rates increased to 50.4, 27.6, and 8.5%, respectively. The growth in the labor participation rate of women aged 60–64 increased from an annual growth rate of 0.89% from 1976 to 2000 to an annual growth rate of 1.89% from 2000 to 2012. For women aged 65–69, the labor force participation rate increased from an annual growth rate of 1.17% from 1976 to 2000 to an annual growth rate of 2.93% from 2000 to 2012; for women 70 and up, the growth in the labor force participation rate increased from an annual growth rate of 1.08% from 1976 to 2000 to an annual growth rate of 3.27% from 2000 to 2012. For all three age groups, the rate of increase was more than double, which indicates that, in the beginning of the twenty-first century in the USA, there were large increases in the labor force participation of older women.

The large jump in older women's labor force participation seems to be due to the convergence of the two forces acting on older women: the increase in women of all ages in the workforce and the increase in older workers in the workforce. At the end of the twentieth century, older women were working more because the effect of the increase of women of all ages working was stronger than the effect of older workers retiring earlier, but this early retirement effect was still limiting how many older women worked. However, in the beginning of the twenty-first century, when even older men began to work more and retire later, the two effects on older women were working in tandem, and the rate of increase of older women in the workforce was more than that of men.

This increase in the labor force of older women is remarkable because, in the USA, from 2003 to 2012, the labor force participation rate of younger women aged 25–54 declined from 77 to 75%. This decline might be because younger women are "opting-out" of careers or it might be because of the recession, which made it harder to get jobs (see *The Economist* 2013c); however, in the same time period, older women were participating more in the labor force. It appears that the generation of women who were over 60 in 2012 has retained their initial enthusiasm for work.

The transformation of the labor force participation of older people in the beginning of the twenty-first century has occurred throughout most of the countries in the OECD (www.oecd.org). For the 33 countries for which there are data, in only five did the labor force participation rates of women aged 60–64 decrease from 2000 to 2011, and, for some of those countries, the decreases were due to economic difficulties in the country. On average, for all of the 33 countries, the labor participation rate increased 66% from 2000 to 2011. In the 23 countries for which there are data,

there was an even greater increase (85%) in the labor force participation rate of women aged 65–69 from 2000 to 2011.

Although, in almost all countries, the labor force participation rates of older women have been increasing, it should be noted that there are vast differences in the level of the labor force participation rates of older women amongst the developed countries of the world, probably due to different cultural factors in the particular counties. According to data from the OECD, in 2011, the labor force participation rates for women aged 60–64 were the highest in the Scandinavian countries (Iceland 74%, Sweden 61%, Norway 56%) and New Zealand (61%) and much lower in Eastern Europe (Hungary 12%, Poland 14%). In 2011, the labor participation rates of women aged 65–69 were highest in Iceland (39%), South Korea (32%), New Zealand (31%), and the USA (27%), whereas the rates were very low in some countries in Western Europe. For example, in Germany the rate was 7%, and in France it was 5%.

In addition, even with the increase in labor force participation, older women still work less than older men do. In 2012, of the 34 countries for whom the OECD reports data (www.oecd.org), only in Estonia was the labor participation rate of women aged 55–64 higher than the labor participation rate of men aged 55–64; on average the labor force participation rate of women aged 55–65 was 17% less than that of men aged 55–64.

Reasons Why Older People Are Working More than in the Past

What brought about this shift in the labor participation of older workers in the beginning of the twenty-first century? Aisa et al. (2012) pointed out that, after WWII, the trend to retire earlier was because people were earning more money and they wanted more leisure; this is known as the income effect. Governments also supported early retirement in order to open up more jobs for younger workers by giving people the opportunity to claim pensions at earlier ages. However, now, instead of encouraging workers to retire early, governments are encouraging workers to work more years in order to reduce the growing problem of funding pensions because of the increase in life expectancy.

Evidence of this change is that, according to the OECD (2011), in 1949, the average women's pensionable age in all the OECD countries was 62.9 years, and this fell to 61 years in 1989. In 1999, it started to increase, and it is predicted that, in 2020, it will return to its 1949 level, and, by 2050, it will be higher at 64.4 years. In the USA, in the 1960s, about one-half of workers were forced to retire at the age of 65. The retirement age was raised to 70 in 1978, and then, for almost all workers, mandatory retirement was abolished in 1986. In addition, the age when a person is eligible for full social security retirement benefits, which effectively determines the age of retirement, is gradually increasing. In 1999, the age was 65; in 2005, it increased to 66; and it is scheduled to increase to 67 in 2022.

Maestas and Zissimopoulos (2010) argued that the changes in social security had only secondary effects on the increase in older workers, and they offered a

variety of other reasons for the increased labor force participation. One of these is the change in the nature of pensions from defined benefit plans (where there are few incentives and even some disincentives to keep working) to defined contribution plans (where the benefits can increase when people work more and continue to contribute to their pension plans).

Another reason is older workers' rising skill level due to an increase in their educational levels, which can lead to higher salaries, which in turn gives them a greater incentive to keep working. As Becker et al. (2010, p. 229) noted:

> Since 1970 there has been a worldwide boom in higher education…. In the United States and throughout the world, the boom in higher education has been primarily a boom in higher education of women, so much so that, in most countries, more women than men now attend college.

The increase in women's educational level reinforces their participation in the labor force. England et al. (2012, p. 9) studied the relationship between the levels of education and employment of women in 17 countries for the years 2004–2006, and they found that, in "each of the 17 high and middle income countries, women with more education are more likely to be employed than women with less education."

This increase in the education level of women in the workforce has been very noticeable for older women in the USA. For example, Macunovich (2012) studied the educational level of older women workers in the USA from 1969 through 2009, and found that, in 1969–1971, less than 20% of women workers aged 55–69 had more than a high school education, whereas, in 2007–2009, the percentage had increased to around 50%.

An additional factor in the increase in the labor force participation amongst older workers is the change in the economy in the more developed nations. Economies can be divided into three basic sectors: agriculture, industry, and services. Countries with lower levels of development focus more on agriculture and have less industry and fewer services. As countries develop, agriculture tends to become less important, and the industry and service sectors increase in importance. With continued development, the service sector becomes the dominant sector, which is known as deindustrialization or post-industrialization. In this stage of an economy, machines are able to replace many of the workers in agriculture and industry, and workers move to service industries, such as health, education, and entertainment. These jobs are generally less physically demanding, which makes them more suitable both for women and for older workers. Although some of these jobs (e.g., waiters, fast food employees, home health aides) are low-paying, others (e.g., physicians, accountants, lawyers) are high-paying professions.

The rise of computers, although at times technically challenging to older people, is another relatively recent change that has increased the labor force participation rates of older workers. Women of all ages tend to be less integrated into the computer industry than men are. In the USA, in 2011, only 8% of female professionals were employed in the computer and engineering fields, whereas 44% of male professionals were employed in these fields (BLS 2012). Furthermore, within the high-tech sectors, for both women and men, most of the workers are younger, (i.e., 50 and under). Thus, the growth of computers in the modern economy does not lead

directly to new jobs for older women, but, indirectly, the presence of computers in all jobs makes numerous tasks less arduous and physically demanding, which allows older women and men to continue working.

Career Jobs, Part-time Work, and Bridge Jobs Amongst Older Women

The increase in participation in the workforce of older workers does not mean that people are continuing to work the same number of hours when they get older; many older workers want to cut back on their hours or, at times, their employers force them to work fewer hours. In the USA, in the 1980s and 1990s, most workers who were 65 and older worked part-time (BLS 2008). However, in 2001, there was a reversal with regard to the number of hours people work in the USA, as more workers who were 65 and over were working full-time, and this trend has continued. In the USA, in 2012, 71 % of the women aged 55 and up were working full-time (www.bls.gov). This change from part-time to full-time work corresponds to the increase in working overall. Just as people are deciding to work when they are older, they are also deciding to work full-time rather than part-time. Nonetheless, this development is not universal. Data from the OECD show that, for women aged 60–64, the ratio of full-time workers to the overall number of workers has declined from 69 % in 2001 to 66 % in 2011, due to declines in Austria, Belgium, Chile, and South Korea, among others.

Another way to examine the role of older women in the workforce is by the number of hours worked. Macunovich (2012) presented data that show the increase in hours worked by older women in the USA. In 1969–1971, women aged 55–61 worked on average 893.2 hours per year, and this increased to 1232.8 for the years 2007–2009, an increase of 38 %. For women aged 62–64, the average number of annual hours increased from 635.3 in 1969–1971 to 780.9 in 2007–2009, an increase of 23 %; for women aged 65–69, the average number of annual hours increased from 314.7 in 1969–1971 to 423.7 in 2007–2009, an increase of 35 %.

Independent of the number of hours worked, many older workers change their jobs before retiring. Quinn (2010, p. 50) noted that “For most Americans, retirement is not an event, but a process, with transitional steps en route.” These steps are that many older workers will move from a career-related job to another type of job before entering retirement; these other jobs are known as bridge jobs. Quinn et al. (2011) have examined data from a health and retirement survey of 12,600 Americans between the ages of 51 and 62 that began in 1992 and continued through 2008, with the respondents resurveyed every 2 years. In 1992, 78 % of the women had full-time career jobs, 11 % had “other jobs,” and 11 % were not employed. By 2008, 66 % of the women had retired, 11 % were still at their career job, and 23 % were at bridge jobs. For the entire period of the survey, the percentage of women working at bridge jobs peaked at 37 % when the women in the survey were between the ages of 59 and 69. In 2008, 22 % of the women who had full-time career jobs in 1992 were working at a bridge job, and 29 % of those who were retired had worked at a bridge job before retirement. Furthermore, it has been found that “the majority

of these bridge jobs are not in the same industry or occupation as the career jobs" (Macunovich 2012, p. 6).

Quinn et al. (2011, p. 11) found an interesting distinction based on earnings with regard to bridge jobs. They reported:

> Men and women at both ends of the wage distribution were more likely to utilize bridge jobs on the way out than those in the middle – more than 70 percent of those making either less than $ 10 per hour or more than $ 50 per hour moved to a bridge job, compared to 60 percent of those making between $ 20 and $ 50 per hour. Answers to questions about why these people were still working suggest that those at the upper end were working because they wanted to (it was a life style choice) while those at the bottom were doing so because they had to (for the pay and/or the medical coverage).

The change from full-time to part-time work and the availability of bridge jobs can be viewed positively or negatively. The positive perspective is that it gives people the opportunity to keep working and earning when they are looking for a change in careers or number of hours of work. From this perspective, older women who choose to work part-time or in bridge jobs are demonstrating their economic power in that they can choose their own lifestyles. However, it is also possible that the people who are moving to part-time and/or bridge jobs are doing so involuntarily. They might prefer to stay at their full-time career job, but their employer forces them to leave or to work less, or they might prefer to retire but cannot afford to stop working entirely, so they end up settling for these other jobs. For these workers, part-time and bridge jobs are indicative of a lack of economic power.

We have seen that older women are increasingly active in the workforce, but this distinction in bridge jobs and part-time work shows the disparity that exists amongst older people, in general, and in women, in particular. For some women, the ability to work when they were both younger and older has given them the economic freedom to choose to work, whereas other women do not have these choices because they have been forced to work in whatever jobs they can get, and they need part-time or bridge jobs to make ends meet as they age.

The Wage Gap, the Glass Ceiling, and the Potential Buying Power of Older Women

This disparity in economic freedom amongst older women is affected by their earnings and wealth. The increases in labor force participation and education have led to increases in the income of women, yet women's wages and salaries remain lower than men's for full-time work, which is known as the wage gap or gender gap. According to the BLS (2012), for full-time workers in the USA aged 16 and up, in 1979 women earned 62% of what men earned; by 2011, women earned 82% of men's wages ($ 684 as compared to $ 832). According to the OECD (www.oecd.org/employment/outlook), the wage gap in the USA was a little larger than the average in developed countries. Overall, for the 28 countries in the OECD, in 2010, for

full-time workers, women's salaries were, on an average, 85% of men's salaries, with the largest gaps in Korea (61%) and Japan (71%).

The difference in earnings between men and women is influenced by the educational levels of the workers. According to the BLS (2012), from 1979 to 2011, the real earnings (adjusted for inflation) of women aged 25 and over who did not have a high school diploma declined 10%, though this was less than the decline in men's earnings in the same educational category, which fell 33%. Conversely, from 1979 to 2011, the earnings of women who had a college degree increased in real terms by 31%, which was greater than the increase by men of the same educational level (16%). This greater increase in earnings by women with college degrees suggests that the wage gap will further diminish in the future as more and more women become college graduates.

In addition to educational levels, it is possible that the age of the workers has a bearing on the wage gap. According to the BLS data, in 2011, in the US, women aged 35 and older earned 75 to 81% (in the different age groupings) as much as men, but women aged 16–34 earned more than 90% of what men earned. These data might appear to indicate that the wage gap grows with age. A reason for this development could be a slower rate of accumulation of human capital by women as they age, if, for example, they take time off from their jobs to care for children or elders, or it could be due to discrimination against older women workers throughout their lifetime. For example, one aspect of sex discrimination is known as the glass ceiling; even though women are equally qualified, they are not promoted as far as men are and they do not receive pay increases equivalent to men's.

Yet, it could be that the difference in 2011 is because when the women who were over 35 in 2011 began their careers, they started at lower salaries, and the size of the wage gap in 2011 is a function of their lower starting salaries. If this is true, then the wage gap has more to do with cohort than with age. In a study of female college graduates from 1989 to 1999, Weinberger (2011) found that the wage growth of these women in the different age groups stayed even with, and in some cases exceeded, the wage growth of men. This indicates that the wage gap does not increase with age. If so, then we can expect the much lower wage gap for women aged 25–34 in 2011 to remain or decrease but not to increase as these women age. Of course, this does not help the women presently 35 and older, who have received some of the benefits of higher earnings, but not as much as they should have.

Weinberger (2011) found a glass ceiling effect for US women with jobs that were considered fast track to very high salary levels, such that women are underrepresented in these top jobs. Similarly, *The Economist* (2011, p. 62) noted:

> The higher you gaze up the corporate ladder, the fewer women you see. According to Catalyst, a researcher in New York, women are 37% of the middle managers in big American firms, 28% of the senior managers and a mere 14% of executive-committee members.

Evidence for the presence of a glass ceiling in top jobs can also be found in a study by Deloitte (2013) of the percentage of women in the boardrooms of companies in 25 countries. With the exception of the Scandinavian countries (Finland, Norway, and Sweden, where the rates were 22–43%), in none of the countries sampled did women's presence in boardrooms exceed 20%; in eight of the countries it was less than 10%.

The presence of the glass ceiling means that although more and more women are working and the wage gap has diminished, women still lack economic power in the sense that they have less say than men do in determining the major decisions of corporations, such as which products to develop, where to locate factories and stores, and overall business strategy. Women's economic power with regard to these decisions will grow to the extent that women become more successful in the future in attaining top jobs in corporations. However, the present generation of older women's economic power is based on their potential buying power as consumers of goods and services.

The buying power of an individual derives from her or his wealth (or access to wealth) and the person's income. Married women's access to wealth includes their partner's income. However, many older women are single. For example, in the US, more than one-half of the women aged 65 and over are either no longer married or were never married (Hartmann and English 2009). Furthermore, this group of single women is increasing due to the rise in divorce amongst older people. Brown and Lin (2012) noted that, in the USA, the country with the highest divorce rate in the world, the overall divorce rate stabilized during the years 1990–2010, but amongst people 50 and over, the divorce rate doubled in the years 1990–2010, which they called the "gray divorce revolution." The increase in divorce amongst older women reduces their access to their partner's wealth, but some of that loss was mitigated due to property having been registered jointly and women having acquired greater legal rights in marriage.

In a study of the net wealth of wealthy individuals (gross assets above $ 1.5 million), Keating et al. (2010, p. 22), noted that the some of the data on the gender distribution of wealth is "pleasantly surprising." They examined estate taxes in the USA and found that women "form 43 % of this high asset group" (p. 24) and the percentage depends on the age of women, "from 38 % of those aged less than 50 to 55 % for those aged over 85" (p. 25). Thus, as the women age, due to their greater longevity than men, they tend to inherit more wealth, and this increases the percentage of older wealthy women in comparison to older wealthy men. These wealthy women have a large potential buying power, but they are only a small segment of the population of older women.

Gornick et al. (2009) examined income and wealth for women over 60 in five countries: the USA, UK, Germany, Italy, and Sweden, for the period 1999–2001, and found an interesting disparity between the income and wealth of older women. They found that, although "older women's income lags median national income in all of these countries, their wealth holdings are typically much higher than their country's median wealth holdings" (p. 294). American older women's net worth was the highest of the five countries, and was nearly four times the median national household net worth in the USA. This result may be because older American women have high rates of homeownership. Owning a home increases the wealth of older women, but it is not always helpful with paying for expenses. Although people can obtain reverse mortgages to convert their homes to more usable capital, this is not a popular option due to the desire to leave houses to their children as an inheritance. This means that wealth that is based on homeownership is not the main

factor in determining a person's consumption because consumption is rooted more in income levels than in wealth.

If women over the age of 60 have retired, then their income, and hence their buying power, is a function of pensions that they have earned from working, government retirement programs (e.g. social security), and earnings from private savings and investments. Although pensions enhance the income of retirees, here too, women have not benefited as much as men. Whereas in some cases, government pensions are independent of earnings or employment history, private pensions are based on earnings and/or employment history; thus, due to the wage gap, women receive less money from pensions than men do. Furthermore, women who are divorced or widowed do not always receive their partner's pension. The latter problem has been partially minimized by including pension assets in divorce settlements and granting widowers survivor pension rights, but there remains a lack of full equality. Also, these additions only help women who were married for some time; they do not help women who never married or who were married for too short a period to gain retirement benefits. Overall, Keating et al. (2010, p. 24) gave a rough estimate that "the average pension wealth of women is one-third to one-half smaller than that of men." This loss of income from pensions reduces the buying power of older women who have retired.

The income of women over the age of 60 who are still working derives from their earnings from their jobs as well as possible private savings and investments. Leonesio et al. (2012, p. 65) calculated that, in the USA, the share of total income attributable to earnings has increased dramatically in the past few years for older workers. The share of earnings of the age group 62–64 has increased from 50 % in 1990 to 66 % in 2009; for the age group, 65–69, the share of earnings has increased from 28 % in 1980 to 42 % in 2009. Because wages are usually the most important factor in determining income, older working women should have much greater buying power than their peers who have retired.

Consumerism and Older Women

Throughout history, being old was synonymous with being poor. Blaikie (1999) reviewed studies on aging from the nineteenth century to the first half of the twentieth century, and he noted that "the image here is one of apathetic victims waiting out their sentence" (p. 48). However, in the twenty-first century, older people have it much better, physically and materially, than ever before. In 1988, Edwina Currie, the junior minister in the UK Department of Health and Social Security, stated that "we are in the era of the Woopie" (i.e., the well-off older person; Johnson and Falkingham 1992, p. 50). More recently, Gornick et al. (2009, p. 273) noted that "men and women are increasingly likely to spend their older years free of poverty and material deprivation….In most rich countries, poverty amongst younger pensioners (under age 70) is no longer a major policy problem." Blaikie (1999, p. 73) noted that popular perceptions of older people have also changed:

> From the dark days when the aged poor sat in motionless rows in the workhouse…to modern times when older citizens are encouraged not just to dress young and look youthful, but to exercise, have sex, diet, take holidays, and socialize in ways indistinguishable from those of their children's generation.

Although many women 60 and over are living comfortably, due to their lower earnings through their careers and their reduced pension levels, women are more prone than men are to being poor when they are old. Gornick et al. (2009, p. 273) noted that "most elderly poverty is women's poverty, as women typically constitute two-thirds or more of the elderly poor in the rich countries." The National Women's Law Center (2011) in the USA provides gendered analysis of the US Census Bureau data, and they pointed out that, in 2010, in the USA, among people over 65, twice as many women (2.4 million) as men (1.2 million) lived in poverty; these women were 10.7% of the female population 65 and over, whereas the number of men in poverty was 6.8% of the male population 65 and over. The poverty rate for women 65 and over is less than the poverty rate of women 18–64, which was 15.3%. However, the poverty rate of women 65 and over who lived alone was higher than in both categories, at 17%.

Older women also face more health expenses than older men do. Hartmann and English (2009, pp. 121–122) noted that women live longer than men, but "they are more physically frail than men and have more chronic conditions that tend to cause disability." Some of the costs due to these health problems are paid for by government programs, but there remain substantial out-of-pocket health expenses, which reduce the disposable income of older women. Furthermore, because women live longer than men, these health costs can become considerably more than men's costs.

In addition, due to the third stage increase in life expectancy, many women in their 60s have become caregivers once again, this time to their parents who are now living into their 80s and 90s. This caregiving, which tends to fall more heavily on older women than on older men, not only entails a huge amount of time but also reduces the disposable income of women over 60.

Accordingly, one cannot aggregate all older female consumers together because some are well-off, whereas others have very limited budgets. Within the growing segment of well-off older women, there exists the potential for buying power, but, even in this group, not all of the older women are active in consumer markets.

Moschis (1996) has proposed dividing older consumers into four groups based on the state of their health and their personalities (i.e., introverts or extroverts) as opposed to their ages. One group is the *healthy hermits*, who are interested in tax and legal advice, home entertainment, and domestic services. The second group is the *ailing out goers*, who are more interested in planned communities, health services, and leisure goods. The third group is the *frail recluses,* whose main need is for home health care and medical services. The last group is the *healthy indulgers,* who are well-off and who want to live well and do new things. They are interested in financial services, travel, entertainment, clothing, cosmetics, aesthetic medical procedures, and high-tech products. This last group is the source of the potential buying power of older consumers, and generally they are on the younger spectrum of the older population (i.e., the "young old").

Another division amongst older consumers is whether they retired voluntarily or involuntarily. According to the life-cycle model, which was initially proposed by Modigliani and Brumberg (1954), one would not expect any changes in consumption due to retirement because, according to this theory, people smooth out their consumption over their lifetime. However, as noted by Barrett and Brzozowski (2012, p. 945), "a substantial body of research, based on data from a variety of countries and time periods, has demonstrated that household expenditure systematically decreases at the time of retirement." This contradiction is known as the retirement consumption puzzle, but Barrett and Brzozowski proposed an interesting explanation for it. They suggested that consumption only falls when retirement is involuntary, but, when it is anticipated, consumption remains relatively constant before and after retirement. If their explanation is correct, then the potential buying power of older women is limited to older women who are the *healthy indulgers*, generally the "young old," who are still working or who were able to plan their retirement. Accordingly, the potential consumer power of older women is only in reference to a portion of older women, and not to older women who are financially strapped.

Older Women's Influence in Consumer Markets

Researchers have attempted to survey the actual buying patterns of older people. In perhaps the biggest recent study, Walker and Mesnard (2011, p. 4) oversaw a global study (23 countries) of 3000 (58% female) "mature consumers" aged 60 and older. Among their findings is that, in 2010, worldwide, people who were 60 and over spent more than $ 8 trillion on consumption, and this figure is expected to increase to $ 15 trillion by 2020. The researchers reported that "mature customers spend proportionally less of their income on clothing and transportation than people under age 60, and more on food, beverages, and non-prescription health products" (pp. 5–6). Among the wealthier mature consumers, the pattern is slightly different, as they "indulge in certain categories—primarily food, drink, and clothing—and prefer high quality cars" (p. 9). They also noted that "older people enjoy shopping, not only as a necessity, but also a social and leisure experience" (p. 5). An example of this is older women who go to malls to shop and to spend their free time.

Yet, even with the large level of purchases, do older women have sufficient power in the market to change or influence it? When the market is geared toward older consumers, such as medical devices for elders, tour packages for older travelers, or classes in yoga or painting for older women, then the needs and wishes of older consumers are a crucial element. However, the more interesting question is: Do older consumers influence mixed markets, which cater both to the young and the old? To phrase the question differently, are the choice and types of goods in a mixed market determined only by the younger consumers, by both the younger and older consumers, or only by the older consumers? If the answer is just the younger consumers, then, for many goods, older consumers lack the ability to choose the

goods they want because they are "forced" to purchase goods that are designed for younger consumers.

The fast growing market for high-tech products does not appear to be a market that is heavily influenced by older consumers. This is confirmed by a study conducted in 2013 by the Pew Research Center concerning ownership of smartphones in the USA (Smith 2013). According to the study, approximately 80 % of all people in the USA aged 18–34 have smartphones, whereas amongst the population aged 55–64, 39 % have smartphones, and among the population aged 65 and over, only 18 % have smartphones. The study also provided data based on income levels. For households with an annual income of at least $ 75,000, 90 % of people aged 18–29 had smartphones, whereas amongst the population 65 and over, only 43 % had smartphones. In contrast, when the household income was less than $ 30,000 a year, 77 % of the population aged 18–29 had smartphones, whereas only 8 % of the population 65 and over had smartphones.

This lack of use of smartphones by older consumers has spawned a new demand for smartphones that are more "user-friendly." Since 2012, Fujitsu in Japan and Doro in Sweden have started marketing smartphones specifically geared to older consumers (Pfanner 2013). This development indicates the growing consumer power of older consumers, but, again, this power is limited to a market that is geared to older consumers.

A field where older women might have more buying power is the food service, restaurants, and take-out industry. In a small study, Lyon et al. (2011) examined differences between 43 older women (60–75 years) and 37 younger women (25–40) in the Scottish city, Dundee, with regard to cooking and eating out. They found that the younger women were significantly more likely than the older women to eat out and order take-out food. The authors noted that their findings might be limited to the group of older women who participated in this study because those women had experienced a period of austerity when they were younger, which might still influence their consumer behavior when they are older, and the sample size of the study was small, but the results from the study indicate that older women do not have buying power in the food service industry.

The clothing industry should be a market where older women have significant power, but clothing companies seem to be ignoring this market segment. Nam et al. (2007, p. 102) noted that "despite the growing number and obvious wealth of older consumers, they remain one of the most under-appreciated consumer segments. Apparel companies have largely neglected the elderly in their feverish pursuit of the youth market." They cited a variety of reasons why this is so. One, people who market clothing tend to be young people who associate more with younger consumers. Two, long-standing business strategies have remained in place regardless of changing demographics. Three, it is believed that older consumers have less interest in fashion. Four, older consumers actually buy less clothing than younger consumers do. In their study of 63 older women (65 and over) in the midwestern USA, Nam et al. found that many of the women were fashion-conscious, but their "decisions were influenced more by fit and comfort than fashion" (p. 102).

This idea that older women are underappreciated in the clothing industry was further confirmed by an incident in a 2011 board meeting of the Marks and Spenser (M&S) department store. Ritson (2011, p. 78) reported that, during the board meeting:

> 75-year-old widow Hilary Roodyn rose to her feet to challenge the assembled M&S leadership team on their targeting strategy. In a brief address that brought rapturous applause from the 2,000-strong crowd at the AGM, the retired sculptor and mother-of-two said: "I feel you are missing a trick. You are not catering for the over-60s".

However, Ritson argued that M&S should not attempt to cater to the older women consumers: "The dynamics of the female fashion market mean that you either go after the young or the old. So you must target the young because they are worth more" (p. 78).

The cosmetics industry is another industry where older female consumers should have buying power, but this market is also focused on younger women. As Mathews (2012) noted, "Women over 50 are not being heard by the beauty industry, despite their growing numbers." Mathews interviewed Caroline Neville, who has worked in the beauty industry since 1963 as head of her global PR agency and as President of Cosmetics Executive Women UK, and she said that "I haven't seen much that leads me to believe that the older beauty customer is really being catered for—the 50–75's."

One surprising field where older women might have buying power is children's toys. With the increase in longevity, grandparents have more opportunities to interact with their grandchildren, and, as reported by *The Economist* (2013b), there has been an increase (almost a million since 2005) in the number of children in the USA who live in households headed by their grandparents. Grandparents are inclined to indulge their grandchildren, and buying toys is one example of this indulgence. Elliot (2009) reported that one company (ebeanstalk.com) that sells children's learning toys online did a survey and found that 40% of their customers were grandparents.

Conclusion

In the twentieth century, there were great changes in lifestyles and in the labor force. People began to live longer, women entered the labor force en masse, and people began to have a period of retirement before they died. In the twenty-first century, the increase in life expectancy is continuing, but, overall, the female labor force participation in the developed countries is no longer increasing. In addition, although a period of retirement has remained the norm, it is being pushed back to older ages, such that people are continuing to work in their 60s and beyond, either full-time or part-time, at their career jobs or at bridge jobs. The most notable result of these changes is the large increases in the labor force participation rates of women over 60.

With this increase in employment, there is great potential for older women to have more power in the economy. Yet, due to the glass ceiling effect, this power is not in the corporate decision-making world, but as consumers with their buying

power. Not all women have this power because many older women live in or near poverty, but there is a growing subset of older women who have sufficient financial resources from inherited wealth or from earnings and/or pensions, and who are not burdened by large health expenses and/or caregiving expenses, to potentially influence the goods that are sold in various markets.

In markets where the main consumers are older women, firms have to produce goods based on the needs of the older women, but, in mixed markets, which cater both to the young and old, there is little evidence yet that older women have been able to transform their potential buying power to change the types of goods being sold to meet their needs. This indicates a lower degree of choices with regard to the goods market than those available to younger women. In this case, there is little governments can do to empower these older women other than aiding financially strapped women, which would increase the market segment of older women consumers and might cause firms to produce more goods that will be designed taking older women's interests and needs into consideration. On the other hand, with the continuing growth of the percentage of people 60 and over in society and the expected future increase in earnings of older women, the market segment of active older women consumers will grow. Thus, it is likely that, in the future, women 60 and over will have a greater influence on, and greater choices in, the consumer market, even when those goods are sold both to older and younger women.

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The Impact of Multiple Roles on the Well-being of Older Women: Strain or Enrichment?

Liat Kulik

In most of the theoretical literature, late adulthood is described as a life stage characterized by numerous changes and developments. Some of the changes relate to social roles that continue in late adulthood, and other changes relate to roles performed in earlier life stages that are no longer performed in late adulthood. For example, after retirement one no longer performs the role of worker, after the death of parents one no longer performs the role of son or daughter, and after the death of a husband or wife one no longer performs the role of spouse. Besides these changes, some new roles are also added in late adulthood, such as the role of grandparent and the role of caregiver to a parent, spouse, or other family member who needs nursing care (Silverstein and Giarrusso 2010). Moreover, in some cases the changes are not only quantitative but also qualitative, and certain roles performed in previous life stages change beyond recognition in late adulthood. One example is parenting, which continues throughout the life cycle but usually changes in late adulthood. In many cases, rather than supporting their children as they did in earlier life stages, older adults are supported by their children. In addition, because many older adults experience a physical and emotional decline, performing some roles involves a considerably greater investment of time and effort than was the case in earlier life stages.

Most studies dealing with the impact of multiple roles on well-being have been conducted among women because it is assumed that women usually perform more social roles than men and that this detracts from their emotional and physical well-being. Notably, most of these studies have focused on young women, mothers of young children, or middle-aged women on the assumption that at these life stages women perform a large number of roles that derive from their simultaneous involvement with family and work. However, there is a serious lack of research on the effects of multiple roles among women in late adulthood. Against that background, I present a conceptual framework for understanding the impact of multiple roles on well-being among older women based on the findings of the few studies that

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exist on the topic. In addition, I offer suggestions for future researches that should be done to expand knowledge about the impact of multiple roles on women's well-being in late adulthood.

Multiple Roles in Late Adulthood: New Developments

Demographic, social, and technological developments in recent decades have considerably enlarged the role set of aging women today. For example, owing to the increase in life expectancy there is a growing population of older persons who experience chronic illnesses and disabilities for a longer period of time, and the need for long-term nursing care has increased. Thus, the burden of caring for older parents, which typically falls on the woman, has intensified and persists for longer than in the past (Bookwala 2012). In traditional social contexts, which are characterized by inequality in gender roles, many women over 60 not only care for their own parents but also care for their husbands' parents (Szinovacz and Davey 2008). Moreover, new developments in medical technology in Western societies have enabled women to remain fertile for a longer time. Thus, women may give birth in middle age and, in contrast to the past, there are women who still have young children of their own even when they are in their early 60s. In addition to caring for their grandchildren and helping their adult children establish their own careers, women in this age group are also often expected to care for older parents (Kulik 2007). Besides these roles, which relate to the family, the role set of older women in Western societies also includes community activities such as volunteer assistance to individuals and groups that aim to promote community issues (Parkinson et al. 2010).

Beyond family and volunteer roles, which constitute a large share of the role set for women in late adulthood, they may also perform roles such as leisure activity, which focus on personal development. In contrast to paid employment, the main purpose of leisure activity is relaxation and entertainment (Adams et al. 2011). Although leisure activity is a matter of free choice, it often requires an investment of time and energy at the expense of the family or work. Thus, older women today may be involved in a diverse set of roles and, contrary to expectations, their role set may be similar to that of women in earlier stages of life. In this context, a recent study conducted in Israel (Kulik et al. 2014), compared the number of roles that women occupy at different stages of family life: the stage of rearing young children, the stage of families with adolescent children, the launching stage of family life (children leaving home), and the empty nest stage. Their findings have revealed that, today, although older women occupy fewer roles than in midlife, their role set number is similar to that of women with young children and women at the launching stage of family life.

The Main Roles of Women in Late Adulthood

In late adulthood, women can perform a diverse set of roles related to the family, community, individual development, and even employment (usually part-time employment, at least during the initial period of that life stage). However, the research literature emphasizes several significant roles that women perform in late adulthood: spouse, parent, grandparent, caregiver for disabled or ill family members, and volunteer. Besides the satisfaction derived from each of these roles, there are also certain aspects that may generate stress and detract from the women's emotional and physical well-being.

Spouse

Being married or in a permanent relationship is viewed as both normative and desirable among younger and older people alike. There is strong epidemiological evidence that in many countries married women have lower mortality rates and better physical health than unmarried women (Cheung 2000; Johnson et al. 2000). Moreover, research findings indicate that over 50% of all older women are widows (LaRochelle-Côté et al. 2012), and differences between men and women in widowhood have been revealed in developing as well as in developed countries. As for the quality of marital life, most studies have revealed a U-shaped pattern for marital quality over the life cycle (e.g., Bengtson et al. 1990; Rollins and Feldman 1970), although there also is evidence to the contrary (Vaillant and Vaillant 1993). According to the studies revealing a U-shaped pattern, marital satisfaction tends to be high in the early years of marriage (before the birth of children), followed by a significant decline in the early child-rearing years, and then by a gradual increase. It appears that older people tend to rate their marriage as happy or very happy because many unhappy marriages may have previously ended in divorce, which results in a "survivor effect." Thus, women in late adulthood may experience a relatively high quality of marital life even if their assessments of marital satisfaction are lower than those of their husbands (Kulik 2002). In this context, the frailty of a partner in later life represents a major stressor in the marital relationship because the strain of providing care is accompanied by a loss of companionship and support. Thus, in old adulthood couples need to negotiate new relationship patterns that take into account changing needs and expectations when one partner becomes frail and requires care (Beach et al. 2000). However, the wife is the one who usually provides more help than the husband, especially in cases of illness (Miller 1990). Moreover, although husbands and wives tend to report similar levels of burden associated with caring for a needy partner in late adulthood, the wives are more negatively affected than their husbands. In addition, caregiving wives tend to report a poorer quality of their past relationship with their disabled spouse (for a review, see Calasanti and Kiecolt 2007). Wives are also the ones who have to deal with their spouse's

demands, his unreasonable requests, and the increased strain on the spousal relationship (Davidson et al. 2000). However, there is also research evidence that contradicts this conclusion (for a review, see Vaillant and Vaillant 1993).

Parents

The parent–child relationship is a particularly strong and unique source of social integration for parents and their adult children (Malach-Pines et al. 2009; Sechrist et al. 2012). Moreover, the continued social identity of parents and children with one another throughout the course of life is strongly encouraged (Silverstein et al. 2002), and behavior toward children and older parents is guided by norms of filial responsibility (Gans et al. 2009). However, during the later adult years, the parent–child relationship is challenged by a gradual increase in parental needs for support and assistance in the aging process, and this leads to asymmetrical relationships as aging parents require more. In light of the shift in self-sufficiency and dependency, aging parents and their children need to modify patterns of interaction that were established in early and middle adulthood. Thus, although both generations have reported affection between aging parents and their adult children (Rossi 1990), there is also some indication that levels of affection may decrease slightly over time due to the burden of the aging parents' declining health (Bengtson 1996). However, there is also evidence that, in many cases, the older parents continue to serve as a source of emotional and financial support for the younger generation, especially when the parents are still healthy (for a review, see Marshall and Levy 1990).

A review of the literature suggests that parent–child relationships might also be influenced by gender. Studies of the impact of gender on parent–child relationships have consistently revealed stronger affectional ties between mothers and daughters than among any other combination of adult parents and offspring. For example, mothers are more likely to confide in their adult daughters than in their adult sons, and they are less likely to become angry and disappointed with their daughters (for a review, see Robinson and Biringen 1995). In addition, Suitor, Pillemer, and Sechrist (2006) revealed that older mothers have expressed consistent preference for daughters over sons as sources of emotional and instrumental support. However, Fingerman (1998) argued that aging mothers and middle-aged daughters are at different points in their adult development; these discrepancies may cause interpersonal tension in their relationships.

Caregiver to Aging Family Members

The research literature clearly shows that women are the primary caregivers for family members with chronic illness or functional impairment (Pope et al. 2012), a tendency that has been linked to traditional gender roles. In the case of aging family members, care is provided by wives more than husbands, daughters more than sons,

and sisters more than brothers (Szinovacz and Davey 2008). Thus, just as women bear the burden of raising children in earlier stages of life cycle, they continue the traditional role of caregiving in late adulthood when their children are replaced with older family members, in most cases older parents. Other researchers have argued that the women's tendency to be the main caregivers to needy family members is a function of social structure. Thus, because women live longer than men and some of them are more likely to be unemployed or work in part-time jobs, they are more available than their husbands or brothers to care for older family members (for a review, see Calasanti and Kiecolt 2007).

Despite the consistent research findings related to the caregiver role of women, the findings dealing with the impact of elder caregiving on the well-being of women in late adulthood are inconsistent. Some studies have revealed that caregiving is related to increased well-being for many women and that it contributes to a feeling of fulfillment and meaningfulness (Abel and Nelson 1990; Lee and Powers 2002; Martire et al. 1997). In contrast, other findings have highlighted the heavy burden of the caregiving role, especially for older women (e.g., Lee 1999). According to some research findings, the expectation that older women can handle all of the difficulties entailed in caregiving may cause them to be more vulnerable to stressors than their husbands are (Calasanti 2006). When it comes to caregiving for older parents, daughters have reported more conflict between this role and other obligations than sons have. In this connection, research has revealed that the stress of caregiving causes daughters to feel that they are neglecting other family responsibilities and that they are sacrificing leisure time. At the same time, daughters may feel guilty when they are angry with the recipients of care (Mui 1995).

Volunteer Work

Although late middle age and older age are associated with more free time, health difficulties may cause older people to engage in fewer activities, including a decline in volunteer activity relative to other life stages (Li and Ferraro 2005). For example, most studies have shown that participation in volunteer associations peaks in middle age and declines slightly in later life (Rotolo 2000).

It has also been argued that volunteer activity in later life yields substantial psychosocial benefits for men as well as for women (Gubrium and Wallace 1990) and that it provides a framework for social contribution and engagement (Krause and Shaw 2000). In addition, there is a large body of empirical evidence to demonstrate that older volunteers have better health than nonvolunteers in the same age group (e.g., Musick and Wilson 2003). Positive health outcomes have also been attributed to the capacity of volunteer work to provide a new role identity for older people. Moreover, it has been argued that volunteers derive a sense of purpose in life from their activity (for a review, see Warburton and Winterton 2010). Continuous volunteering can also result in better adjustment to critical life events such as changes to the family structure, loss of paid work, or loss of spouse. Furthermore,

findings have revealed that over time, volunteer work can improve various aspects of well-being, such as happiness, life satisfaction, self-esteem, sense of control, and self-assessments of health (Musick and Wilson 2003; Thoits and Hewitt 2001; Van Willigen 2000). Research has also revealed that participation in volunteer organizations promotes longevity (Moen et al. 1989) and reduces the risk of functional dependency (Morrow-Howell et al. 2003). An Australian study (Parkinson et al. 2010) shows that older women who had volunteered continuously over a 9-year period had better mental health than more sporadic volunteers. Moreover, an Israeli study (Kulik 2010) conducted among volunteer women throughout the life cycle reveals that the experience of volunteering was more positive for older women than for younger women. Moreover, in the same study, it was found that older women reported a lower sense of sacrifice as a result of volunteering, as well as lower levels of burnout. They also reported a higher sense of satisfaction with their activity and higher levels of empowerment than did women in earlier stages of life. In contrast, Lum and Lightfoot (2005) found that, although volunteering over age 70 can yield positive outcomes, it does not affect existing physical medical conditions. Moreover, high levels of volunteer activity may have diminishing benefits, or perhaps even become harmful to health, because affiliation with an organization might involve some degree of commitment that can lead to strain.

Grandmotherhood

Grandmotherhood has been discussed as an integral part of later life, with emphasis on the supportive role of grandmothers in the family. Grandmothers help their children and grandchildren, and they maintain social and emotional connections that are essential for the well-being of young people as well as for intergenerational transmission of family values. Most of the time, becoming a grandmother is considered a happy occasion because of the potential for biological renewal, continuity, and self-fulfillment. However, it also has a symbolic association with old age, regardless of the grandmother's chronological age or vitality, and may therefore also be a source of stress (Gauthier 2002).

In contemporary society, the role of grandparents has expanded and intensified due to social changes that have weakened the family unit. This, in turn, has increased pressure on families and led to higher rates of children at risk (Hayslip and Page 2012). Moreover, the grandmother's role today is diverse and ambiguous, so that many grandmothers may also act as a reserve parent (caring for their grandchildren when necessary), family arbitrator (mediating in family conflicts), or family historian (transmitting the family's identity, traditions, and legacies to the younger generation; Cherlin and Furstenberg 2009). Although the styles and types of grandmothering vary, most grandmothers value their relationships with their grandchildren and derive satisfaction from that role (for a review, see Anderson et al. 2007). Nevertheless, conflicts and strains may accompany grandmotherhood when family members have different views about that role. For example, Duarte-Silva,

Henriques-Calado, and Camotim (2012) found that, among grandmothers in Portugal, the experience of stress was related not only to their grandchildren's temperament and their relationship with the grandchildren, but also to factors such as the grandmother's personality (e.g., neuroticism), her health situation, her relationship with her husband, and a feeling of social isolation. Thus, the levels of stress, conflict, and intimacy between the generations often depend on characteristics of both the grandmothers and the grandchildren, as well as on the extent to which the grandmothers' definition of their role fulfills the expectations of the grandchildren's parents.

In light of the research findings, which point to the potential for experiencing satisfaction versus strain in each of the late adulthood roles discussed above, the question arises: How does occupying multiple roles affect women's well-being?

Multiple Roles and Well-Being: Role Strain or Role Enrichment?

There are two main theoretical approaches related to the impact of multiple roles on well-being. In most cases, these theories have been examined among young and middle-aged women, based on the assumption that women in these age groups occupy more roles than women in late adulthood. One approach is *role strain theory* (Goode 1960), also known as *role scarcity theory* (Marks 1977), and the other approach is *role accumulation theory*, also known as *role enrichment theory*. Role strain theory is based on the premise that individuals have a limited supply of emotional and physical energy, as well as a limited amount of available time. Thus, a large number of roles lead to overload and strain, which can have negative effects on physical and psychological well-being. According to this approach, people who perform multiple roles may experience a feeling of distress, which is manifested in a decline in physical health (Lapierre and Allen 2006) and a decline in emotional well-being (Baltes and Heydens-Gahir 2003). A frequent source of stress among people performing a large number of roles is the presence of incompatible demands from their role partners (Duxbury and Higgins 2003). Researchers have suggested that role conflict derives from three main sources: time, energy, and behavior (Greenhaus and Bentell 1985). Regarding the first source of conflict, the amount of time that women devote to one role might detract from the amount of time they devote to another. The second source of conflict relates to stress generated by the physical and emotional demands of each role, which often conflict with each other. As for the third source, conflicts related to behavior arise when the behavior demanded in one role conflicts with the behavior demanded in another role.

In contrast to role scarcity theory, enrichment theory assumes that multiple roles usually have more positive than negative effects on role incumbents and that the rewards that derive from those various roles may outweigh any potential negative effects. Greenhaus and Powell (2006) identified three psychological mechanisms that can account for the positive outcomes of performing multiple roles. First, to

the extent that each role increases well-being, performing multiple roles can have a cumulative impact on enhanced well-being. Second, the positive experience of participation in one role can buffer distress experienced in another role. Third, satisfaction with one role can enhance experiences in other roles. The third mechanism refers to the concepts of work–family facilitation, enhancement, positive spillover, and enrichment. However, studies based on these two theoretical frameworks have yielded inconsistent results. Some researchers (Amstad et al. 2011; Baltes and Heydens-Gahir 2003) have found support for the role strain theory, whereas others (Hong and Seltzer 1995; Jackson 1997; Miller et al. 1991) have not found evidence to support this theory. In addition, there is evidence to support the enrichment theory (Blom et al. 2007; Carlson et al. 2006). A recent study (Kulik and Liberman 2013) conducted among working mothers in Israel revealed an indirect relationship between multiple roles and well-being through reducing the experience of role conflict. The experience of a good feeling that results from accomplishing many tasks can reduce the intensity of role conflict. This, in turn, reduces levels of emotional distress.

Despite the compelling evidence in favor of these theoretical approaches to examine the impact of multiple roles on well-being, there has also been some criticism. For example, in an early review of research on multiple roles, Thoits (1986) noted that most studies in the field have focused on examination of three main roles (i.e., spouse, parent, and employee) and ignored other roles. Thus, in a study on the relationship between multiple roles and individual well-being, Thoits (1986) expanded the scope of this research to include eight roles. The results of that study revealed that a larger number of roles was associated with lower levels of psychological distress. Moreover, a recent study conducted in Israel (Kulik et al. 2014), which examined the relationship between a large role set among women (spouse, parent, worker, caregiver, student, volunteer, daughter, grandmother, friend, community roles, leisure roles) and distress, provided partial support for the role enrichment theory.

Strain or Enrichment? Later Developments

In an attempt to expand the two theories presented above and examine the relationships between multiple roles and well-being on the basis of a more complex perspective, subsequent studies have focused on qualitative dimensions of the roles performed rather than on quantitative dimensions. These studies are based on the assumption that it is not the quantity of roles per se that explains the experience of well-being and that more complex aspects of the experience of occupying multiple roles should be considered, including role satisfaction, role centrality, and the meaning of roles for the role incumbent (Reitzes and Mutran 1994). Based on this perspective, the above-mentioned study conducted in Israel (Kulik et al. 2014) revealed that the quality of roles (rather than the number of roles), as expressed in the extent of satisfaction derived from performing the role, is what affected different measures of well-being among older women. Moreover, findings have revealed

that the relationship between multiple roles and well-being is affected by a variety of factors, including psychological characteristics (Moen et al. 1995). In the same vein, Bernas and Major (2000) reported that the personality trait hardiness, which consists of a sense of commitment, control, and challenge (Kobasa 1979), was negatively related to the experience of role conflict. Likewise, a number of studies have suggested that an individual's sense of control or efficacy may be an important resource in combating the stress of multiple roles (Houle et al. 2009). Moreover, researchers have also focused on the amount of choice that individuals have in performing multiple roles (e.g., voluntary vs. obligatory roles; Thoits 2003) as well as on the level of control in performing the role (for a review, see Barnett and Hyde 2001). Although most of these studies have focused on the individual level, a few comparative studies have examined the effect of culture on the experience of occupying multiple roles among members of different ethnic groups. In general, comparative studies conducted in different countries have revealed that culture has a significant effect on the experience of role conflict. For example, Kikuzawa (2006) found multiple roles to be less beneficial for the mental health of Japanese participants than for their American counterparts. More recently, Cinamon (2009) found significant differences between Arab and Jewish residents of Israel, where Jewish women reported higher levels of role conflict than did their Arab counterparts. Support networks were also found to be related to lower role conflict among Jewish women, but not among Arab women.

Activity Theory vs. Disengagement Theory and Well-Being

Besides role enrichment versus role strain theories, which provided a framework for analyzing the impact of multiple roles on individual well-being across the life cycle, there are two other theoretical perspectives that focus on the impact of multiple roles in late adulthood: activity theory versus disengagement theory. The activity theory of aging proposes that older adults are happiest when they stay active and maintain multiple social interactions (Havinghurst 1961; Rowe and Kahn 1997). According to this theory, when older people remain active, the aging process is delayed and quality of life is enhanced. Being active helps older people replace lost life roles after retirement, and therefore enables them to counteract the experience of stress. In the same vein, it has been argued that activity is positively associated with life satisfaction and that, by occupying multiple roles, older people can maintain the equilibrium developed in middle age. In keeping with that argument, older adults who face role loss can be expected to substitute their former roles with other alternatives in order to enhance their satisfaction. Havinghurst, Neugarten, and Tobin (1968) found three types of active people who reported high life satisfaction: the first group is "reorganizers," who start new activities to replace the loss of social roles in the aging process. The second group is "holders on," who maintain their midlife roles; and the third group includes older persons who focus on staying active but narrow the scope of their activities.

In contrast, the disengagement theory suggests that it is natural for older persons to disengage from society (Cumming and Henry 1961). Accordingly, disengagement has been described as inevitable, universal, and satisfying to both the person and society. It may also serve important psychological and social functions in that it allows older people to reduce their activity naturally as their strength declines, and it enables a smooth transfer of power and responsibilities from one generation to the next. Critics of this theory have claimed that it perpetuates the stereotype of old age as a time of weakness and decline. Another criticism relates to the assumption underlying this theory (i.e., that all older people respond to the world in the same way in the process of disengaging from social roles). Over the years, many studies have been based on the activity and disengagement theories. However, empirical evidence has provided much more support for activity theory than for disengagement theory (e.g., Adams et al. 2011), especially among older women (Kim et al. 2013). Consistent with activity theory (Cutchin et al. 2010), numerous studies have shown that people who are more socially integrated in middle and later life (e.g., those who are members of clubs and other organizations or who spend time volunteering) enjoy better health and a higher quality of life (Baker et al. 2005; Barrett et al. 2012; Hinterlong et al. 2007; Thomas 2011). This pattern holds across measures of social engagement, such as number of activities and amount of time invested, as well as indicators of well-being, such as depressive symptoms, self-assessed health, functional limitations, cognitive decline, life satisfaction, and mortality.

Although the enrichment theory and the activity theory both predict an increase in the well-being of individuals in later life, they differ from each other. The activity theory is more concerned with the total amount of time spent on activities, whereas the role enrichment theory focuses on the number of roles an individual performs. However, both of the theories predict an increase in older women's well-being when they are active, defined as occupying a large number of roles.

Multiple Roles and Well-Being Among Older Women: Research Findings

Do multiple roles benefit women in late adulthood, or are they a burden that depletes the women's strength? Besides the theoretical predictions related to the impact of multiple roles on the well-being and physical health of women in later life, we can also gain insights from the findings of the few empirical studies conducted among older women, most of which have adopted a comparative perspective. Some of the studies have compared older women versus men in the same age group, and others have examined the impact of multiple roles among older women versus women at earlier stages of the life cycle. Moreover, some studies have adopted a cross-cultural perspective to examine the extent to which cultural context contributes to the beneficial impact of multiple roles on well-being in late adulthood.

In general, research findings have indicated that multiple roles help to improve the health of women in later life by reducing their isolation and providing

opportunities for social support. However, it has been argued that this contribution is culture-dependent. For example, Kikuzawa (2006) found that American women are more likely to occupy roles related to family, work, and community, whereas Japanese women tend to limit their involvement to family and work roles. Moreover, differences were found between Japanese and American cultures with regard to the impact of multiple roles on well-being. That is, the impact of multiple roles on mental health was found to be less beneficial for older Japanese women than for their American counterparts.

An Australian Longitudinal Survey on Women's Health (Lee and Powers 2002) explored the relationship between role occupancy, well-being, and health among three age groups: young women (aged 18–23), middle-aged women (aged 40–50), and older women (aged 70–75). The findings of this study revealed that, among the younger women, the best level of health was associated with occupying one role; among the middle-aged women, the best level of health was associated with occupying three or more roles; and among older women, occupying one role was again associated with the best health. Finally, support for the enrichment approach was found by Adelmann (1994) and Moen et al. (1992), who revealed that occupying multiple roles was associated with well-being among participants in the USA.

Recently, Kulik and Shilo-Levin (2014) examined number of roles, levels of well-being, and the relationship between number of roles and levels of well-being among women and men throughout the life cycle: young adulthood through midlife (age 31–40), midlife (age 41–60), and late adulthood (age 61+). Their findings revealed differences by age group among both men and women with regard to the perceived importance of the roles they perform. In late adulthood, the number of roles that were evaluated as highly important was smaller than in midlife, when the number of important roles reached a peak. That is, the overall number of roles that people perform and the number of roles that they consider to be important increased from early adulthood to midlife and declined from midlife to late adulthood. As for gender differences, in late adulthood, as in other life stages, women have reported lower levels of well-being than men. Moreover, the findings have revealed gender differences in the associations between multiple roles and measures of well-being. In late adulthood, the association of multiple roles with different measures of well-being was stronger among men than among women. However, it was only among women that the number of satisfying roles rather than the actual number of roles were related to well-being. It is possible that, in light of the traditional gender role norms that typify the older generation, the role set of women is usually larger than that of men. In that context, women are the ones who tend to perform roles such as care of older and chronically ill family members, which are not necessarily satisfying. Because some of these roles are performed out of a sense of social obligation, women are not empowered as much as men by the number of roles they occupy in late adulthood. Rather, women tend to place more emphasis on the quality of social relationships, which are reflected in enjoyable roles (Gilligan 1982; Jordan et al. 1991; Miller 1990). Therefore, the number of *satisfying roles* rather than the number of multiple roles *per se* has a significant impact on well-being among women in late adulthood.

Recommendations for Future Research

The following are several ideas that are worthy of consideration in future studies of older women's multiple roles.

First, because several of the studies discussed in this chapter highlight the importance of the quantitative dimensions of roles rather than the qualitative dimensions of roles, future researchers should give more consideration to qualitative measures such as perceived role centrality, role satisfaction, and perceived meaningfulness of roles.

Second, assuming that a person's general identity consists of several sub-identities, it would be worthwhile for future researchers to examine the extent to which the roles older women occupy contribute to their general identity.

Third, there is a need to consider the extent to which women are free to choose the roles they occupy. Roles that older women choose to perform, even if they demand a considerable investment of resources and energy, do not have the same impact as roles that are imposed on older women. Another factor that can influence the impact of multiple roles is the sense of being trapped in the role that the woman occupies, even if she initially chose the role of her own free will. When a woman knows that she is free to stop occupying a role whenever she wants, it might be easier for her to perform unsatisfying roles. This, in turn, might reduce the detrimental effects of those roles.

Fourth, there is a need to consider the combinations of roles that women perform. For example, intensive care of a grandchild/raising a child in place of the child's parents while simultaneously caring for her own needy parents involves an extensive investment of time and effort, and does not have the same impact on well-being as occupying the role of grandmother and self-development roles such as leisure activity and continuing education.

Fifth, more attention should be devoted to the women's coping resources. Women with physical, mental, and financial resources can bear the burden of multiple roles more easily than women who lack those resources. The issue of resources is relevant to research on the impact of multiple roles at all life stages, but is particularly relevant in late adulthood, which is characterized by a decline in physical health as well as a decline in income following retirement. Late adulthood is also typically characterized by a decline in social support networks when friends and relatives pass away. Therefore, in an attempt to gain further insights into the impact of multiple roles on women in late adulthood, there is a need to develop a hybrid theoretical framework that takes into account various perspectives such as resources, personality, and cultural theories. This framework should also address the above-mentioned aspects, which have not been emphasized sufficiently in existing research, particularly among women in late adulthood.

Summary and Conclusions

The impact of multiple roles on women in late adulthood has not been examined sufficiently**.** Based on two theoretical frameworks, role strain versus role enrichment theories on the one hand, and activity theory versus disengagement theory on the other hand, we attempted to draw a general conclusion regarding how multiple roles affect the well-being of older women. In light of the lack of research evidence on women in late adulthood, we cannot reach definitive conclusions regarding the relationship between multiple roles and well-being solely on the basis of studies conducted among women in this age group. Therefore, the findings of studies conducted among women in earlier stages of life can be also applied to women in late adulthood in an attempt to gain further insights into this issue. Overall, it appears that sometimes multiple roles lead to enrichment, and sometimes they lead to strain. Therefore, the role enrichment and role strain theories might be too simplistic, and a combined approach that integrates the main premises of each theory might be more appropriate. In line with this perspective, it would be worthwhile to adopt an approach that proposes that, in late adulthood, women can simultaneously experience role conflict and role enrichment. Accordingly, the relevant question is not whether women experience strain or enrichment when they perform multiple roles, or whether activity or disengagement leads to well-being. Rather, the main question is: When women occupy multiple roles in late adulthood, under what conditions will those roles enhance their well-being, and under what conditions will they cause role strain and reduce their well-being?

Recent studies of the relationship between multiple roles and well-being have adopted the role context perspective (Pavalko and Woodbury 2000), which focuses on the contexts in which roles are occupied. The conceptualizations of the term "context" in these studies were mostly at the macro level, and refer to the culture and socioeconomic background of the role incumbents. The dimension of culture is characterized by different value systems that can impact on the experience of multiple roles among working mothers through its emphasis on priorities in life such as work vs. family, achievement vs. harmony, and collectivism vs. individualism (Aryee et al. 1999). Because cultural values are an important determinant of human experiences as mentioned earlier, assessments of the impact of multiple roles on older women's well-being should take their cultural context into consideration (Aycan 2008). In that connection, Yang, Chen, Choi, and Zou (2000) revealed that, whereas conflict between roles is perceived as a threat in the USA, it is perceived as an opportunity for personal development in China. In addition, it can be assumed that cultures with a collectivist orientation restrict women from taking on roles that do not conform to collective–familistic goals, whereas societies that emphasize individualistic values encourage women to take on roles that increase their sense of meaning in life and contribute to their feeling of fulfillment.

Regarding the second contextual dimension (i.e., the socioeconomic background of the role incumbents), it can be assumed that older women who are healthy and have economic resources can adjust better to performing multiple roles. In contrast,

the lack of resources among disadvantaged older women can create a barrier that prevents them from developing supportive social networks which, in turn, limits their ability to cope with the strain of occupying multiple roles (Belle and Dodson 2006). In this connection, the importance of the employee role as a source of economic resources should be highlighted. Because women usually can only be employed at a relatively early stage of late adulthood, I chose not to deal here with employment as a role that typifies older women in general. However, it is important to note that, besides its economic contribution, the employee role also provides social resources, such as contacts with customers and coworkers. Moreover, in the later phase of their career, particularly at the beginning of late adulthood, women may have senior positions at work that involve mentoring younger persons (Denmark and Williams 2012). These roles enable them to experience a sense of worth, meaning in life, generativity, and fulfillment.

In sum, part of the answer to the question of whether or not to take on multiple roles in late adulthood is related to the cultural and socioeconomic contexts of older women. Empowered women with resources, who belong to a culture that encourages self-expression and self-fulfillment, can afford to take on nonobligatory roles and enjoy a diverse range of activities. In contrast, belonging to a culture that restricts women from taking on enjoyable roles and forces them to occupy prescribed roles can weaken them and have a harmful effect on their well-being.

Beyond Theory: Hannah's Story

An example of being empowered by multiple roles is summarized well by Hannah, one of the women who participated in the above-mentioned Israeli study. Hannah is a privileged woman who has the capacity to plan her retirement years and to exercise control over her life and her roles in late adulthood. After having completed the research questionnaire, Hannah asked about the aims of the study. When we told her that the study was designed to examine whether performing multiple roles enriches older women or causes a feeling of strain, she indicated that she thought she experienced enrichment and gave us her own interpretation of what enrichment is at this stage of life:

> I always dreamed of teaching painting. I worked as a nurse at a hospital for 30 years. Most of the time I enjoyed my job, but my real enjoyment is my hobby of painting portraits, which I began doing at a relatively late stage of my life. … This activity brings a lot of happiness. There's so much one can express through this medium. I wanted to expose others to the world that I discovered when I started painting. And here it was… After I retired, a window of opportunity opened for me, and I started volunteering at a community center where I taught a painting class to women who were 65 and 70 years old and even older. We meet every Sunday, a small group of older women who are strongly connected through our love of painting… No one is late, and no one misses a class. No excuses. Everyone is there. Two weeks ago we had an exhibit of our work at the community center. There was a demand for our paintings—even a large demand. As hard as it was for us to let go of our work, the paintings sold out. We didn't make a lot of money, but it was enough for us

to purchase painting accessories for disadvantaged children… Some of the women in the group go to the southern neighborhood in the city. They opened a painting workshop there for disadvantaged children, and they transmit their love of painting to their young students. Two weeks ago, when the weather permitted, we left the classroom and had our lesson at the neighborhood coffee shop. Our assignment was to look around us and draw our impressions of the natural surroundings as they were reflected from the window of the coffee shop. I watched these women, powerful women… All of them are busy with so many roles. All of them are mothers and grandmothers. Some of them are married, and some are not. They are so dedicated… After the painting class, some of the younger women run to the old age home to care for their aging parents. Others are busy with their grandchildren, and some of them occupy all of these roles at the same time. But no matter how busy they are, all of these older women try to express themselves through paintings… As for myself, by becoming a painting teacher for older women I added the role of painting student, and some of them also added the role of volunteers who work with disadvantaged children. Each one of us does different things, but we are connected by our love of painting. It gives us a lot of good energy, meaningfulness, something to look forward to…. All of us are determined to paint, to develop, and above all to enjoy ourselves. Isn't that what enrichment means?

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Older Women, Leadership, and Encore Careers

Florence L. Denmark, Hillary Goldstein, Kristin Thies, and Adrian Tworecke

This chapter considers the opportunities for older women to obtain leadership positions in this stage of their lives. In addition, opportunities to reenter the workforce are discussed. These occasions, known as "encore careers," can provide meaning, as well as an opportunity for leadership. Encore careers can be defined as work in the second half of one's life that may combine sustained income, greater personal meaning, and social impact (Freedman 2008). The concept and definition of leadership are introduced, as are the concepts of role models, mentors, and coaches. Specific examples of older women's leadership and ways of obtaining leadership positions are suggested.

The age structure of the US population has changed considerably in the past century. Since 1900, the percentage of Americans 65 years of age and older has more than tripled. Roughly 13.7 % of the population is now 65 years old or older; that percentage is projected to rise to 20 % by 2030 (U.S. Census Bureau 2014). The majority of these older persons are women. The rapid growth of the older population is estimated to continue into the future as the substantial baby boom generation reaches age 65 and beyond.

Similar population change is happening around the world, especially Europe, Australia, Japan, and other developed countries. Not only are women living longer, but more women than men are surviving past the age of 65 (Huber et al. 2009). Because women outlive their male companions, many of them need to continue or return to work (Huber et al. 2009). The proportion of people aged 65 and older in the US workforce grew to 16.1 % in 2010 (Brandon 2013). A recent survey showed that 62 % of people aged 45–60 plan to delay retirement (Brown 2012). Thus, many older women are working at this stage in their lives.

The number of women who continue working past the typical age of retirement and into their 60s and 70s is growing rapidly. This growth is occurring at such a rate

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that the U.S. Department of Labor has indicated that this group of older women will compose the fastest growing portion of the workforce over the next 5 years (Reuters 2013). In particular, the number of working women over 65 increased 147% between 1977 and 2007, and the number of women over 75 increased by 172% (U.S. Bureau of Labor Statistics 2013). Although this change in the employment-related choices of women in later life may be, at least partially, attributable to longer life spans, the aging generation of baby boomers, and/or the recent state of the economy and financial need, many women have given other reasons for rejoining or continuing on in the workforce. Some of these reasons include compensating for time out of the workforce to raise children, making up for missed opportunities due to past experiences of sex discrimination when they began their careers in the 1950s and 1960s, or the desire to remain in their jobs due to years of hard work and sacrifice to attain their current career position (Fideler 2012).

In order for women around the world to obtain leadership positions, gender equality within the workforce must first be obtained. Many countries, especially traditional, patriarchal ones, are lagging far behind in equality. The United Nations Development Programme (UNDP) plays an incremental role in bridging the gender gap within the workforce, enabling women in developed countries to take on more leadership positions. By empowering women to claim their internationally agreed upon rights in every development sphere, and by supporting and encouraging governments to be both proactive and responsive in advancing the realization of these rights, UNDP attempts to leverage the broadest possible expansion of choice and opportunity for all (UNDP 2008). In addition, the UN Development Fund for Women (UNIFEM) provides financial and technical assistance to promote women's human rights, political participation, and economic security. UNIFEM works in conjunction with other UN organizations, governments, and nongovernmental organizations to promote gender equality. Through their work, more women internationally are able to obtain higher-level positions in the workforce (UNIFEM 2008).

Definitions

Leadership

With the growing number of older women in the workforce, there are more women at this stage in their lives taking on leadership positions in their fields. Yet, there is little agreement on the meaning of leadership. The emergence of leaders is often situational, and their length of service as leaders varies (Spotts 1976). Michener, DeLamater, and Schwartz (1990) defined leadership as a process that takes place in groups in which one member influences and controls the behavior of other members as they move toward a common goal. Others, such as Sternberg, have suggested that certain innate personality traits or skills make a leader. Despite the disparity among the definitions of leadership, all theories have one element in common: A leader is one who exerts more influence within a group than any other member of that group (Denmark 1977).

The ways of becoming a leader also vary. The group may nominate a person, or the role may be inherited, or even assumed by default if no one else is willing or able to perform the function. Physical or economic power also may be utilized to gain a leadership position (Lassey 1976). Older women face a challenge in obtaining leadership positions: They are often forced to delay their leadership ambitions while they spend their younger years more focused on family, and then they are often judged as past their peak when they try to obtain a leadership position (Lips and Hastings 2012).

There is no one kind of successful leader. People often think of leaders as politicians or CEOs of large corporations or businesses. One can be a leader in many different arenas, and not everyone is going to be a political leader or business leader. Individuals might achieve leadership status in academia or within a volunteer setting. Both the situation and possession of inherent leadership personality traits influence one's chances to become a leader (McGregor 1976). What makes one a successful politician may differ from what makes one successful in business or education or a community group. Even within a single organization, different circumstances require different leadership capabilities; this means that different leaders will be selected at different times.

The concepts of power and empowerment are closely intertwined. Power often brings about thoughts of control and domination, such as the ability to make others do what the leader wants, regardless of their own wishes (Page and Czuba 1999). Not all leaders, however, demonstrate power over others in the group. The most effective leader is able to empower others. Astin and Leland (1991) defined empowerment in their study through the eyes of the empowerer:

> As an empowerer, I really think that the highs for me have been making people do things they could never do before. Giving them the confidence and the criticism and help and the ideas, and sharing my chutzpah, the chutzpah I was born with, and making them have it, too. So that's the empowerment. (p. 107)

Empowering others is the process of supporting people to create new meanings and use their freedom to choose new ways to respond to the world, often to the benefit of others. It involves providing individuals with the appropriate tools and resources to enhance their self-confidence and self-esteem, to develop their leadership skills, and to strive for personal and professional success. Empowerment entails making a concerted and sustained effort to provide others with more information, knowledge, support, and opportunities to use their power for mutual benefit (Denmark and Klara 2007).

Role Models

Empowerment may also involve acting as role models for others. What is a role model? A positive role model can be defined as an individual who has achieved outstanding success and may inspire others to pursue excellence (Lockwood et al. 2002). Older women can provide positive role models for others, such as younger women and adolescent girls, particularly because they have gained the experience

necessary during their life to influence others. For example, Hillary Clinton, in her 60s, provides a positive role model for younger women hoping to enter politics. Whereas in the past there were few prominent female politicians, Clinton has shown that women can play an integral role in the US government. The presence of female political role models has been shown to promote political interest and the intent to become politically active (Campbell and Wolbrecht 2006). In addition, when female candidates such as Clinton are visible in the media due to campaigns for high-profile offices, girls report increased anticipated political involvement (Campbell and Wolbrecht 2006). In the area of academic medicine, women with role models reported higher overall career satisfaction (Levinson et al. 1991).

Mentors

Whereas role models act as examples for others to live up to, mentors create a personal relationship and guide less experienced individuals. Often young, or even old, individuals look for help as they seek to continue their learning and acquisition of new skills. They look to more experienced people for guiding, nurturance, and training. Mentors help their protégés develop to their full potential (Denmark and Klara 2010). Johnson and Huwe (2003) described the psychosocial functions of mentors as sponsorship, exposure and visibility, coaching, protection, providing challenging assignments, role modeling, acceptance and confirmation, counseling, and friendship/mutuality. Mentors utilize their prior experience and connections to facilitate the professional development of their protégé. Mentoring can be an enriching experience for the mentor as well as the protégé. The mentor gains personal satisfaction from helping, and also increases the support group to whom she can look for assistance and support when needed (Denmark and Klara 2010).

Mentoring a younger person who is emerging in the field is extremely beneficial to the more experienced person (Denmark and Williams 2012). Mentoring is a way to give back to one's community and field. It is a great way to give time and wisdom to up-and-coming professionals and to provide them with things that can only be learned from someone who has been through similar experiences. Being a mentor also generates personal satisfaction (Denmark and Williams 2012). After having achieved a certain level of status and influence in one's field, older women can feel invigorated and empowered through giving back by guiding emerging professionals.

Mentors have experienced positive and negative aspects of their fields, and are able to use this experience to guide individuals who may be naïve when it comes to situations such as interoffice politics (Denmark and Williams 2012). By guiding others, mentors can add to their current skill set within the field, as well as enhance their coaching skills and ability to delegate responsibilities and tasks.

A mentorship can be viewed as a mutually beneficial relationship (Denmark and Williams 2012). The mentor increases the number of connections she has. Over time, the protégés will have a network of colleagues of their own to introduce to the mentor, or even take on their own protégé to pass on the knowledge that was

shared with them. In essence, the mentor creates a legacy within her profession, and a protégé may eventually offer the mentor an opportunity that was not foreseen (Denmark and Williams 2012).

Older women who have succeeded in areas such as business, medicine, or academia can serve as mentors to less experienced individuals. How does one become a mentor? Frequently, women with expertise in their fields want to become mentors to up-and-coming professionals, but do not know how to go about it. The first step is deciding that one wants to act as a mentor and/or leader (Denmark and Williams 2012). Mentoring can begin in numerous ways. For example, it might simply begin by meeting a student or young professional in one's field. Younger colleagues and graduate students frequently look to their more experienced colleagues for guidance. One can begin mentoring by establishing a time for students or young colleagues to meet with more experienced colleagues in the field (Denmark and Williams 2012).

Florence Denmark has acted as a mentor to numerous graduate students throughout her career. She stated:

> As an academic, one of the greatest satisfactions I get is mentoring students and new faculty members and other newcomers to the field of psychology. As a feminist, I feel it is particularly important to mentor young women entering the field, who are often unaware of how to maneuver through the politically charged atmosphere of graduate level psychology departments, as well as how to succeed in the job market once they complete their degrees… The importance of collaboration, whether in publishing papers or protesting against social injustice, cannot be overstated. One of the highpoints in my career is when former students who are well-established in their own careers, as well as people from abroad whom I've interacted with, tell me and others what a great mentor I have been and how important I have been in the profession. (Denmark and Klara 2010, p. 15)

Coaching

Mentoring and coaching are often seen as one; however, there are differences between the two. Whereas mentoring is relationship-oriented, coaching tends to be task-oriented (Management Mentors 2014). In addition, coaching is viewed as more short-term than mentoring. A coach can successfully be involved with an individual for a short period of time—maybe even a few sessions. Another differentiator between coaching and mentoring is that coaching is viewed as more performance-driven, whereas mentoring is concerned with professional development (Management Mentors 2014). Although coaching is distinct from mentoring, it similarly benefits the coaches by providing them with the means to help others and to form a larger group of connections. Coaching is usually financially reimbursed, and older women may turn to coaching after retiring from a first career (Management Mentors 2014).

One example of a female coach is Carol Heiss, in her 70s. Heiss was an Olympic figure skater who became the 1960 Olympic Champion in Ladies' Singles and was five-time World Champion. After her retirement from skating, she returned to coach

several skaters in her hometown of Akron, Ohio. She has become a prominent, and sought after, figure-skating coach.

Barriers and Gender Differences in Leadership

Both ageism and sexism are unfortunate considerations in obtaining leadership positions. Sexism is prejudice or discrimination based on a person's sex. Sexist attitudes may stem from traditional stereotypes of gender roles and often include the belief that a person of one sex is inherently superior to a person of the other sex (Ridgeway and Correll 2004). As a result of sexist attitudes, a job applicant may face discriminatory hiring practices, or, if hired, receive unequal compensation or treatment compared to that of their other-sex peers.

Ageism is stereotyping and discriminating against individuals or groups on the basis of their age, and it may be casual or systematic (Quadagno 2008). According to Butler (1980), the term ageism is a blend of three interconnected features. Among them are prejudicial feelings about older persons; discriminatory practices against older people; and institutional policies that propagate stereotypes about older people. Many preconceived notions need to be examined in order to make progress on reducing ageism in the workplace. It is not only companies but also individuals themselves who hold fast to these outdated notions. The best way to combat such stereotypes is to find sectors where age is appreciated, wisdom is welcome, and experience is valued. But it is important to dispel ageist stereotypes as well.

More and more, older women are beginning to pursue previously closed-off career opportunities. Women who continue to work into later life often pursue work and leadership roles to explore their identities, reach new achievements, and gain power. Serving as a leader also provides older women with a sense of competency and accomplishment, new opportunities for social contacts, and the possibility of challenge and personal growth (Etaugh 2008). Though there are still fewer older women than older men working in leadership positions, those women who have done so have been successful in politics, business and industry, and other organizations.

Politics

There are a number of recognized women leaders in politics around the world, including prime ministers, presidents, senators, and legislators. For example, in the USA there are currently 10 women over 60 serving as senators. These women are not only serving in the senate, but they also have impressive prior political careers. For example, Dianne Feinstein was elected as a senator from the state of California in 1992, at age 59. Prior to this she served as the mayor of San Francisco (1978–1988). She became California's first female senator and is also the first woman to preside over a presidential inauguration (San Diego Union-Tribune 2009). More-

over, she is currently the oldest US senator. Barbara Boxer is another notable senator over the age of 60 from California. She is the chair of the Environment and Public Works Committee, as well as the chair of the Select Committee on Ethics; Boxer is the only senator who has simultaneously presided over two committees. Mazie Hironi of Hawaii is another senator over 60; she is also the only current US senator of Asian ancestry. The other female senators currently in office who are over 60 are Barbara Mikulski, Elizabeth Warren, Debbie Stabenow, Claire McCaskill, Debra Fischer, Jeanne Shaheen, Kay Hagan, and Patty Murray. Other than Patty Murray, who entered the senate at age 43, all of these politicians began their careers as US senators in their 50s or 60s.

There are many recognized and notable women leaders who have worked in politics and led their countries, both past and present, across the globe. For example, Sükhbaataryn Yanjmaa of Mongolia was the second woman to be elected or appointed as a head of state; she was 60 years old at the time (Worldwide Guide to Women in Leadership 2014). Another notable leader over 60 is Vigdís Finnbogadóttir of Iceland. Finnbogadóttir served as the fourth President of Iceland from 1980 to 1996. She was not only Iceland's and Europe's first female president, but she was also the first democratically elected female head of state in the world. Though she took office at age 50, she continued to serve as prime minister until age 66. Other presidents include Mary McAleese, who served as president of Ireland until age 60; Sirimavo Ratwatte Dias Bandaranaike of Sri Lanka, who completed her third and final term as prime minister at age 84; Chandrika Bandaranaike Kumaratunga of Sri Lanka, who served as president until age 60; and Jóhanna Sigurðardóttir, a former Prime Minister of Iceland, who served until age 70. Gloria Macapagal-Arroyo of the Phillipines was the country's second female president. She took office at 54 and continued to serve as president until age 63. In India, Indira Priyadarshini Gandhi was the third Prime Minister, and she served until age 67. Pratibha Devisingh Patil, the first female president of India, served until age 77. Sheikh Hasina has been Prime Minister of Bangladesh since 2009, and is still in this position at age 65.

Golda Meir, who became prime minister of Israel in 1969, at age 71, was not only Israel's first female prime minister, but she was also the third woman in the world to become a prime minister. She served until she was 79. Margaret Thatcher was the UK's prime minister from 1979 until 1990, when she was 65. Veronica Michelle Bachelet Jeria, now aged 62, previously served as the president of Chile (2006–2010), and was the first woman in her country to do so. After her presidency, she was appointed the first Executive Director of the newly created United Nations Entity for Gender Equality and Empowerment of Women. Édith Cresson was the first woman to hold the office of the Prime Minister of France, and is the only woman to have done so to date. She remained in office until the age of 65. Other notable international leaders who have served while in their 60s or older include Soong Ching-ling, honorary president of the People's Republic of China; Ellen Johnson Sirleaf, current president of Liberia; Christina Fernández de Kirchner, current president of Argentina; Kamla Persad-Bissessar, current prime minister of the Republic of Trinidad and Tobago and the country's first female prime minister; Dilma Vana Rousseff, president of Brazil; Portia Lucretia Simpson-Miller, prime

minister of Jamaica; Joyce Hilda Banda, President of Malawi; and Park Geun-hye, president of South Korea.

Business and Industry

Regardless of age, women leaders are largely missing from business and industry. Although the women's movement, in addition to various lawsuits and affirmative action policies that resulted from the women's movement, has continuously attempted to bring attention to the existing gender gap in the corporate business realm, they have met with little success. Though in the USA women are climbing up the corporate ladder to gain middle-management positions, there are still few female presidents, CEOs, and other senior managers. For example, only 4.2% of Fortune 500 companies and 4.5% of Fortune 1000 companies in 2013 had female CEOs (Catalyst 2013). When the intersection of gender and age discrimination is considered, it is not surprising that there are few female business leaders over the age of 60 in the USA; a notable exception is Patricia Woertz, now aged 60 and president and CEO of Archer Daniels.

Although older women undoubtedly enhance their sense of personal power as leaders, research suggests differences in how women and men wield and exhibit their power. In particular, women tend to assume a leadership position by helping those whom they lead and typically inhibit their displays of overt power (Claes 2001). This style of leadership and management is beginning to be highly valued by businesses because it promotes flexibility, collaborative problem-solving, and teamwork, which allows businesses to adapt to the constantly evolving global environment. Older women not only enhance and improve the functioning of the institutions that they lead due to their style of management and leadership, but their absence from these positions of power could be detrimental (Claes 2001). For example, without the perspective of women, the scope and focus of research and available knowledge would likely be limited. Further, as previously mentioned, older women leaders serve as mentors to young women in the field who are beginning their careers and could also be on the path toward becoming leaders in their own right (Novotney 2010).

This conceptualization of gender roles in the workplace has frequently been offered to explain differences in leadership styles between men and women. Though it may be useful in explaining some of these differences, feminist research offers a different perspective and continues to shed light on why this explanation may be problematic and oversimplified. In particular, this perspective assumes that all women lead in the same way, which is not true. For example, some women may choose not to engage in overt displays of power because it is typically perceived as not being feminine, and may result in the woman being disliked within her workplace. Though a thorough explanation of feminist research regarding these gender differences is beyond the scope of this chapter, readers are encouraged to seek further information (e.g., Chrisler and Clapp 2008; Eagly and Carli 2007; Sandberg 2013).

Leadership Opportunities

Despite the aforementioned female leaders over 60, there are relatively few women who hold these positions in comparison to the vast number of men, across all ages, in positions of power. What chance does a woman who is over 60 have to hold these positions and gain power? Encore careers, in addition to career change, are a viable pathway for women to emerge as leaders later in life; these opportunities are discussed later in the chapter. Another avenue older women can pursue to achieve power includes self-employment (McHugh 2012).

Self-Employment

Until recently, women were not often self-employed for a variety of reasons. In addition to the differences in socialization practices between boys and girls, which historically taught girls to be dependent and soft-spoken, many institutions of finance have employed discriminatory practices that make it extremely difficult for women to take out loans or build up credit that would enable them to begin a business independently. This gender discrimination undoubtedly reflects deeply engrained sociocultural attitudes toward women. Older women must deal with this discrimination doubly, as they face challenges associated with gender as well as with age. The stigma associated with aging exists across all aspects of older women's lives, and work is no exception. Older women experience gender and age discrimination during the hiring process, when they are eligible for promotions, and as they negotiate wages; moreover, women begin confronting ageist discrimination at a younger age than men do (Rife 2001).

Self-employment not only affords older women an opportunity for independence, power, and achievement at a later stage in life, but it also allows them to bypass gender and age inequalities in hiring, promotion, and pay (Wirth 2001). Self-employment also allows women a greater sense of control over their lives. Though women at this stage may no longer face the same challenges in juggling family and work responsibilities, self-employment makes it possible for them to take care of spouses, children, and older relatives while still earning a viable income for their household. Older women who are self-employed may also use their self-employment as an opportunity to continue to accomplish career goals (Etaugh 2008). In the USA, women own more than 7.8 million businesses (Kaya 2007), and these women not only experience higher autonomy, but they also enjoy higher levels of work satisfaction than women who are corporate employees (Anderson and Hughes 2009). This discussion of self-employment of older women does not only pertain to women in the USA; many women around the world are self-employed as entrepreneurs, shop owners, craftswomen, and farmers.

Recently, there has been a rise in the number of self-employed older women. The Chartered Institute of Personnel and Development (2012) published a report on employment in Canada that documents that there are 271,000 more women between

the ages of 50 and 64 in the workforce now than there were prior to the recent global recession, and these strong employment numbers primarily reflect the 16.3 % increase in the number of self-employed women. Moreover, the number of self-employed women increases with age; specifically, one quarter of working women between the ages of 65 and 69 are self-employed, and more than one third of working women over the age of 70 are self-employed (Uppal 2011).

There is no specific "type" of older woman who is likely to pursue self-employment, though past research has pointed to certain factors that increase the likelihood of becoming self-employed. For example, in Canada both women and men with college degrees and those with another self-employed family member are more likely to be self-employed themselves (Uppal 2011). In general, self-employed women are similar to self-employed men across many characteristics, though women are more likely than men to be older and married and less likely than men to have children at home (U.S. Department of Commerce 2010).

Despite the significant increase and the undeniable presence of older women in the workforce, older women still have to fight to get their voices heard and to be perceived as leaders. A report by Yoo (2011) indicates that, even though there are few major differences between self-employed women and men, there are considerable differences between the types of businesses that they run and the incomes that they earn. For example, businesses owned by women begin on a much smaller scale, have lower rates of survival, have lower employment levels and levels of revenue, and do not expand as rapidly as businesses owned by men. In addition, there is a stark income difference between men and women: Female business owners earn less than male business owners. Despite these disheartening and persistent differences, labor statistics continue to indicate the ever-growing presence of women, and older women in particular, in positions of leadership in the workforce. Older women leaders in this arena are continuing to take steps to address issues of inequality, foster the development of female-owned businesses, and increase the number of self-employed older women through networking and mentoring efforts to share relevant information and encourage participation. Furthermore, many women may choose self-employment as an encore career.

Encore Careers

As women are living longer, many are working longer, too. The employment picture has slowly been improving for baby boomers and pre-retirees over the past few years. In addition, research has shown that some people in their 50s and 60s are holding onto jobs longer, and others are pursuing "second acts" or "encore careers" as the next chapter in their professional lives (e.g. Brown 2012; Denmark and Klara 2007; Fideler 2012).

An encore career is work in the second half of one's life that may combine sustained income, personal meaning, and social impact (Freedman 2008). Financial security is not the only motivation for an encore career. In fact, often women who

start an encore career are not necessarily looking for monetary gain. A recent study (MetLife Foundation/Civic Ventures 2008) showed that older people want more flexibility in work schedules, the ability to remain active and effective, the chance to use their skills in fresh ways and share them with others, and the opportunity to make a positive impact. In addition, an encore career is a chance for older women to take on a leadership role.

Encore career jobs can be paid or unpaid positions frequently in public interest fields, such as education, health, government, fundraising, social services, and other nonprofit areas (Arthur and Rousseau 1996). Further, an encore career typically provides personal satisfaction by offering an opportunity to "give back." Many older women want to be able to pursue fields and reach positions that fulfill their passion (Denmark and Klara 2007). A recent study showed that about 20% of all new businesses were started by entrepreneurs aged 50 to 59 years, and 15% were started by entrepreneurs aged 60 and over. Over the past decade, the highest rate of entrepreneurial activity belongs to those in the 55–64 age group (Hannon 2014).

Volunteering

Many encore career opportunities are volunteer-based (Freedman 2008). Volunteering is one way to gain valuable experience that can be used as a basis for further growth within an organization. Generally, the more active one is within an association, the quicker one may be able to climb the ladder toward a paid or volunteer leadership position in that organization. Sonia Collazo is a prime example of a woman who started out volunteering, but her hard work and dedication quickly led to a leadership role. After working for 27 years, Collazo retired from her job in conflict resolution for Philadelphia's Commission on Human Relations. She knew she wanted to work in the Latina/o community. When she read that Congreso, a multiservice nonprofit for low-income local communities, was starting a group for older Spanish-speaking adults, she volunteered. Two months later, she was asked to take on a leadership role as the networking and presentations coordinator. Collazo finds speakers and arranges presentations on topics such as living wills, voter registration, and HIV/AIDS (Abrahms 2013).

Volunteering is a way for women of all ages to gain power and act as leaders. Not only does volunteering provide women with a pathway to leadership, but many organizations depend upon the time and work that volunteers contribute (Cook and Sladowski 2013). For example, many religious organizations need volunteers to help run their social services and programs related to education, health, art, culture, and humanities (McHugh 2012). Through this work there is potential for growth and leadership opportunity. There are additional volunteer opportunities in the political field. Volunteering on a campaign is a great way to get involved politically and support a candidate in whom one believes, and it also may lead to potential leadership roles (McHugh 2012).

In a comprehensive research report put forth by the European Union regarding volunteering within elder populations, many key points are made to highlight the

multiple benefits afforded to older women and men who participate in volunteer activities (Ehlers et al. 2011). Volunteering affords older women a viable avenue to decrease social exclusion and its negative side effects and simultaneously promotes active aging. More specifically, the report noted that volunteering affords older individuals the opportunity for social inclusion; it is an opportunity for older women to develop and assert their leadership skills, either following the end of a career and transitioning into retirement, or concurrently with an ongoing career. In addition, studies have indicated the health benefits older women acquire through volunteering, including being more physically active and sustaining this activity over time, as well as improvements in memory and executive functioning (McHugh 2012; Muhlbauer and Chrisler 2012; O'Brien and Whitbourne 2014).

There is no specific "type" of woman who is more likely to volunteer. Though the characteristics of volunteers are broad and varied, there are some trends that are apparent. For example, many older women begin committing time to volunteer work following major life events to aid in adjustment and coping, such as transition to retirement, divorce, or following the loss of a loved one (Ehlers et al. 2011). A report on volunteering activities of elders in Canada noted that they contribute more hours to volunteering activities per year than any other age group (Cook and Sladowski 2013). In addition, women are more likely than men to volunteer, and they are likely to give time and money to public causes (DiMaggio and Louch 1997; Hodgkinson and Weitzman 1996).

The specific types of volunteer activities that older women engage in also vary widely. For example, a study of volunteer activities among individuals 65 and older showed that these individuals participate in a number of different activities including organizing or supervising events, fundraising, sitting on committees and boards, teaching, educating, mentoring, counseling, office work, providing health care or support, environmental protection, collecting or delivering food, and coaching (Cook and Sladowski 2013). Thus, older women with interests and expertise from such diverse fields as social services, education, research, arts and culture, business, law, religion, politics, and more can give back to their communities while also accruing health benefits, engaging in positive social interactions, and pursuing leadership opportunities. Volunteering can allow older women to develop or refine skills, including interpersonal, organizational, communication, technical, and fundraising skills.

There are various international organizations that provide opportunities for individuals who have retired from a career to engage in volunteer activities that may lead to leadership positions. The Red Cross is one such organization that provides opportunities around the world. As a volunteer for the Red Cross one could help people who have been displaced by war or disaster. The Red Cross looks for technical skills one may have acquired in a previous job such as information technology, telecommunications, and logistics. There are other ways to volunteer that may lead to leadership positions as well; being a blood drive, hospital, or disaster volunteer can lead to management positions within the organization (Red Cross 2014).

The United Nations (UN), with headquarters in New York, Geneva, and Vienna, is another example of an organization with excellent opportunities that allow

individuals, primarily in the USA and Europe, not only to engage in volunteer activities, but to also work as leaders. In particular, individuals may choose to serve on nongovernmental organization committees related to their prior careers. For example, psychology, organizations including the American Psychological Association, the International Council of Psychologists, and the International Association of Applied Psychology, all are active at the UN, and their members (both current and retired psychologists) serve on committees. Regardless of the specific field, however, once an individual is on a committee, leadership opportunities include pursuing an elected position such as treasurer or chair. The UN is just one of many examples of the opportunities that are available to older women who wish to pursue and obtain leadership positions in later life.

Entrepreneurship

Numerous additional opportunities arise outside of professional organizations. In addition to serving as a path toward leadership in later life, self-employment is also an example of an encore career, whereby people create their own company or service. An increasing number of workers aged 50 and older are starting new businesses. A new AARP/Society for Human Resource Management (SHRM) survey of 50-plus employed workers shows that one in 20 plans to start her or his own business. Nearly one in five unemployed workers would like to do the same (Brown 2012). Older businesswomen have a lot of things working in their favor—a strong work ethic, management experience, and well-established networks of potential customers (Claes 2001).

Fundraising and event coordination are examples of work that one could do independently from a corporation. This would give older women the flexibility and freedom that many are looking for in an encore career. Further, there is a sense of empowerment that comes from starting one's own business and being one's own boss. Between 1997 and 2012, the number of woman-owned companies increased by more than 50%, according to the American Express OPEN Forum, an online meeting place for entrepreneurs (OPEN Forum 2012). One business woman is Wendy Volhard, 72, a former reporter for the Wall Street Journal. She is currently a dog trainer and author who owns and operates Volhard Dog Nutrition, a company that makes and sells Natural Diet Foundation 2, a natural dehydrated dog food as well as nutritional supplements for dogs (Hannon 2014). When Sherry Robinson turned 55, she left her former role managing small businesses in Toronto. She remembered advising her clients to focus on their passion and took her own advice by opening Spa Sedona a year later. "I was getting older and I didn't want to have regrets of not going after my dream of having my own business," Ms. Robinson, now 62 told a reporter ("Over 50 Crowd" 2007, p. 1).

Opportunities

If women are interested in working or volunteering after retirement, employment counselors can help reduce perceived, and actual, barriers to becoming employed, thereby expanding potential retirees' choices. Canaff (1997) noted that many older persons may lack knowledge about available work opportunities and could benefit significantly from counselors who offer this information. Employment counselors can both advocate for ample training opportunities for older workers and encourage late-career employees to attend trainings that would help them reach leadership positions once hired.

It helps if women thinking about an encore career have done previous work in a field related to the one they are entering. However, people who would like to start an encore career may not have the history of opportunities, such as a well-developed set of skills that are readily transferable to new settings. Thus, preparation is important for women at any age who want to make a career change. There are training opportunities available to update and enhance older workers' job skills. Canaff (1997) has recommended ongoing training for older workers. This recommendation is in line with changes projected for careers in the twenty-first century in general, when employees will be expected to update skills continually and to develop new competencies routinely (Arthur and Rousseau 1996). To this end, a variety of institutions are starting to respond to these needs. Dozens of community colleges, for example, have established encore career transition programs to help baby boomers retool their skills.

Continuing education is one way to further one's skills and gain additional certificates or licensure for an encore career. Ruth Wooden left her job in public relations at age 57 to become president of the nonprofit think tank Public Agenda. Just a few years later, she started to feel restless. However, she found her second act through studying psychology and religion at the Union Theological Seminary. Wooden plans to open a practice as a counselor for family-support programs after she earns her MA degree. (Overholt 2013).

Once one has secured an encore job, it is helpful to find a mentor within the company or organization. As previously discussed, there are many definitions of mentoring, including an extreme classical view, which sees mentor relationships as interactions between an older person and a younger person. This view stresses the part of the older person as a wise guide or sage to the younger person. A more modern view of mentoring is not focused on age; rather the focus is on a more experienced person who provides career development and psychosocial support to a less experienced person (Kram and Isabella 1985). Encore careers challenge the classical view by asking not only how young women can learn from older women, but also how older women can learn from younger women. This type of mentoring is common in encore careers, as a younger employee shows an older one the way in the company or organization. This can be especially important in learning about new technology and social media (Stephens 2012). The best way to stay competitive and relevant is to figure out how to have intergenerational relationships in the workplace. Mentoring is a two-way process through which people share important skills and knowledge.

Conclusion

Women have long faced many obstacles on the path to employment and leadership; they continue to face discrimination and often have to struggle to obtain opportunities equal to those afforded to men. However, much progress has been made, particularly in recent years (Denmark et al. 2005). Though changes in the composition of the workforce have occurred across all ages, significant changes have taken place related to the number of older women who are working. Not only are women continuing to work later in life, but they are pursuing and obtaining leadership positions. Older women are serving as leaders in numerous fields including politics, academia, and business and industry, through traditional means as well as through self-employment and volunteer opportunities. Women are living longer and thus continue working, or return to work, at later stages of life (Brandon 2013). As the number of older women working, volunteering, and serving as leaders continues to increase, there will surely be more changes related to both the composition of the labor force, as well underlying societal structures and relationships.

Women who continue to work into later life often look for work and leadership roles to explore their identities, reach new accomplishments, and gain power. Encore careers and leadership roles also provide older women with a sense of capability and achievement, new opportunities for social contacts, and the possibility of challenge and personal growth (Etaugh 2008). Whether through politics, nonprofits, academia, or business, work later in life can enhance a woman's own health and well-being, as well as the well-being of society at large, which benefits from her wisdom and continued contributions.

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Sexuality and Older Women: Desirability and Desire

Maureen C. McHugh and Camille Interligi

Introduction

Aging threatens women's sense of themselves as women, as sexual beings, and as sexually desirable (Clarke 2011). Even as midlife women are said to come into their own, pressure to engage in beauty work escalates with age. Ageist media messages incorporate a cultural obsession with youthfulness and beauty and depict signs of aging as objectionable and unattractive. Beauty is associated with youth, and old bodies are perceived to be ugly, asexual, and undesirable (Calasanti and Slevin 2001; Clarke 2011; Furman 1997). When their age is reflected in wrinkled faces and sagging bodies, the appearance of old women is culturally viewed as a liability in youth-oriented cultures such as the USA. As women age, they lose the power that beauty brings (Lakoff and Scherr 1984).

Older women are encouraged to use all manner of lotions, oils, creams, and makeup to maintain the unwrinkled and unmarked appearance of younger women. They are encouraged to disguise or repair their appearance, to put on a different, younger face, and, at the same time, older women are ridiculed for their attempts to mask their age (Furman 1997). Furman (1997) argued that women are *required* to engage in beauty work, yet are condemned for doing so.

In addition to being viewed as unattractive or ugly, older women are often stereotyped as experiencing physical and sexual decline. In multiple ways and in varied media, images of and discussions about older women present a picture of decline and decay. For example, older women are often stereotyped as frail, weak, and ill (Velkoff and Kinsella 1998), as suffering from heart disease or dementia. This medicalized view of aging overstates the physical decline and ailments of older bodies. Menopause is also medicalized and viewed as a time of declining sexual desire and activity; postmenopausal women are devalued as asexual and unattractive women who are "past their prime." Older women also face stereotypical assumptions that they are asexual or incapable of sex, and, if they are interested in sex, their interest is deemed inappropriate.

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Despite the unrelenting forms of ageism in contemporary society, ageism has been "under theorized and under-researched within the socio-cultural literature" (Clarke 2011, p. 2). People, including women's studies scholars, tend to ignore ageism until they themselves become old (Calasanti and Slevin 2001). The limited theorizing of ageism reflects an androcentric emphasis on age discrimination against older workers and rarely considers the centrality of appearance concerns to ageism or the embodied nature of older women's experiences (Clarke 2011). The research concerning older women's sense of their appearance, their bodies, or themselves as sexual beings is sparse. There is evidence (Calasanti and Slevin 2001; Clarke 2011; Lemish and Muhlbauer 2012) that contemporary beauty ideals and cultural stereotypes about old women combine to undermine older women's sense of their own desirability; however, there are also indications (Clarke 2011; Slevin 2006) that women's experience of their own sexual desire and desirability are more complex, contextual, and even contradictory.

Lips and Hastings (2012) examined the ways in which older women negotiate the competing discourses of aging—to accept limitations and physical declines or to measure their own worth based on internal standards rather than youth-oriented values and cultural constructions of older women. Consistent with Lips and Hastings, we question how older women might exercise agency to resist inconsistent and negative cultural constructions of aging to arrive at an authentic expression of their own sexual desirability and sexual desire.

Older women around the world are known to have sexual desire and to engage in sexual activity (Lusti-Narasimhan and Beard 2013). The World Health Organization (as cited in Tiefer 2001) affirmed the right of women internationally to sexual health, which includes sexual experiences that are pleasurable and free from coercion, violence, and disease. However, little research has been conducted internationally on older women's sexual desire and sexual activity except to document sexual declines, diseases, dysfunctions, and victimization. As we move away from ageist, heteronormative, and androcentric perspectives regarding the sexuality of older women, we realize that the degree to which the sexuality of older women is expressed depends on sociocultural contexts (Lusti-Narasimhan and Beard 2013). In many contexts, older women may conceal their sexuality to fit into social norms; in other cultural contexts, older women may feel compelled to exaggerate their desire and their sexual activity. An activity acknowledged as pleasurable in one culture or country may be unspeakable in another. Although we acknowledge the importance of considering older women's sexuality across all sorts of boundaries, most of the research discussed in this chapter has been conducted in the US and/or other Western countries.

In our discussion of the sexual desirability and desire of older women, we acknowledge the varied and complex perspectives that older women have on their bodies, their appearance, and their sexual selves. We attempt to address the impact of contextual factors on women's experience of themselves as sexual beings, including the larger sociohistorical context of their lives and the particular context in which they experience sexual desire, such as the availability of a partner and the quality of their relationships. In addition to examining the impact of ageist perspectives on older women, we examine the degree to which older women themselves may voice ageist attitudes.

Ageism, Sexism, and the Double Standard of Aging

Ageism refers to individuals, policies, and practices within a society that set older individuals apart, discriminate against older individuals, and/or view them as different in general and simplified ways (i.e., stereotype them). Many contemporary cultures are both sexist and ageist; individuals who fall into the social categories "male" and/or "adult" are valued and treated as normative, whereas others, including old people and women, are marginalized or oppressed. In many countries, including the USA, older women are doubly discredited; belonging to neither of the valued categories is considered to be grounds for their marginalization, oppression, and devaluation. In many cultural contexts, ageism encourages younger adults to dehumanize older adults (Canales 2000), who are viewed as undesirable, a social problem, a burden, and as not worthy of attention. Sexism allows for the further devaluation of older women. Being an old woman, then, is often an undesirable condition—a position that must be resisted at all costs. When older women internalize this perspective, they dislike themselves, reject other older women, and engage in beauty practices (e.g., cosmetic surgery)—if they can afford them—in order to pass as younger than they are (Dingman et al. 2012).

There is a very clear double standard of aging, by which older women are judged more harshly than older men (Wilcox 1997) Whereas men are often seen as becoming more distinguished with age, older women are often seen as becoming less desirable—particularly when judged in terms of their pleasantness to be around, their physical attractiveness, and their potential as romantic and sexual partners (Calasanti and Slevin 2001). Men's value and attractiveness is not diminished by age to the same degree as women's (Lakoff and Scherr 1984). Aging is not a homogenous experience for men or women; social statuses, such as race, ethnicity, class, and sexual orientation, shape how both women and men experience aging (Calasanti and Slevin 2001). For example, positive perspectives on older women are more often found in collectivist cultures that recognize important roles for older women in society such as grandmother (Calasanti and Slevin 2001) or healer, whereas older women are judged more harshly in cultures that value women mainly as sex objects or for their reproductive potential (Chrisler et al. "Older Women, Power and the Body," this volume).

Positive Aging: Agentic or Ageist?

The concept of "positive aging" has been promoted in both the popular and the academic literature on older individuals. For example, one-half of the current textbooks on the psychology of women include a focus on "positive aging" and "vital older women" (McHugh and Interligi 2013). These concepts are meant to inspire women to embrace and enjoy old age rather than simply to endure it. However, the notion of aging positively or successfully is rooted in ageist values. Critics have argued that images of positive aging often involve older people who maintain middle-age

appearances and activities and who stay fit and busy—essentially, by not appearing to age at all (Calasanti and Slevin 2006; Cruikshank 2003; McHugh 2000). Indeed, numerous accounts of positive or successful aging are intensely focused on the maintenance of expectations and values of middle-adulthood, such as functional ability, activity, performance, productivity, independence, health, and sociability (Tornstam 2005). Though it is important to do more than endure old age, the ideals of what it means to age positively should not be based on the ideals of young or middle adulthood. This approach also allows both older and younger individuals to reject or criticize older individuals who are not aging "successfully," including those who are ill, poor, sad, or physically or mentally incapacitated in some way. Often young adult and middle-aged theorists fail to consider the possibility that older people could generate or maintain meaning in their own lives. Late adulthood is a distinct developmental period during which development continues; it is not simply the maintenance of patterns of middle adulthood. It is inappropriate for individuals to force middle-age values and expectations on older adults and consider them abnormal when they fail to meet others' expectations.

Older Women and Desirability

Media Messages

Media in the United States reflect a sexist and ageist culture. The media operate from a white, male, adult worldview, thus older women are doubly marginalized and nearly invisible (Lemish and Muhlbauer 2012). When older women are included, they are often portrayed in a prejudiced and stereotypical manner. For example, beauty is a resource perceived to belong to young women; older bodies—especially older women's bodies—are perceived to be ugly, repulsive, asexual, and undesirable (Calasanti and Slevin 2001; Furman 1997). As a result, older women are underrepresented in all forms of media in the USA and in other countries (Chrisler 2007; Kessler et al. 2010; Lemish and Muhlbauer 2012; Pliner et al. 1990). Only 20 % of the top actors over 50 are female, and women over 50 are portrayed in only 12 % of the roles in popular movies (Haskell and Harmetz 1998). Older women are dramatically underrepresented or negatively portrayed in television, film, and print (Healy and Ross 2002; Kessler et al. 2004).

The invisibility of older women in US media is well documented, and their absence sends the message that women should either hide the signs of aging or stay hidden themselves (Chrisler 2007; Etaugh 2008). When older women are actually made visible in film and television, they are often portrayed according to stereotypes. For example, older female characters on television or in movies are usually depicted as asexual, dependent, burdensome, comic or eccentric, gossipy, interfering, unfriendly, unintelligent, unattractive, scary, wicked, or villainous (Lemish and Muhlbauer 2012; O'Beirne 1999). When women can no longer be represented as the sexy body and object of male desire, they are rendered invisible or portrayed as nagging and controlling mothers or mothers-in-law (Lemish and Muhlbauer 2012).

The media often inaccurately dichotomize older women into good or bad using images of "grannies" and "witches": Old women are either warm, nurturing, helpless, and unfashionably outdated grandmothers, or they are "mothers-in-law from hell," selfish manipulative older mothers, or even greedy, evil, power-hungry, ugly monsters, as often seen in Disney films (Canetto 2001; Cruikshank 2003; Perry 1999). Through these portrayals, the media undermine the complex and human aspects of women of all ages. In particular, women are unlikely to be shown as both positive and powerful. Dominant media messages "continue to promote restrictive ideologies of femininity, glorify heterosexual romance… stress the importance of beautification through consumption, and dismiss the validity of women's own sexual feelings and desires apart from men's desires for them" (Lemish and Muhlbauer 2012, p. 169).

Desirability

Negative stereotypes of older women are more common than positive views in individualistic, industrialized, and Western cultures, which tend to be youth oriented (Chrisler et al. "Older Women, Power and the Body," this volume). In Western cultures, the pursuit of beauty is a key component of what is perceived as feminine behavior, and most women spend a lot of time, money, and energy to look as attractive as they can (Saltzberg and Chrisler 1995). The current beauty ideal in Western cultures includes a youthful, thin body, with medium to large breasts, small hips and waist, toned muscles, and European hair and facial features (Brown and Jasper 1993; Smith 2008). Wrinkles, age spots, sagging flesh, and weight gain—all associated with aging—contribute to older women's inability to achieve the ideal of beauty associated with youth (Chrisler 2011).

Media also marginalize older women by communicating the message that looking old is something to strive against, "the ultimate failure" (Clarke 2011, p. 105). Signs of aging are viewed as unattractive in both men and women, but especially contribute to ratings of unattractiveness in both mature women (Harris 1994). People expect women, more than men, to conceal signs of aging. Women attempt to modify their aging faces and bodies through the use of both commonplace and extreme means. For example, O'Beirne (1999), in a comment on the message that women should maintain a youthful and beautiful appearance, suggested that the media have found a use for the older woman's body—"to coerce her into an excess of consumption, self-surveillance, self-discipline and self-regulation to avoid looking old" (p. 19). Thousands of products and services are marketed to older women, sold with the promise of making them look younger, including hair dyes; cellulite creams; antiaging and antiwrinkle moisturizers, masks, and eye gels; firming body lotions; anti-stretch mark creams; anti-aging makeup; slimming undergarments; and cosmetic surgeries and treatments such as Botox®, breast- and face-lifts, and "vaginal rejuvenation." That these products and services exist points to the fact that older women's bodies are devalued and seen as ugly, abnormal, and in need of repair or change.

Older women who have remained visible in popular culture, such as the comedian Joan Rivers, have had repeated cosmetic surgeries to maintain a younger appearance. When older women are championed in the media, they are usually being praised for meeting the beauty ideal: for looking exceptionally youthful and thin. Yet, age concealment through beauty products and surgery are not satisfactory solutions to aging. Harris (1994) reported that, in a study of adult men and women, women were significantly more likely than men to report that they use or would use products to conceal signs of aging, such as hair dye or antiwrinkle cream. However, her research also indicates that there is disdain for older women who do attempt to conceal their age through beauty products, which places older women in a double bind when faced with the task of whether and how to maintain a youthful appearance (Harris 1994).

Clarke (2011) examined the language of print advertisements in women's magazines and the response of women to media messages. Seventy-eight percent of the 293 ads from women's magazines published in 2004–2005 made direct references to antiaging discourses regarding market products, and many of the ads actually used the phrase "antiaging." This message was often accompanied by images of youthful models. Most of these ads (86%) targeted women's faces for treatment, and they often used pseudoscientific terms, which implicitly suggest that science can now "reverse" the aging process. The ads are generally successful in encouraging women to purchase products designed to reduce visible signs of aging and "produce" luminous, radiant, and improved looks.

Resisting cultural stereotypes and pressure to present oneself as young may be an example of the empowerment of older women. Clarke (2011) interviewed older women (ages 50–90) who by and large rejected the images employed in advertising antiaging products. They specifically rejected the models employed in advertisements by describing them as ridiculous, appalling, sickly, unattractive, and anorexic, and they expressed admiration for women, such as Marilyn Monroe, with more shapely bodies as indicative of feminine beauty. Some of her respondents commented on the change in ideal beauty images over the decades, as models became increasingly thin, but also increasingly communicated messages about cosmetic enhancement and physical fitness. Her respondents recognized that the shift in standards detracted from their own status in terms of attractiveness. Despite their critical perspective, the older women typically maintained an emphasis on young women as models of attractiveness, and they felt pressured to buy products to try to look good (i.e., younger). Recognizing their own culpability in the reinforcement of sexist and ageist cultural values, the women were unable to completely reject the products and standards associated with them. "The constant bombardment of media messages asserting the need to be thin, young, and wrinkle-free reflected and reinforced sexist and ageist ideologies that the women encountered, negotiated, and embraced in their everyday interactions" (Clarke 2011, p. 114).

Resisting Cultural Messages Regarding Our Bodies

Beauty work is a lifelong requirement of being feminine (West and Zimmerman 1987). Some researchers have concluded that women's concerns about their

attractiveness decrease with age, as concerns about the health and functional aspects of their bodies increase (Hurd 2000). Others, however, have documented that women devote more time to beauty work as they age in an attempt to counteract the impact of aging on their appearance (Baker and Gringart 2009). Although some research indicates that older women report preferences for more curvaceous and heavier figures than younger women do (Clarke 2002, 2011), both young and old women hold body ideals that are thinner than their actual bodies (Hallinan and Schular 1993). Many older women report dissatisfaction with their weight, and most of them practice dieting or weight management (Clarke 2011), including lesbians (Slevin 2006). Furman (1997) interviewed older heterosexual white women, and reported that her respondents felt shame and stigma as they increasingly felt judged by younger individuals even as they were decreasingly the object of the male gaze.

Although Tiggemann (2004) concluded that, in general, women's overall level of body satisfaction/dissatisfaction remains relatively stable across the life course, other research has indicated that women's perceptions of the importance of appearance decreases with age (Ferraro et al. 2008; Pliner et al. 1990). Some studies show that weight concerns are not related to self-esteem in mature women (Tiggemann and Stevens 1999), and postmenopausal women who were dissatisfied with their weight were not ashamed of it (McKinley 1999). This research suggests that at least some older women are resisting cultural messages regarding the thin ideal. For some women, feelings of beauty are inextricably linked to self-identity, whereas others do not relate appearance to their identity and are, therefore, much less concerned about age-related bodily changes. The degree to which older women place importance on their appearance—and the way they conceptualize appearance—varies (Liechty 2012). In one study (Leitchy 2012), older women who placed a high value on appearance and considered appearance to be related to looking young and thin tended to feel dissatisfied with their bodies. Those who considered appearance to be unimportant (and thought that they were beyond expectations that their body should look a certain way) were more satisfied with their bodies. Some older women considered appearance to be more related to clothing choices, public presentation, and personal style. These women—even if they placed a high value on appearance—generally felt better about their bodies, as clothing allowed them to present their bodies in "flattering" ways (p. 84).

The older women interviewed by Clarke (2011) were both influenced by and resistant to the cultural messages about aging and attractiveness. Social discourse that rejected older women made them feel insecure and ambivalent about their bodies. The women were aware that "their social currency and level of social inclusion were directly related to their appearances, and to the appearance evaluations of others" (p. 112). Thus, the women engaged in various beauty practices to maintain their current or future relationships and their social status as a person worthy of attention.

Further, older women respondents in recent research often perceived body satisfaction as impacted by a combination of factors. For example, many older women felt simultaneously satisfied and dissatisfied with their bodies (Liechty 2012). Some felt differently about their bodies when naked than when clothed. Clothing

choices made older women feel better about their bodies by helping them to feel sexy, confident, or positive. Through clothing, they could control how they presented their bodies to other people and create a flattering public appearance that concealed the aging bodies with which they were less satisfied. Still, even clothing can be separated into those garments deemed appropriate and inappropriate for mature women. Society dictates that "sexy" garments, which display the body in a provocative manner (e.g., miniskirts), are inappropriate for older women because their bodies are not desirable enough to "show off."

The use of clothing to transform, conceal, and more positively present one's body publicly highlights the importance of the perceived appraisals of others on older women's body image, which some women noted (Leitchy 2012). Through the pane of the "looking glass body" (Waskul and Vannini 2006, p. 2), older women may be constructing a perception of their own bodies based on the imagined opinions of others, such as their partners, friends, and strangers. Given that most messages about older women's bodies are negative (i.e., that they are ugly, diseased, or undesirable), older women may perceive others' perceptions of their bodies to be negative as well, regardless of those individuals' true opinions.

Older women's body satisfaction may include other factors in addition to their feelings about their appearance and how it is perceived, including feelings about health and functional ability. Feeling that one has a "healthy body" free of illness or disease is an important factor in some older women's body image (Liechty 2012). Other older women report that maintaining a prior level of physical ability (e.g., strength, stamina) is an important component. For some, body satisfaction may be more contingent on feeling capable of doing things that younger people do, as opposed to looking like younger women.

Sexual body image—or, the way that women "perceive their physical selves as sexually desirable" may be a distinct subdomain of older women's body image (Montemurro and Gillen 2013, p. 4), and it is similarly influenced by media and the perceptions of others. For many women, looking attractive (i.e., in accordance with the young and thin ideal) is tightly linked to feeling or being sexual. Yet, for some older women, looking sexually desirable is unimportant—either because they are uninterested in being sexual or because their feelings of desire and desirability are less contingent on appearance. But other women in their 60s and older, whose bodies are far from the ideal, may feel that their sense of desirability is challenged by changes in their level of conventional attractiveness: Because they do not believe that they are attractive to others, they do not feel sexually desirable. Dating may be a particular challenge for older women who have a negative sexual body image, as the potential to be seen naked may cause them to question whether a new partner could be attracted to their aging body (Weinberg and Williams 2010).

Older women's sexual body image may also be influenced by how they feel about their own genitals. This is often referred to as genital self-image, and includes perceptions of how one's genitals look, smell, and function (Herbernick et al. 2011). Women's genital self-image has been found to be significantly related to their sexual function and sexual behavior (Berman et al. 2003; Herbernick et al. 2011; Schick et al. 2010; Swart 2004). Women with a positive genital self-image tend to report

greater levels of arousal, desire, and overall sexual function, as well as lower levels of sexual distress and depression than those with negative genital-self image (Berman et al. 2003; Herbernick et al. 2011; Swart 2004). In addition, women with more positive genital self-image are more likely to masturbate (Herbernick et al. 2011). It may be that women with a positive genital-self image are more comfortable with their genitals and hence their sexuality, which could make them more likely to desire and to participate in sexual activity (Berman et al. 2003).

The research reviewed here suggests that older women in North America have complex and varied perspectives on their bodies and appearance. Not all women express dissatisfaction with their own faces, hair, and bodies, but older women, as a group, agree that aging women are negatively viewed in North American cultures. Even women who critically expose methods of the marketing of beauty products generally are impacted by the relentless pressure to "improve" their aged appearance or to lose weight (Muise and Desmarais 2010). Older women often view their physical signs of aging as undesirable and their inability to lose or control their weight as a moral failure (Chrisler et al. 2012; Clarke 2011). Yet, Clarke (2011) referred to many of the women in her studies as expressing pragmatic acceptance. Even women heavily invested in their appearance recognized the need to accept the appearance realities of growing older (Hurd 2000). "Even as they expressed resignation and appreciation for the wisdom and experience they had acquired over time, the women also bemoaned the loss of their youthful, sexually desirable, and culturally esteemed bodies" (Clarke 2011, p. 62).

Medicalization of Aging

In many developed nations, women's bodies of all ages have become increasingly medicalized. Medicalization has defined aging and aged appearances as unhealthy and in need of medical attention. Increasingly, the "natural" changes in the aging female body—including menopause, weight gain, and changes in skin tone—are viewed as medical conditions or problems that need to be remedied. The medicalization of weight is a particular issue for older women, as weight becomes increasingly difficult to lose with age (Bedford and Johnson 2006). Millions of dollars are spent on low-calorie foods, diet pills, exercise regimens and machines, and gym memberships, which are marketed to older women in order to sell them the ideal of thinness that is highly valued in the USA. Older women, like their younger counterparts, are generally dissatisfied with their weight and body shape and are preoccupied with dieting and weight loss (Allaz et al. 1998; Clarke 2002; Tiggemann 2004).

Aging is increasingly seen as a condition correctible by medical procedures (Dingman et al. 2012). The development and marketing of cosmetic surgery and nonsurgical cosmetic procedures are presented as a correction of aging and as a means of enhancing self-esteem (Dingman et al. 2012). They are also a demonstration of the ways the medical industry profits from women's belief that their aged appearance is inadequate. For as many as two thirds of women, facial wrinkles are

considered unattractive and as signaling aging and physical deterioration. Unwanted wrinkles were seen as making women seem cross, angry, and crabby (Clarke 2011). Prior to the development of nonsurgical procedures (e.g., Botox, dermabrasion) most women interviewed by Clarke (2011) rejected the possibility of cosmetic surgery. Although the women were frequently opposed to cosmetic surgery, their response to non-surgical procedures was more positive. For the physicians, treatment of wrinkles is a consumer-driven and scientific response to unquestionably negative physical blemishes that require medical intervention (Clarke 2011). Calasanti and Slevin (2001) argued that feminist critiques of cosmetic surgery have focused on the double standard of aging that requires women to work harder to look younger, yet failed to recognize the ageism inherent in the negativity that is generally attached to looking and being old for both men and women. The negative media messages and images of old women create pressure in women, even feminist (Chrisler et al. 2012) and lesbian women, to disguise their aging selves through hair dye, weight management, and cosmetic surgery.

In the USA in the 1960s hormone replacement therapy (HRT) was widely marketed as a solution for menopause, which was considered a "hormone deficiency disease." From the medical perspective, menopause and the decline in estrogen in later life is a form of hormone imbalance. HRT was marketed not only as an intervention for declining sexual interest, but also for hot flashes and disrupted sleep, wrinkles, and sagging body parts. The product promised to keep women "forever feminine" and to restore "full womanhood" (Marshall and Katz 2006). Later, prescriptions were issued to prevent osteoporosis, heart disease, and cognitive deficits. Although some older women continue to take HRT, use of HRT decreased suddenly in 2000 after it was shown to have increased the risk of cardiovascular problems, breast cancer, and stroke (Chrisler 2007). Thus, HRT, not aging, actually presented the greater health risk to women. As they age women lose some aspects of feminine appearance and move toward a more androgynous presentation. "The older woman's body demonstrates that femininity is fleeting, that it evaporates with time, and that adherence to beauty regimes and reconstructive or cosmetic surgery will not halt the inexorable passage of time" (O'Beirne 1999, p. 13).

HRT, cosmetic surgery, and nonsurgical cosmetic procedures are medicalized methods for staving off the onset of a more androgynous authentic self. Marshall and Katz (2006) commented on the contemporary "hormonal, medical, and pharmaceutical technologies for sexual enhancement and the re-sexing of the aging body" (p. 76). The prescription of testosterone to prevent aspects of aging in men is parallel to the use of HRT by women. Testosterone is currently marketed not only to address declines in men's sexual potency, but also to maintain masculine vitality and vigor. Marketing for testosterone features men who appear to be middle-aged, attractive, and physically fit, and the images of vigorous men and feminine women in advertisements have displaced the traditional models of convergence and androgyny of older men and women. Marshall and Katz (2006) recommended that we consider critically the fact that medical approaches are not only ageist in their equation of age with decline, but they also attempt to maintain the sexual dichotomy of masculine and feminine into old age and thus resist the androgyny of aging.

Diversity

Although there is consensus on the cultural association of beauty and youthfulness, not all women have internalized a similar beauty ideal, and women possess varied body images. "Body image and internalized beauty ideals reflect a negotiation between individuals' sociopolitical, cultural, and historical positioning and emergent social norms" (Clarke 2011, p. 24). Age, class, ethnicity, sexual orientation, and gender attitudes impact the beauty ideals held by women (Cash et al. 1997). For example, social class has been found to impact the body image of women, as more educated and more affluent women express more dissatisfaction with their bodies (McLaren and Kuh 2004), and they also have the means to purchase the antiaging products and services that are marketed to them.

Research indicates that cultural and racial groups hold diverse beauty ideals and report varied levels of body satisfaction/dissatisfaction. For example, some research indicates that African American women may be less concerned with weight and dieting than European American women are (Thomas and James 1988), but researchers have not specifically examined the body satisfaction of older African American women. Similarly, the research on eating disorders and body dissatisfaction among Asian women has not included older women in their samples. Kaminski and Hayslip (2006) found that older women with physical disabilities tended to have lower levels of appearance-related body esteem than nondisabled older women did.

We have limited knowledge of how older heterosexual women experience their bodies, and we know even less about how lesbians experience their bodies as they age. How sexual orientation impacts women's body satisfaction across the age span is a contested area of research. Some theory and research suggests that lesbians are buffered from the negative impact of idealized beauty norms, and are less dissatisfied with their bodies than heterosexual women (e.g., Bergeron and Senn 1998; Brown 1987; Winterich 2007). Other theorists have observed that lesbians and heterosexual women are exposed to the same socialization and cultural pressures (Dworkin 1989), and subsequently demonstrate similar body dissatisfaction (e.g., Cogan 1999; Slevin 2006). In an analysis of interviews with a small sample (N = 9) of older lesbians (aged 60–78 years), Slevin (2006) noted that the respondents' experiences were impacted by their class and educational status, as well as by their ethnicity. Although her respondents felt positive about growing old in a women-centered community, and reported that they were able to reject dominant negative notions of aging, ageist attitudes about appearance still surfaced in the interviews. Slevin (2006) concluded that the attitudes of the lesbians were shaped by hegemonic ideals that value youth and denigrate old women. All of the respondents expressed dissatisfaction with their weight. They also distanced themselves from other older women through ageist attitudes, including by stating that they look and feel younger than they are, that they are energetic and active, that they keep busy, and that they are intellectually engaged or productive. Slevin (2006) concluded that lesbians share the gender socialization of heterosexual women; like heterosexual women, lesbians reveal complicated perspectives on aging, including internalized

ageism. Lesbian respondents attempted to pass as younger, directed ageist attitudes toward other older women, and distanced themselves from their age peers. However, Winterich (2007) found that lesbians (and women of color) were more accepting of gray hair than were the white heterosexual women in her sample. The research suggests, then, that lesbians, like heterosexual women, have complex and contradictory attitudes towards cultural standards of beauty and ageism.

Older Women and Sexual Desire

Older women are often offered competing views of their sexuality. They are sometimes unfavorably compared to younger women and devalued as sexual partners. Older women are often perceived as being in sexual decline by younger individuals and men of their own age group, and they are often considered asexual or incapable of sex, and as declining in vitality, beauty, and sexual attractiveness. If older women are interested in sex or participate in sexual activity, this is often considered by younger people to be inappropriate or "gross"; when older women are sexually active, they are often viewed as oversexualized, predatory "cougars," and their sexual behavior and desire are ridiculed. Yet, from the medical perspective, older women's interest in sex may be labeled as a sexual dysfunction if it is too low. In each case, older women's sexuality is subject to ageist, androcentric, and heteronormative perspectives that offer women a rigid, limited, and unfulfilling sexual script.

Contrary to the stereotypes about older women (and men) as engaging in little or no sexual activity, research continues to document that many individuals aged 60 and older do participate in sexual activity (Herbernick et al. 2010), a result confirmed by research conducted around the world (e.g., Laumann et al. 2006; Nicolosi et. al. 2006; Winn and Newton 1982). For example, in an examination of the responses of individuals from five English-speaking countries to the Global Survey of Sexual Attitudes and Behaviors, Nicolosi et al. (2006) reported that 79 % of men and 78 % of women disagreed or strongly disagreed with the statement "older people no longer want sex." According to Winn and Newton (1982), older individuals continue to be sexually active in 77 % of the 106 cultures studied. Further, age provided a disinhibiting effect on the sexual expression of women in 22 % of the cultures studied. Cultural factors were viewed as key determinants in the sexual behavior of older individuals; in this global analysis, US society was generally viewed as one that restricts the sexuality of older women. However, the older women interviewed by Hinchliff and Gott (2008) positioned themselves as women to whom sexual activity was either important or very important, and they demonstrated resistance to the asexual older woman stereotype.

In a global study of sexual satisfaction and well-being in older individuals (aged 40–80 years), Laumann et al. (2006) found that the predictors of sexual well-being were largely consistent across 29 nations and included physical pleasure, physical pleasure, emotional satisfaction with their relationship, emotional satisfaction with their relationship, current sexual health, and the importance of sex overall.

This research also demonstrated that, across national and cultural boundaries, men reported higher levels of sexual satisfaction and well-being than women did. Although this is not surprising for countries characterized as traditional patriarchies, lower levels of sexual satisfaction and well-being were also reported by women in countries characterized as "gender-equitable." Thus, in the USA and elsewhere, older women, although still sexually active, must cope with a variety of factors that can impact their sexual satisfaction and ability to express their sexual desire.

What is Desire?

Women are traditionally viewed as positioned to engage in reproductive sex, respond to men's overtures, and be receptive to men's sexual needs. Some see old age as a time when women are nonreproductive, less desirable to male partners, and less interested in sex, but others have suggested that menopause actually represents for some women the opportunity to define their sexuality based on their own desires and needs rather than on the cultural expectation of reproduction or satisfaction of marital duties (Barbach 1975).

A sex-positive approach to older women's sexuality recognizes the importance of authenticity, agency, and a broader definition of sex. In later life, women might become more authentic in their decision to engage in sexual activity as they become free from society's expectations of reproduction or marital duty. As they age, some women may become more open about their sexual desires and partner attractions, and they might possibly increase their levels of sexual activity. For example, Kayce, age 66, interviewed by Price (2006), reported that she felt "more free, adventurous, and open about what [she] wants" (p. 46). Many women learn to embrace changes in their sexual activity. As Lily, age 60, stated, "I have sex less than I did when I was younger, and the intensity is much less. I still enjoy sex as I did when I was younger. I don't feel like I am missing anything because of the changes as I age" (Price 2006, pp. 46). Still other women may decide that sex is not important to them and choose not to engage in any sexual activity. An empowerment perspective on older women's sexuality should emphasize women's right to be sexual (or not) in response to their own sexual desire.

Tolman (2002) discussed desire as part of women's embodied and relational self, and she argued for its importance in understanding women's sexuality. Desire connects us to our bodies and, at the same time, connects us to others (Tolman 2000, 2005). Older women, like the adolescents Tolman studied, need to understand and construct their own sexual desire, and they need to claim sexual agency and sexual entitlement in resistance to androcentric, contradictory, and stereotypic discourses. Both adolescents and older women are in developmental transitions with potential for both self-agency and derogation by others. Similarly, Koch (1995) argued that women have different and varied aspects of sexual desire, rather than the single biologically based desire posited in many models. For example, women report being sexual to enhance emotional closeness (Basson 2002), as well as to express

attraction and to share physical pleasure. Basson (2000) characterized women's sexual desire as intimacy based; it involves both physical and emotional components and is less linear than men's sexual desire. In a study of midlife women's narratives of desire (Brotto et al. 2009), respondents described desire in relation to genital and nongenital physical responses, but also in terms of cognitive and emotional responses. Desire was triggered by touch, memories, and the partner, and it included an emotional connection. Participants in a study of partnered Canadian women also reported that they understood their desire in the context of their relationship, rather than as an autonomous experience (Goldhammer and McCabe 2011).

Though some researchers continue to investigate sexual desire as experienced by women (e.g., Meana 2010; Sims and Meana 2010), women's desire has not been adequately acknowledged in a male-oriented culture that emphasizes men's desire and women's responsiveness. Tolman (2000) saw these cultural attitudes as an explanation for women's inability or reluctance to admit to their own sexual desire. "When one is treated as the object of the desires of others, and treats oneself as such, the ability even to know one's own needs and desires is undercut" (Tolman 2000, p. 199). Older women, in particular, may be reluctant to acknowledge their own sexual desires.

A close examination of previous work suggests that researchers have difficulty conceptualizing and measuring women's sexual desire at any age. A single item inquiring about a woman's level of sexual desire is inadequate (Myers 1995), and it is also problematic to use sexual activity as a proxy measure of desire (Kinsey et al. 1953) because frequency of intercourse assumes heterosexuality and probably represents men's desire or capacity rather than women's. Several researchers have concluded that women's sexual desire is not appropriately measured in terms of sexual fantasies or number of sexual acts, as men's desire often is (Basson 2002; Tolman 2002). There may not be very close correspondence between women's experience of desire and their frequency of sexual activity.

In her challenge to contemporary constructions of sexuality, Tolman (2002, 2005) argued that women's experience and understanding of sexual desire differs from men's. There is evidence that women's sexual desire is experienced differently than men's (Basson 2002). For example, Schwartz and Rutter (2000) concluded that, for men, who usually initiate sex, their own desire is a sexual cue, but, for many women, the partner's sexual desire is the cue for the women's own desire, and women learn to experience their partner's desire as erotic (Schwartz and Rutter 2000). Wood et al. (2007, p. 196) concluded that many of the older women they interviewed had "learned to place their sexual desire outside of their own experiences, thereby surrendering their sexual agency." The sexual double standard and the cultural script that privilege men's sexual needs and desire had apparently stifled women's ability to experience desire as part of their sexual response. Although this may be a problem for women at any age, it may be especially true for older heterosexual women who have spent years responding to their partner's needs and directions.

Nicolson and Burr (2003) also found their female sample (aged 19–60) constructed their own sexuality as different from men's. Respondents characterized men's sexuality as "active, needy and demanding of sexual satisfaction", whereas

women's sexuality was experienced as "active, but with a different type of desire" that involves intimacy, communication, and some level of ambivalence about sexual intercourse. Respondents negotiated the contradictory discourses about women by positioning themselves as women who desire sex and have a "need" to fulfill, and their experiences depended on their partner's experience.

The Medicalization of Older Women's Sexuality

The idea that women's sexuality declines post menopause is widely held by the general public and professionals alike. Many women report changes in their intimate relationships and in sexual interest and behavior as they age, but it is not clear that hormonal changes are the primary determinant of women's sexual desire or activity (McHugh 2007; Myers 1995). Assuming that women around the world experience declines as they age indicates an adoption of the biological/medical model that views women's sexuality as influenced largely by biological factors. However, a recent study (Laumann et al. 2005) of the sexual problems of people in 29 countries does not support this belief. For women, lack of interest in sex and inability to reach orgasm were the most common sexual problems reported across the world's regions. However, age was not associated with either problem; there was no indication in this study that older women are more likely than younger women to report a loss of interest in sex. Of all the sexual problems experienced by women globally, age was only associated with the likelihood of experiencing lubrication difficulties. Women aged 50–59 years, in comparison with those aged 40–49, are more likely to report lubrication problems, which confirms that this experience is tied to hormonal changes in the body. The authors concluded that, for women, the effects of aging are less important in relation to sexual issues when the effects of the relationship are taken into account. However, men's sexual problems were more associated with age; the likelihood of reporting erectile difficulties, in particular, increased with advanced age. This study demonstrates that aging effects are more relevant for men than for women.

Older adults as a group experience a decline in sexual frequency; on average, they participate in sexual activity about three fewer times per month than individuals in middle adulthood (Karraker et al. 2011). In addition to physical changes (e.g., decreased lubrication, erectile difficulty), both women and men may experience the loss of a sexual partner, illness, disability, surgery, or medications that contribute to a decline in sexual activity. Yet, even when researchers reported finding a decline in the sexual interest or activity of older women, other women in the studies have typically reported an increase, and still others' sexual activity levels remained stable; individual variability is clearly demonstrated (McHugh 2007). In an extended review of the literature on sexual decline in postmenopausal women, McHugh (2007) concluded that there was little evidence for hormonally based declines, there were no indications of important universal effects, and there were a variety of sociocultural and interpersonal influences on women's sexual responses.

Changes in desire and/or frequency of sexual activity are not necessarily viewed as problematic by women themselves, but are increasingly labeled as "problems" or "dysfunctions" by the medical profession and pharmaceutical industry. In the USA, Canada, UK, Australia, and New Zealand, about 75 % of older adults with a sexual "problem" have not consulted with a physician about it (Nicolosi et al. 2006). Common reasons for not consulting a doctor included not considering the problem to be bothersome (72.1 %) and not considering the sexual "problem" to be a medical problem (53.9 %). Use of a biological or medical model to explain women's sexual problems fails to acknowledge that sexuality is constructed, experienced, and evaluated within a sociocultural context. Biological aspects of aging are only one of many changes that occur in women's lives; women's roles, family structures, and employment also change with age. In their older years, women often experience the loss of a partner and, when women remain partnered, their partners are also aging.

Decreases in sexual activity have been viewed as pathological and labeled as hypoactive sexual desire. Some researchers, including Tiefer (2001), McHugh (2006, 2007), and Richgels (1992), have critiqued the efforts of the pharmaceutical industry to pathologize women's sexual experiences in an effort to expand profits and control women's sexuality. Tiefer (2001) has described the process by which the pharmaceutical industry has strategically labeled "low" levels of sexual activity as the disease *hypoactive sexual desire* and presented the "cure," which has resulted in big profits. The development of the new disease leaves older women wondering if their own sexual activity is enough. But who gets to decide how much sex is enough (McHugh 2012)?

The biomedical approach employs the disease concept, labeling dissatisfaction and deviation from the norm as dysfunction. Women who do not engage in "normative" quantities of sexual activity are labeled pathological and dysfunctional (Tiefer 2001). The standards established to distinguish between functional and dysfunctional behavior are also often based on youthful (and male and heterosexual) expression as the central criterion of a "good" sexual response (Mansfield et al. 1998). Conceptions of function and dysfunction are grounded in biological perspectives of sexuality, and do not consider women's unique sociocultural position with regard to sexual desire and expression (Richgels 1992). Basson (2000) studied women's sexual desire as part of an attempt to resist the trend toward pathologizing and medicalizing women's sexual responses. Her model takes a biopsychosocial view that women's sexuality is influenced by factors other than hormonal changes, including the availability of a partner, the state of their relationship, cultural constructions of women's sexuality, and women's knowledge about and attitudes toward sex. Research demonstrates that, when women do lose interest in sexual activity in later life, the reasons are complex and attributable "to the material, discursive and intrapsychic factors that impact on women's lives" (Ussher 2006, p. 139).

Women of all ages have sexual problems, especially when sexual problems are defined as discontent or dissatisfaction with any emotional, physical, or relational aspect of a sexual experience (McHugh 2006). In a survey of 2500 women, 99 % of them reported having had at least one of the 23 sexual problems listed (Ellison 2001). Thus, there are a variety of sexual problems, and even more possible causes

and contributing factors (McHugh 2006). Emphasis on biological factors may limit our investigation and understanding of other sociocultural contributing factors, such as education, violence, media, and the objectification of women. The adoption of a pharmaceutical/medical approach to women's sexual problems has limited, distorted, and pathologized women's sexual experiences (Kaschak and Tiefer 2001).

Is absence or reduction in sexual desire or sexual activity a dysfunction? The question of when it is appropriate to call a pattern of behavior a sexual problem or a dysfunction has been raised (Bancroft et al. 2003; McHugh 2007; Tiefer 2001). Bancroft et al. (2003) found no significant relationship between age and self-defined "problems." According to Koch et al. (2005), older women tend to be sexually satisfied regardless of the sexual changes they reported. The effects of aging on the levels of women's sexual interest were not a cause of concern. Older women seemed to have more sexual problems (as defined by the researchers) than younger women, but were less distressed by them. The women who were not having partner sex were older and masturbated more frequently; they reported more distress about their relationship than about their own sexuality. This is consistent with the perspective that intimacy, more than frequency of sexual intercourse, is important to African American senior women and positively related to their sexual self-esteem. (Conway-Turner 1992). The existing research provides substantial evidence that relationship duration and quality has an important impact on women's sexual satisfaction.

Sexuality, Desire, and Partner Relationships

Women's sexuality has been shown to be impacted by partner factors, such as presence or absence of a partner, the partner's health, and feelings toward the partner (Dennerstein et al. 2001; Schwartz and Rutter 2000). Researchers have reported that women's sexual activity is strongly related to marital status (Diokno et al. 1990; Mansfield et al. 1998; Koch et al. 1995). Karraker et al. (2011) found that widowed, divorced, and separated older women have significantly less sex than married older women. Because women live about 5 years longer than men (CDC 2012), heterosexual older women who are widowed, divorced, or separated are often left with limited partner choices in their age group. The reality that men typically choose to marry or date younger women further restricts the pool of available male partners and decreases the likelihood that heterosexual older women will be having partner sex. Generational attitudes toward sex as restricted to marriage may also contribute to the decline of sexual activity seen among widowed, divorced, and separated older women. However, some studies have shown that the most commonly cited reason for a decline in sexual activity—by both older women and men—is the male partner's physical health limitations (Karraker et al. 2011; Lindau et al. 2007). A number of female respondents have reported that their husbands are the reason that they were no longer engaging in sexual activities (Pfeiffer et al. 1972). However, in most marriages, sex becomes less frequent, but not less pleasant, with age (Schwartz and Rutter 2000).

Dennerstein et al. (2001) stressed that women's relationships with their partners have a particularly powerful effect on women's sexual desire. Nicolosi and Gingell (2006, p. 331) found that, in the UK, Canada, New Zealand, and the USA, about 74% of men and 75% of women aged 40 and older agreed that "satisfactory sex is essential to the maintenance of a relationship." Researchers report a strong positive correlation between relationship satisfaction and sexual satisfaction for older women (Traupmann et al. 1982); sexual satisfaction is also positively correlated with passionate love. According to Schwartz and Rutter (2000), declining sexual activity among older adults may be more related to the length of the relationship and habituation than to aging. That is, couples evolve into partners rather than lovers (Schwartz and Rutter 2000), as companionate love surpasses passionate love. However, a positive emotional relationship and the presence of affectionate behaviors are the context for many women's sexual desire. Older women (and older men) in Brazil, Germany, Spain, Japan, and the USA cited physical intimacy, including frequent kissing, cuddling, and caressing, as predictive of satisfaction with one's sexual relationship (Heiman et al. 2011). Ellison (2001) emphasized that women associate sexual satisfaction in relationships with closeness, love, acceptance, and safety and that women's sexual problems and concerns often center on intimacy and relationship issues. In research by Ellison and Zilbergeld (as cited by Ellison 2001), the top three items associated with satisfying sex for women were feeling close to a partner before sex, emotional closeness after sexual activity, and feeling loved.

Some relationship problems that impact sexual satisfaction include a lack of spontaneity, initiative, or romance. In their study, Mansfield et al. (1998) found that women wished for more sexual responsiveness and more desire for themselves, but they also wanted more fulfilling sexual relationships. Couples with well-established sexual routines may find that they no longer elicit much excitement or interest. On the other hand, the sex lives of 60-year-old newlyweds resemble the sex lives of younger couples more than those of long-married couples of the same age, and they follow the same pattern of eventual decline over time (Blumstein and Schwartz 1983). This suggests that marital relationships, as well as individuals, go through developmental changes over time. However, when expectations and norms are developed from a medical model, relationship development and maintenance are not considered.

Barriers to Healthy Sex for Older Women

Many older adults apparently engage in risky sexual behaviors. Sexual risk behaviors in late adulthood are similar to those in adolescence, and include not using condoms with every sexual encounter, using condoms incorrectly, and having multiple sex partners (Foster et al. 2012). One or more of these risk behaviors may be performed by up to 74% of older adults. Largely due to these risk behaviors, rates of sexually transmitted infections (STIs) are increasing among the older adult population (CDC 2008). Heterosexual contact is the main mode of HIV transmission in older adults,

and individuals aged 50 and older accounted for 17% of new AIDS cases in 2009 (CDC 2008; Foster et al. 2012). Biological changes also create barriers to healthy sex. For example, changes in older women's bodies, such as the thinning of vaginal walls and decreased lubrication, leave them particularly susceptible to vaginal tearing and STIs. Older men may still be able to impregnate a younger partner, and they are also capable of contracting and spreading STIs. In developing nations, sexual risk taking may be especially high among those women who are widowed or divorced (Tenkorang 2014).

Though sexual problems, such as STIs, may be common among older women, they are infrequently discussed with physicians (Langer-Most and Langer 2010). Older women may not feel comfortable discussing their sex lives with doctors, and doctors tend not to ask older adults about their sexual activity, which may increase sexual risk-taking and delay treatment of STIs (Foster et al. 2012). In part due to this mutual discomfort, older adults typically do not get tested for STIs on a regular basis. They may even mistake symptoms of STIs (e.g., pain) for those typical of the normal aging process (CDC 2008).

Some older women may not have received helpful sexual information at any time in their lives. Sex education has been inadequate for many (if not most) girls and women over the past century, and some older women may have not received comprehensive sex education. Women in their 80s may not have received even basic information about sexuality in their youth, and they are unlikely to have learned about orgasm, masturbation, or alternatives to heterosexuality and intercourse. Public health educators go into schools to educate youth about STIs and sexually related health problems, but they do not address audiences of elders. Currently, there is only one formal sexual health education curriculum that specifically caters to older adults (i.e., Our Whole Lives) (Unitarian Universalist Association of Congregations 2013). Though this program has been operating since 1999, there have been no published empirical evaluations of its success. There are currently no guidelines for sex education with adult or older adult populations nor are there guidelines for sex therapy with older adults.

Women and Sex Revisited

Mature Women as Sexual

Women aged 60 and older do participate in sexual activity. Though both partnered and unpartnered sexual activity generally declines among women from ages 50 to 70, at least one third of older women remain sexually active into and past their seventies (Herbernick et al. 2010). In one recent study, 46.5% of American women in their sixties said that they masturbated (Herbernick et al. 2010). In the same study, about one fourth of women in their sixties said that they gave and received heterosexual oral sex, 42.2% recently had vaginal intercourse, and 4% had received

anal sex. Though these percentages declined for women in their 70s and older, the decline in heterosexual sexual activity may be due to the decrease in available male partners (Herbernick et al. 2010). Mature single women in an interview study by Hinchclifft and Gott (2008) reported frustration with finding a willing and able sexual partner in their age group. Women in their 70s and older participate in more lesbian oral sex than those in their 60s (1.5 vs. <1 %) (Herbernick et al. 2010), which may also be related to the availability of male partners.

A survey of 1300 respondents by the National Council on Aging (Leary 1998) showed that 70 % of sexually active women over 60 reported sexual satisfaction (equal to or more than reported by individuals in their 40s). Similarly a study of aging and sexuality in 106 cultures (Winn and Newton 1982) showed that 84 % of older women in 106 cultures were sexually active and expressed strong sexual interest. Hite (2000) reported on older women who felt positive about their sexual experiences post menopause. According to Hite, older women enjoy doing as they please as opposed to pleasing others. Some women reported to Hite (2000) that they experienced an increase in self-confidence in their later years, and others enjoyed sexual interactions more without concerns about pregnancy. Hite's report (2000) not only helped to dispel myths about older women's sexuality, but it also called attention to the importance of sociocultural factors that impact women's sexuality (Katz and Marshall 2003).

Hinchliff and Gott (2008) interviewed older women and reported that some of their respondents rejected the repressive posture of traditional "experts" that mature women should acquiesce to age-related changes in sexual desire and activity. Aging without sex was seen as literally old fashioned. Some of their respondents contended that they were sexually active, but that other women their age or older were sexually inhibited. Other respondents did seem to be inhibited by cultural mores about "appropriate" behavior for women their age. Several older women volunteered that they had been feeling "sexual urges' in recent years, but, for many of the respondents, discussion or action related to their desire was inhibited by concerns that they would appear to be "oversexed." Others were willing to be sexual, but had difficulty finding a male partner who could perform.

A Sex Positive Approach for Mature Women

A woman's sense of herself as a sexual being, the meaning of sex to her, and her awareness of her own sexual desire are all constructed in a particular socio-historical context (McHugh 2007). Women in their 60s today were born in the late 1940s and early 1950s and lived through "the sexual revolution." Many had access to birth control pills and to legal abortion for most of their lives. They lived through the AIDS epidemic, and they can now meet new partners online. Older women's experiences of intimacy and desire, and their constructions of sexuality as mature women are probably different from those of their mothers at age 65 or those their

daughters might have at age 65. Even within a specific historical era, women's experiences are diverse. As we have noted, women's sexuality is impacted by a number of factors, including religion, social class, ethnicity, sexual orientation, and history of violence. Older women, like younger women, vary enormously in their sexual desire, arousal, and frequency of experience of orgasm (Leiblum 1990).

In addition to being authentic in their sexual choices, a sex-positive approach to older women's sexuality highlights older women's agency. Wood et al. (2007) referred to this as "negotiating" sexual agency, which refers to women's ability to act on behalf of their own sexual needs, desires, and wishes. When making decisions about their sexual behaviors, such as decisions to have or not to have sex, older women may have more agency than they did when they were younger. Older women can initiate sex with partners of their choice, and they may participate in "solo-sex" (i.e., masturbation). As Ulla, age 61, stated, "I used to feel dependent on someone wanting me instead of initiating anything or following my feelings and desires. It was all about pleasing my partner. Now there's no pressure to perform or prove anything. I don't worry whether it was good for him the way I used to. I'm more in control of when I want it and am more outspoken about what I want and also when I don't feel like it. Not doing it out of obligation is really good" (Price 2006, p. 47). Catherine, age 65, noted, "…you don't need a man to validate you. If you're feeling horny, think sexy thoughts and stimulate yourself" (Price 2006, p. 15).

Further, older women can enjoy a wide range of sexual activities—including those not traditionally identified as such. Though they may continue to participate in penetration- and genital-focused sexual activities, older women may increasingly engage in nonpenetration- and nongenital-focused activities, such as kissing, cuddling, fondling, and caressing. Erica, age 62, reported that she "loves[s] being stroked" (Price 2006, p. 116). Penny, age 60, noted that "it really turns [her] on when [her] lover just turns down the covers and looks at [her]" (Price 2006, p. 116). Activities that stray from an androcentric model of sexuality may be particularly important to older women.

Conclusion

Women in many cultural contexts lose status as they age due to a loss of beauty in cultures that equate beauty with being thin and young with smooth skin. To what extent can older women resist messages regarding their lack of worth in cultures that reward women for their sex appeal, and to what extent can they resist marketing pressure to maintain a younger appearance? Our review suggests that women vary in their response to ageism and sexism in media and marketing. Older women's responses to the competing discourses regarding aging are themselves complex and contradictory. Even as women recognize the ageism inherent in media messages, their statements regarding their own weight and their reactions to other women suggest that they have at least partially internalized cultural constructions of older

women. Moving from invisibility to fit, attractive, and youthful representatives of older women in the media may not be the solution to cultural devaluation and social marginalization of older women. Along with Lips and Hastings (2012), we question how women might be empowered to accept and value their own bodies and to pursue activities and companions as opposed to beauty and youthfulness.

In particular, women need to continue to question medicalized approaches to the "condition" of aging and the medical products and procedures that are marketed as the "cure" or solution to the natural processes of the body as it ages. Even if such medical solutions were successful, they would divide the aging population into haves and have-nots, and thus contribute to the devaluation of aging and elders. Marketing approaches are designed to make being old and looking old an undesirable condition, and others profit from older people's anxious pursuit of youth, beauty, and vitality. Recognizing the dilemma does not result in personal resolution when people around us continue to view aging through cultural lenses. Older women need to be empowered to resist ageist discourse and to age authentically with self-acceptance.

Older women are frequently viewed as asexual, or as showing serious declines in their sexual desire. Yet international research (Laumann et al. 2005; Nicolosi et al. 2006) confirms that at least three quarters of older women are sexually active and that age is not statistically associated with women's sexual problems. The World Health Organization (as cited in Tiefer 2001) affirmed women's rights to sexual health, which includes sexual experiences that are pleasurable and free from coercion, violence, and disease. However, research conducted in 29 countries indicates that women's experience of sexual satisfaction is lower than that of men across cultural and national boundaries (Laumann et al. 2006). In international studies (Laumann et al. 2006) and in interviews conducted with small groups of older women (Dennerstein et al. 2001; Mansfield et al. 1998), issues regarding their spouses or partners are an important factor in women's levels of sexual satisfaction. Yet relationships are not highlighted in the research that labels women's (low) levels of desire as a medical dysfunction. Again, the marketing of medical products has the potential to influence women's sense of themselves as sexual beings and to make older women question whether they are having enough sex.

What role do agency and empowerment play in older women's experience of sexual desirability and desire? What does positive aging for women entail? Applied to sexuality, a positive approach argues *against* an emphasis on the quantity and frequency of sex experienced by mature women and argues *for* meaningful sex that supports older women's social and intimate connections with others. Even more important, successful aging entails acceptance of a wide variety of ways of being old that include activity as well as inactivity, contemplation as well as physical exertion, and acceptance by others as well as oneself. Lips and Hastings (2012) argued that older women often negotiate their own path through the competing discourses of aging, developing personal and complex ideas about their bodies, their activities and themselves as aging individuals. A path toward positive aging may involve finding a sense of agency and authenticity. Positive aging means feeling good about oneself and how one is participating in life. It means fostering a sense

of acceptance about the process of aging and not feeling limited by that process. It means participating in activities that are personally worthwhile and fostering a level of independence and social engagement that is personally chosen, not suggested by someone else. An appropriate approach to aging might be rooted in the central tenants of Tornstam's (2005) theory of gerotranscendence, which suggests that older adults accept themselves and their position in life. They may become interested and participate in activities that are qualitatively different from those in which they engaged during middle adulthood or earlier developmental periods.

Leiblum (1990) observed that women of all ages vary enormously in sexual desire, sexual satisfaction, orgasmic experience, and arousability. Similarly, Kliger and Nedelman (2005) argued that there is not a single best way for mature women to be sexual. Many older women have a fulfilling, exciting, and creative life without any sexual desire or sexual activity; others report increased appreciation for sensual experiences as they age. Their research confirms that there are at least a small percentage of women for whom desire increases in the older years and others for whom desire remains at a steady state. Kliger and Nedelman (2006) concluded that sexual desire waxes and wanes over time. In their older years, women express their sexuality in varied ways; variability is experienced by both married and single, heterosexual and lesbian women (Kliger and Nedelman 2006). Women's sexuality at all ages is multifaceted, complex, and dynamic. Evaluating the adequacy of women's sexuality on a single standard dimension is never appropriate. Applying homogenized prescriptions and androcentric standards to women's sexual desire works against women's goal of being in touch with themselves and learning to be comfortable with their own levels of desire and activity, whatever those may be.

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Lesbians Over 60: Newer Every Day

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Lesbians over 60 from present and future cohorts in the USA, Canada, and most other developed countries might reasonably expect aging to be a joyful and empowering phase of life. This is partly due to the greater social acceptance and legal protections available in these countries, as well as the advantages of woman-to-woman relationships, such as more equitable roles and mutual financial independence. In addition, the international trend toward legalization of same-sex marriages continues to shift cultural values toward greater acceptance of lesbians. These factors suggest that, at least for lesbians in developed countries, later life might well fit the poet Emily Dickinson's vision of old age: "We turn not older with years, but newer every day" (Dickinson 1986, p. 499).

In this chapter, we provide an overview of current research on older lesbians drawing primarily from the research done in the USA, including (a) the "visibility" of older lesbians; (b) the theories of lifespan development and their application to older lesbians; (c) the research on older lesbians including cross-sectional studies of lesbians and sexual minorities more generally; and (d) social contexts affecting older lesbians, including personal relationships (partners, friends, and community); minority stress and resilience; and race, ethnicity, and social class. In addition, we also briefly review the status of lesbian rights in other parts of the world. We examine the impact of living in countries where there are few or no legal protections for lesbians and where powerful homophobic cultural attitudes still prevail. Last, we propose directions for research and speculate about what the future will bring for lesbians over 60.

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Older Lesbians: Slowly Becoming Visible?

Older lesbians have been described as a "triple invisible minority" (Kehoe 1986, p. 139), and, despite some advances, this largely holds true today (Averett and Jenkins 2012). At present, lesbians over 60 are even less visible than heterosexual women of the same age—or of any age. In general, women over age 50 have been described as invisible because that is the point in life when they begin no longer to attract the attention of men or younger women (Chrisler 2007). Any older woman is likely to feel she has crossed that threshold when a cursory glance looks through her, signifying that she has no status, is irrelevant. Harriet Harman, the Deputy Leader of the British Labour Party, summarized the three phases of adulthood as follows in a report from the Commission on Older Women: "men have three primes, as young thrusters, as virile fathers, then valued for age and experience. But young (heterosexual) women are treated as ditsy decoration, mothers too distracted to be reliable, and finally after 50, they're past it—so when exactly is their moment?" (Toynbee 2013, p. 4).

Older lesbians might also reasonably ask: When exactly is our moment? The answer will be increasingly important as the number of lesbians age 60 and older increases. From 1.75 million to 4 million Americans over the age of 60 are estimated to be lesbian, gay, bisexual, or transgender (U.S. Administration on Aging n.d.), and that number is expected to double by 2030 (Sage n.d.). A recent national poll indicated that about 53 % of lesbian, gay, bisexual, and transgendered (LGBT) individuals in the USA are lesbians (Gates and Newport 2012). Thus, there may be an estimated 900,000–2,100,000 lesbians over the age 60 in the USA at present. Yet little is known about this minority. Lesbians' conformity or nonconformity to the typical life cycle of the heterosexual woman has not been studied. A specific media focus on lesbians is rare despite current headlines about lesbians and gay men in the military and same-sex marriage.

The lack of visibility is also reflected by the research on stereotypes that suggests that many people do not have a cognitive schema for older lesbians. Most people have stereotypes of older adults, and many have beliefs about homosexuality, but few people consider them simultaneously (Grossman et al. 2003). For instance, stereotypes of sexual-orientation-unspecified older women tend to be based on gender roles. Older women are perceived to be more feminine in appearance (soft), personality (warm), and behavior (e.g., do laundry) than older men. In contrast, older men are perceived to be more masculine in terms of physical characteristics (sturdy), traits (competent), and behaviors (e.g., assume financial obligations) (Kite et al. 1991). However, the stereotypes of older women are not congruent with the stereotypes of lesbians; age-unspecified lesbians are perceived as more similar to heterosexual men than to heterosexual women (Kite and Deaux 1987).

Overall, stereotypes of lesbians are less defined than those for gay men or heterosexual women or men. For example, eight different types of lesbians emerged from one study of young heterosexual adults' stereotypes, such as "lipstick lesbian" and "soft butch" (Geiger et al. 2006). Similarly, Wright and Canetto (2009) reported

that white college students who were cued to select the traits, roles, and physical characteristics of one of four targets (i.e., a 65-year-old heterosexual man or woman or lesbian or gay man) perceived lesbians to be similar to heterosexual women in terms of having feminine traits (e.g., warm, kind) and also similar to heterosexual men in terms of having masculine traits (e.g., independent, makes decisions easily, stands up under pressure). Older lesbians' physical qualities were perceived to be somewhere between traditionally masculine features (e.g., short hair) and traditionally feminine appearance (e.g., wear feminine clothing). These results suggest that lesbians as a group are perceived to be more heterogeneous than gay men or heterosexual women or men, at least by young white adults. The greater visibility of gay men compared to lesbians might contribute to this result as well. Stereotypes may be even more variable when race or ethnicity is considered.

The time is ripe, however, for current and future cohorts of older lesbians to inherit a more visible and positive future than was possible in preceding generations. A few lesbians are now conspicuous in the mainstream US media, most notably Ellen DeGeneres, Portia de Rossi, Rosie O'Donnell, Queen Latifah, Melissa Etheridge, Wanda Sykes, Rachel Maddow, Martina Navratilova, Kate McKinnon, and Jane Lynch. There are even a few lesbian celebrities over the age of 60 whom the average person might be able to identify as openly lesbian, such as Billie Jean King (former World No. 1 professional tennis player), Lilly Tomlin (comedian), and Suze Orman (financial expert). Furthermore, American lesbians who are now between the ages of 60 and 70 were either in their mid–twenties or younger during the 1960s and 1970s and experienced the second wave of feminism and the Stonewall era of gay rights. Many have been part of those continuing movements. This political involvement and the more positive social atmosphere it created will lead to even higher expectations for the quality of their life during old age.

The relative social invisibility of older lesbians to date raises questions concerning how well the lifespan theories of development encompass them. In addition, a small but growing body of research provides an insight into lesbians' old age. These issues are addressed below.

Lifespan Theories and Older Lesbians

> Sometimes I feel like a figment of my own imagination.
> Lily Tomlin in *The Search for Signs of Intelligent Life in the Universe* (http://izquotes.com/quote/276071, accessed 24 Aug 2014).

The role of theory is to provide an organizational framework that guides research and clinical practice; thus, it is imperative to examine relevant lifespan theories for potential bias. Theories of aging have been criticized not only for gender bias, but for a pervasive assumption of heterosexuality and a complete exclusion of issues pertaining to older lesbians (e.g., Brown 2009; de Vries and Blando 2003; Gergen 1990). The social gerontology literature highlights the ageism inherent in theoretical discourse, yet never addresses the issues pertaining to older lesbians

(Jacobs et al. 1999). By contrast, queer theory has offered important critiques of the heterosexism inherent in the predominant psychology and sociology theories about lifespan development. However, queer theory almost exclusively ignores issues pertaining to older lesbians and gay men (Brown 2009). Omissions in both areas lead to damaging assumptions of homogeneity—a form of theoretical ageism and heterosexism, respectively. This level of rhetorical silence, as noted by Brown (2009) and Pugh (2002), further disempowers this already marginalized population. Pervasive exclusion from intellectual discourse creates a sense of invisibility to both the self and others.

Even though one of the strengths of gerontology is that it is multidisciplinary, it lacks an overarching central theoretical focus (Bengtson et al. 1997). This is particularly true for research with older lesbians. Although research with this population has increased over the last decade, it is mostly atheoretical and has been published outside the typical publications of gerontological research (Pugh 2002). Some have argued that more data are needed to drive theoretical development for marginalized populations (Herdt 2003). However, empirically driven theorizing can itself be problematic in that lesbian and gay elders are an exceptionally difficult population to recruit. Consequently, the majority of samples in this area of research include mostly white, middle class, self-identified "out" lesbians or gay men, which creates a self-selection bias that impacts the development of theory because the results are not generalizable to other groups with intersecting identities (e.g., older Hispanic lesbians) (Rosenfeld 2010).

Below is a brief review of four of the most influential and relevant theories in aging research and the critiques of these theories in relation to older lesbians. The following is not intended to be an exhaustive review of gerontological theories but is instead a discussion of the strengths and limitations of a few highly influential theories with regard to concerns salient to older lesbians.

One of the most frequently cited and highly influential theories in modern day gerontology is Erikson's theory of psychosocial development (Alley et al. 2010). This deterministic stage theory is an extension of Freud's work on the development of the personality. Erikson saw development from the perspective of the epigenetic principle in which, similar to embryological growth, an individual's physical maturation and interaction with the social context propels development (Erikson 1963). Erikson theorized that normal development occurs through a series of predetermined linear stages that require the individual to resolve specific crises. The resolution of each crisis forms the foundation for the subsequent stages and the eventual mature integrated identity.

Erikson devoted the majority of his writings to explaining the earlier phases of life in great detail (Kooden 1997; de Vries and Blando 2003). Even though gerontological research frequently cites Erikson's theory, Erikson did not provide much specificity about the later stages of the lifespan. His work has even been characterized as biased against later stages of development (Greene and Kropf 2011). For aging adults, Erikson only briefly outlined two stages, middle adulthood (age 40–65) and maturity (age 65–death), which are centered on resolving the crises of generativity versus stagnation and then ego-integrity versus despair. During the middle

adulthood stage, Erikson posited that mature adults shift their focus onto the next generation. He claimed that, if this shift does not occur, stagnation and pathological self-absorption develops (Erikson 1963). Success during the maturity phase occurs when older adults are able to reflect on their life and feel a sense of fulfillment rather than a sense of regret, bitterness, or despair.

One critique of Erikson's theory or interpretations of his theory is the heteronormative assumption that the normal life experience includes having children and that the mature adult shifts away from a focus on self to a focus on parenthood. To be sure, more and more lesbians are raising children. However, de Vries and Blando (2003) pointed out that the concept of generativity should be expanded to include numerous other experiences, such as choice of profession, friendships, and participation in volunteer activities. They posited that the central challenge of this stage of life is to shift the focus away from the self but that this shift can take on many forms besides parenthood. Similar to their heterosexual counterparts, childless older lesbians engage in numerous activities that could be viewed as an expression of generativity.

As a result of the sociopolitical changes in the USA and other developed nations over the past few decades with regard to lesbian and gay rights, many lesbian couples have gotten married and have adopted and/or given birth to children. As such, some of the more heteronormative markers referred to by Erikson and other developmental theorists can be applied to lesbians. However, for a majority of older lesbians this is not the case. Therefore, the importance of expanding the theoretical discourse to include a wide range of developmental norms cannot be overstated. Some preliminary research has been conducted to examine the application of Erikson's theory with older sexual minority samples, but this research has mostly been conducted with gay men (e.g., Cohler et al. 1998; Cornett and Hudson 1987). There remains a need for an examination of how Erikson's propositions apply to the multifaceted experiences of older lesbians.

A second theory quite often cited in gerontology research is the life-course perspective (Alley et al. 2010). This is a multidisciplinary framework that developed in reaction to the earlier more deterministic stage theories of development. The life-course approach emphasizes the role of individual agency in making life choices that are interwoven with the social and historical context (Elder 1974). The life course is conceptualized as an individual interacting with her/his context and experiencing a series of turning points in life, which subsequently impact the course of development. For example, Elder's pioneering work (1974, 1994, 1998) in this area of research examined the impact of the Great Depression on subsequent life-course development. This person-in-context perspective acknowledges that an individual's development cannot be extricated from the social and historical realities that she or he experiences. The inclusion of context in life-course theory positions it to serve as a guiding framework for examining older lesbians' and gay men's life experiences. Although Elder and colleagues never explicitly included issues related to older lesbians, the life-course perspective has been used as a framework for examining the varied life experiences of sexual-minority individuals (Fredriksen-Goldsen and Muraco 2010; Hammack 2005). The life-course perspective is sensitive to the

rapidly changing social and political context experienced by different lesbian and gay cohorts over the last few decades (Rosenfeld 2010). A handful of empirical researchers have explicitly cited the life-course perspective as a guiding theory (e.g., Herdt et al. 1997; Muraco et al. 2008; Orel and Fruhauf 2006).

Criticisms of life-course theory stem from its overly deterministic perspective for individuals who have experienced exposure to trauma or other adverse events early in life. Some have posited that this perspective has led to an overemphasis on developing interventions for youth at the expense of these later stages of life (Fine and Kotelchuck 2010). This is a particularly salient criticism when we consider the life experiences of the current cohort of American lesbians over the age of 60, and especially for those over 70, who came of age in the era when homosexuality was still criminalized and pathologized. The experience of coming to terms with a non-normative sexual identity in a hostile environment, and subsequent experiences of discrimination and alienation from family and society at large, could be perceived as risk factors for healthy development along the life course. However, in a 25-year review of the literature on aging and sexual orientation, Fredriksen-Goldsen and Muraco (2010, p. 396) found numerous "manifestations of resilience" despite the inordinate challenges of sexual-minority status for this older generation.

An additional criticism of the life-course perspective has been aimed at its failure to challenge the dominant culture's marginalization of atypical family structures and life experiences (Demo and Allen 1996). There are numerous deterministic assumptions inherent in life-course theory with regard to the timing of life events based on generation and cohort (Hagestad and Neugarten 1985). These assumptions are mostly heteronormative and do not consider, for example, the complexity of the coming out process. The coming out process occurs throughout many stages of life with varied consequences—it is not a one-time event. Sexual-minority individuals have to make decisions regarding self-disclosure with every new social interaction throughout life (Pugh 2002). Although the life-course perspective seems to be a valuable framework for examining this type of complexity, empirical research with lesbians is still needed to confirm this.

A third more positive aging framework has emerged in the field of gerontology in recent decades in contrast to previous views that represented aging only in terms of loss (Johnson and Mutchler 2014). The emphasis has moved away from documenting gerontological decline and toward identifying the factors associated with healthy aging and life satisfaction. Activity theory, which developed in reaction to the now-discredited disengagement theory, is an example of this theoretical shift (Neugarten 1979). Activity theory is still commonly cited in gerontology research (Alley et al. 2010) and emphasizes the positive aspects of aging. Its premise is that a key factor for successful aging is involvement in formal activities and social interactions as a compensation for loss of other roles, such as retirement from paid employment. Simply put, this theory asserts that staying involved in activities is linked to life satisfaction for older individuals. Lee (1987) referred to this perspective not as an explanatory theory of aging but more as a prescription for how to age successfully. Activity theory has also been criticized for inherent assumptions that people have control over the kinds of activities to which they have access. Those who are physically

impaired, poorer, or who have less access to social support are constrained in their range of activities available to them. Most of the empirical work on LGBT aging that has been done from this perspective has been conducted with gay men.

As the shift toward more positive perspectives on aging occurred, some authors began to publish work that conceptualized lesbians' and gay men's life experience from a strength-based perspective (e.g., Friend 1990; Kimmel 1978). As lesbians and heterosexual women age, they deal with similar fears and challenges—concerns about life partners, family, financial stability, and health. However, it has been suggested that some lesbians may have better skills to deal with these challenges than their heterosexual counterparts do. Kimmel (1978) introduced the concept of crisis competence, which refers to the skills that lesbians and gay men acquire as they successfully manage the crises associated with identifying as a sexual minority in a hostile environment, particularly with regard to dealing with alienation from family and friends. Kimmel (1978) contended that these crisis management skills can be later transferred to dealing with the challenges associated with aging—another stigmatized identity. Friend (1990) proposed that, in addition to crisis competence, older lesbians have the further advantage of having had more experience in questioning and rejecting the rigid gender roles ascribed to their heterosexual counterparts. For example, the negative stereotypes associated with aging for women, such as older women being judged as far less attractive than older men of the same age (Deutsch et al. 1986), appear to be have less effect on lesbians who generally identify less with typical male-defined standards of the importance of youthful beauty for women.

The crisis-competence perspective has been disputed in that, for some lesbians and gay men, the high levels of strain associated with sexual-minority status and self-disclosure have led to greater difficulties with aging (Fredriksen-Goldsen et al. 2013). In addition, it remains to be seen whether over time this "advantage" becomes less and less salient for younger lesbian cohorts, who have disclosed their sexuality in more supportive environments and do not have the same need to develop these crisis-competency skills.

A fourth lifespan theory with a more woman-centric approach is one proposed by Deanow (2011) based on the Stone Center model of relational development. The theory posits that women's psychological core is based on the development of relational skills, in contrast to the theories based on men's norms of development, which emphasize separation and individuation. The model asserts that the goal of development is to be able to engage in mutually enhancing relationships that result in five good things: increased energy, increased clarity about the self and others, greater self-worth, the ability to be one's authentic self within a relationship, and the desire to be in a relationship (Miller and Stiver 1997). In old age, those who have the capacity to engage in a mutually enhancing relationship will be able to remain engaged in their relationships and community even if physical capacities and health wane. Friendships assume even greater importance for women as they age (Rose 2007). Those without this relational capacity may withdraw from their relationships or be abandoned by family and friends.

The relational model is somewhat more embracing of lesbian experience. Deanow (2011) noted that lesbian couples might provide a template for how to accomplish the relational work of mutuality because their relationships provide equality, companionship, and the valuing of communication and emotional support by both partners. However, the model is implicitly based on the lifecycle of heterosexual women in which separating and individuating from the family is not regarded as necessary to mature and may not occur. Many lesbians undergo significant separation and individuation from their family of origin during the process of coming out due to rejection, harassment, or even victimization by family members, or in order to conceal their sexual orientation (e.g., Pilkington and D'Augelli 1995). In addition, most lesbians also expect to be self-supporting financially (Peplau and Huppin 2008); this also may lead to greater individuation in terms of educational and professional goals. In other words, lesbians' lifespan development appears to encompass the features of successful aging presented in theories based on the norms for both women and men.

In summary, by imposing deterministic theories of aging, which assume heterosexual norms over the life course, the heterogeneity of life experiences among marginalized groups, particularly those of older lesbians, is simply not taken into account. Theory is often used to guide research questions; however, if researchers ignore heterogeneity, it is almost inevitable that their research will be biased (Herek et al. 1991). This is particularly salient for older lesbians because there needs to be greater elaboration and understanding of the aging life experience that is not necessarily linked to heteronormative developmental milestones. Although gerontology as a professional community recently has shown more recognition of lesbians (e.g., American Society on Aging's LBGT Aging Issues Network (LAIN)), theories are still sorely lacking to guide research with this population (Brown 2009). The older lesbian community is diverse, with variation in sexual identification, sexual-disclosure status, social class, race, ethnicity, immigration status, discrimination experiences, gender presentation, and family structures. There remains a critical need for theories that can account for this plurality over the lifespan. The process of expanding theoretical discourse by making invisible older lesbians more visible is an important agenda that will serve to validate the life experiences of this marginalized group and empower them in the process of successful aging.

Lifespan Research on Older Lesbians

Social science researchers began to study older lesbians and gay men in the 1970s, despite the lack of lifespan theory development for older lesbians. Their findings dispelled previous negative stereotypes of lesbian elders as old, unwanted, and alone, or as alcoholic and depressed. Older lesbians were found to be functioning well in middle and old age (e.g., Minnigerode and Adelman 1978; Raphael and Robinson 1980; Van Wagenen et al. 2013). Many were in long-term relationships and had supportive friendships. Although these studies were based on nonrandom

white American samples, they illustrate that negative life outcomes are not inevitable for older lesbians.

Older lesbians studied over two successive decades have adapted well to aging according to two recent review articles. The first review focused on research on aging and sexual orientation conducted from 1984 to 2008 (Fredriksen-Goldsen and Muraco 2010). A total of 58 empirical peer-reviewed articles with samples of lesbian, gay, and bisexual adults aged 50 and older in the USA and Canada were selected for the review. Of those, 22% of the samples were exclusively women, 55% included both women and men, and 22% were exclusively men. All samples that specified the ethnicity of the participants were entirely or predominantly white and middle class.

Fredriksen-Goldsen and Muraco (2010) summarized the first wave of research in the 1980s as concerning the mental health status of lesbians and gay men. The findings illustrated that, contrary to stereotype, most rated their mental health as excellent or good, had positive self-esteem, were content with their sexual orientation, and had positive psychosocial adjustment (e.g., Berger 1984). The focus of the second wave of research was identity development (e.g., coming out), and these studies demonstrated that accepting a lesbian or gay identity was affected by social and historical contexts (e.g., Parks 1999). Subsequent research addressed psychosocial adjustment to aging and showed that older lesbians and gay men were functioning well despite having experienced discrimination (e.g., D'Augelli and Grossman 2001). Current researchers now aim to understand the social support and community-based needs and experiences of older lesbians and gay men, such as the need for housing, health, and other human services, and their samples more often include bisexual and transgender people (e.g., Richard and Brown 2006).

A limitation of the research cited above is that issues or findings uniquely relevant to lesbians often were not studied, differentiated, or discussed. When gender is taken into account, differences often emerge. For instance, Herdt et al.'s (1997) life-course study showed that older lesbians and gay men have very different lives and overall patterns of identity development. Other researchers have reported that, compared to older gay men, older lesbians had lower incomes, were more likely to have partners and larger social networks, and were less likely to live alone (Grossman et al. 2000; Quam and Whitford 1992). When lesbians are the sole focus of the research, questions are more likely to be asked that pertain uniquely to their experience (e.g., lesbian ex-lovers as friends, menopause). This points to the importance of examining gender differences as well as conducting research focused specifically on lesbians.

A second review article by Averett and Jenkins (2012) provided a more complete picture of older lesbians for the predominantly white middle-class participants who were sampled. The authors examined 28 articles published between 1997 and 2010 that focused exclusively on older lesbians who ranged in age from 50 to 70. Two major findings were identified across the 14 empirical studies that were included. First, most of the older lesbians had developed adaptive responses to a lifetime of discrimination and marginalization. They recognized that experience with oppression had made them resilient (Jones and Nystrom 2002), rejected cultural

definitions of beauty (Thompson et al. 1999), and learned to convert obstacles into opportunities (Hall and Fine 2005). Second, most formed their own informal support networks that included friends, ex-partners, the lesbian community, and online networks (e.g., Butler and Hope 1999; Comerford et al. 2004; Hash and Netting 2009; Richard and Brown 2006). Older lesbians were generally in good health, had a partner or friend to care for them if ill, and preferred to receive health care within a lesbian-friendly environment. A majority had positive feelings about being a lesbian and about being older. Major concerns for some were worries about financial security and a potential loss of control over their own lives as they aged.

Claassen (2005) conducted an interesting study of 44 mostly white middle- and upper-class lesbians aged 62 to 82, which showed that they were aging but vital. She also explored the impact of social and historical context over their lifetime. The women were recruited via personal contacts and were living in towns with notable gay communities, including Sarasota, Bradenton, and Tampa in Florida and Boone in North Carolina.

The first cohort of 15 women in the Claassen (2005) study was born during the Progressive Era and the roaring twenties (1917–1929), experienced the Depression in their youth, and became adults (age 18) during World War II. Thus, these women were born in the 1920s with the expectation that they would marry, but, during the World War II era, they were exposed to hundreds of women working in nontraditional jobs, living in groups in urban settings, and having financial independence. Three women in this cohort joined a branch of the military. The second cohort was comprised of 29 women born between 1930 and 1938 who came of age in the postwar years (1948–1956) when middle-class women were expected to be homemakers and mothers. In addition, almost all in the second cohort had read *The Well of Loneliness*, the novel by Radclyffe Hall (1928) (Hall 1990) that showed lesbians as socially isolated and rejected, but also as a natural state that should be accepted. About one half of the women in both cohorts married, and most of them had children.

The historical context had a lifelong impact on the experience of coming out and sexual identity in both youth and old age for both cohorts (Claassen 2005). The majority (77%, N=34) had identified their sexual orientation prior to the 1969 Stonewall riots. Being homosexual in the pre-Stonewall era meant keeping one's same-sex attraction private and cultivating other public aspects of the self. At the time of the study, three women (20%) from cohort 1 and six (20%) from cohort 2 still did not consider themselves to be "out." However, most appeared to enjoy the more open atmosphere of the twenty-first century. Almost all of the older lesbians had a partner and were involved in lesbian, gay, or women's community groups. About one third identified themselves as feminists and, when active, they tended to focus on abortion rights. A few were involved in the national lesbian and gay rights movement. Old age was a positive experience for most (e.g., one said: "On a scale from one to ten, life is now a twelve," p. 167).

In summary, older lesbians are still largely absent from mainstream research, and the few studies that have been done tend to be atheoretical and to use relatively small, self-selected, white, US samples. In addition, the research to date does not

tend to include an assessment of three important social contexts that are related to mental health and well-being, including: (a) personal relationships, (b) minority stress, and (c) race, ethnicity, and social class. Some findings concerning these issues from research with young and midlife lesbians, sexual minorities, or heterosexual women are reviewed briefly below and extended to older lesbians.

Social Contexts Affecting Older Lesbians

Personal Relationships

An increasing amount of research conducted in the USA indicates that personal relationships, including romantic relationships, friendships, and community relations, may provide greater benefits in old age for lesbians than for their heterosexual or sexual-minority peers. For instance, the protective factors of social support and social networks were clearly advantageous to the older lesbians studied by Fredriksen-Goldsen et al. (2012); older lesbians were more likely than older gay men to live with someone, to have more social support, and to have larger social networks.

Lesbian love relationships typically have three defining features that may contribute to successful and satisfying relationships in old age: (a) a value of equality in relationships, (b) a concern for autonomy, and (c) an expectation that each partner will contribute economically or will be economically self-supporting (see review by Rose and Eaton 2013). Compared to heterosexual couples, lesbians are more egalitarian in terms of sharing household responsibility and decision making (Connolly 2005; Kamano 2007), are more satisfied with their relationship (Kurdek 2003), work more harmoniously together (Roisman et al. 2008), demonstrate more mutual empathy, empowerment, and authenticity in the relationship (Mencher 1997), and express more relationship satisfaction when there are high levels of equality (Markey and Markey 2013). These qualities contribute to relationship longevity and satisfaction, which are likely to be beneficial to the health and well-being of older lesbians. Autonomy refers to having friends and interests outside the relationship and to making decisions independent of partner pressure. Lesbian couples typically have a high level of autonomy as well as intimacy in their relationships (e.g., Kurdek 1998) that may result in being better prepared as they age to face retirement or loss of their partner. Most lesbians expect to be financially self-supporting (Peplau and Huppin 2008), and this expectation appears to motivate lesbians to pursue higher education, seek better paying nontraditional jobs, and strive for greater career opportunities. Thus, it appears that lesbians may be well positioned to move into retirement both interpersonally and financially.

Lesbians' generally high quality relationships and autonomy in terms of interests outside the relationship may serve to mitigate loneliness, which is a significant problem that reduces well-being and health among some older adults (Hawkley and Cacioppo 2007). In a US sample of older heterosexual adults who had been married

an average of 44 years, Liu and Rook (2013) reported that emotional loneliness (i.e., lack of closeness) was a greater challenge than social loneliness (i.e., lack of companionship) for married heterosexuals, whereas social loneliness was the greater challenge for widowed or formerly married heterosexuals. Companionship was effective at reducing both types of loneliness (Liu and Rook 2013). Although untested, one might speculate that loneliness would be less prevalent among older lesbians than among older heterosexuals because lesbians' relationships and networks tend to provide high levels of both emotional intimacy and companionship.

Older lesbians may be better prepared to maintain physical intimacy with a partner as well, even if sexual interest declines over the lifespan (Garnets and Peplau 2006). Some studies have shown that lesbians tend to have sex less frequently than heterosexual or gay male couples (e.g., Blumstein and Schwartz 1983; Laumann et al. 1994), but others show no difference in frequency between heterosexual and lesbian women (e.g., Matthews et al. 2003). Lesbians are more likely than heterosexual women to experience orgasm during sex, and their sexual interactions typically last longer (e.g., Nichols 2004; Laumann et al. 1994). In addition, lesbians place more emphasis on hugging, cuddling, and fondling than on orgasm (Masters and Johnson 1979). Thus, lesbians may continue to report high satisfaction with their sex life in old age.

Kehoe (1986, 1988) conducted the only two studies that have been done to examine sexuality among lesbians age 60 to 86 (N = 100). The majority of the participants viewed sex as important in a lesbian relationship but indicated that commitment and compatibility were more important than sex. Nearly one half of the women in both studies had been in heterosexual marriages before coming out. When asked to compare having sex with women versus with men, most said that lesbian relationships were less sexually demanding and more sexually gratifying, more emotional, and more affectionate than heterosexual ones (Kehoe 1986). However, a majority of lesbians in both studies had not had sex in the past year, primarily due to lack of opportunity. Only 20 % of the older women in the 1986 sample and 43 % in the 1988 sample had a current partner. One might expect that older lesbians today might have a better chance than older heterosexual women of finding a partner, especially as social acceptance of same-sex relationships increases.

Several findings by Kehoe (1986, 1988) have been upheld consistently by research in the decades since the 1984 data were collected. Specifically, older lesbians: (1) placed a high value on friendship and focused their social lives around women friends; (2) were active in lesbian-only or lesbian/gay groups; (3) seldom maintained close connections with family members; and (4) avoided seeking help due to anticipated discrimination.

The physical changes associated with aging such as loss of beauty and weight gain also may be less stressful for lesbians than for heterosexual women or gay men. Norms for women's attractiveness, such as youthful, thin, beautiful, and feminine, appear to be less important to lesbians because they are not trying to attract men (Rothblum 1994). A lesbian partner's physical beauty does not affect her partner's sexual fulfillment, happiness, or belief that the relationship will last (Blumstein and Schwartz 1983). Lesbians have fewer body-weight concerns after coming out than

before coming out (Krakauer and Rose 2002), are less preoccupied with weight and body image than heterosexual women (Siever 1994), and show less concern about age-related physical changes than gay men do (Minnigerode and Adelman 1978). Similarly, menopause appears to be a more positive experience for lesbians than for heterosexual women. Winterich (2003) found that menopausal lesbians, unlike menopausal heterosexual women, reported feeling free to discuss their menopausal symptoms with their partners, as well as to talk about sex and to act on their desires. Furthermore, none of the lesbian partners complained about their partner's menopausal symptoms, but husbands complained about wives' symptoms.

In terms of retirement planning, Mock and Cornelius (2007) reported that US lesbian couples were more interdependent in their financial planning for retirement but did less planning than heterosexual married and cohabiting couples. Degree of retirement-lifestyle planning also was more strongly associated with relationship satisfaction for lesbians than for heterosexual couples. This suggests that there may be a greater need for lesbians to engage in financial planning for retirement, especially when they live in places that have no legal protections for lesbian couples to guarantee entitlement to each other's estate.

Women's friendships also play a critical role in health and well-being at midlife and beyond (Rose 2007). Close friendships are more predictive of older women's life satisfaction than are income or marital status (Trotman and Brody 2002). Lesbians' friendships provide affirmation, support, and love (Stanley 1996) that may become increasingly important with age. Given that formal home care social services may not provide sufficient support to older lesbians, many will have to rely on friends. Lesbians also tend to have strong friendships with ex-lovers, who remain vitally important in each other's lives as best friends, companions, or surrogate family (Shumsky 1996; Weinstock 2004). Lesbians are twice as likely as gay men or formerly married heterosexual women to have a former partner as a best friend (Fertitta 1984; Nardi and Sherrod 1994). Friendships may be even more important for single older lesbians. Raphael and Robinson (1980) found that, compared to coupled lesbians, midlife single lesbians had more lesbian friends. Single lesbians also were more likely to be involved with the gay community and to spend more time with close friends (Beeler et al. 1999).

Lesbian communities in the USA are another form of social support that may boost well-being among older lesbians. A lesbian community is defined as having four features: (1) social networks of lesbians who have a history of continuing interaction; (2) a shared group identity; (3) a set of shared values, typically feminist values; and (4) an institutional base, including LGB-defined places and organizations (Lockard 1985). Such communities most often exist in urban areas, but many also have been established as living or intentional or retirement communities (e.g., Carefree and Sugarloaf in Florida, Feminist Ecovillages in several US states). Black "woman-loving women" who are out to more people and who are more connected to the LBGT community tend to engage in higher levels of LGBT sociopolitical activities as well (Harris and Battle 2013). Lesbians' internet communities also play an important role in providing social support that is available regardless of an individual's mobility or location (Rothblum and Sablove 2005).

Overall, the positive aspects of lesbians' relationships, friendships, and community relations reviewed here suggest that older lesbians may be less lonely than other older adults, have a stronger network of friends and community members, and experience greater life satisfaction and health.

Minority Stress

Minority stress is a concept that has been developed to assess the impact on LGBT people of cultural victimization. Lesbians live in societies that stigmatize them and that routinely deny and denigrate their identities and relationships. In countries that criminalize homosexuality, lesbians may be forced into heterosexual marriages, assaulted, or even killed (e.g., Chow and Cheng 2010; Strudwick 2014). This may lead to shame, negative self-concept, self-destructive behaviors, and a victim mentality (Neisen 1993).

Meyer (1995) defined minority stress as including internalized homophobia, stigma (expectations of rejection and discrimination), and actual experiences of discrimination and violence. DiPlacido (1998) included hate crimes, discrimination, the stress of coming out, the stress of concealment, and internalized homophobia as comprising minority stress. Lesbians of color who are minority group members within white-majority countries experience dual cultural victimizations of both racism and heterosexism (Greene 1994). Ageism also compounds the stigma for older lesbians (Balsam and D'Augelli 2006). Any understanding of the impact of aging on lesbians must be understood in the context of their ability to cope with ongoing difficulties due to these various forms of heterosexism and racism.

Minority stress has been linked to health disparities for lesbians in the USA (Meyer 2003), although this has not been explored much among older lesbians. Among younger samples, minority stress has been found to affect lesbians' psychological health. For instance, lesbians (and sexual minorities in general) with greater exposure to stressors (e.g., victimization, discrimination, stigmatization, expectations of rejection, and vigilance) have been found to have higher levels of psychological distress (e.g., Lewis et al. 2001; Mays and Cochran 2001; Meyer 2003). Bias-related victimization has been linked to PTSD, depression, anxiety, and anger as well (e.g., Herek et al. 1999). Even if not personally victimized, lesbians may experience psychological distress if their friends, family, or acquaintances are victims of bias incidents. Last, the homophobic cultural context also shapes the treatment of lesbians who seek mental health or medical services; such services often are not sensitive to the unique challenges lesbians face (e.g., Brotman et al. 2003).

Minority stress also may affect lesbians' physical health, but findings are not consistent. Some researchers who compared LGB and heterosexual older adults in the USA reported health disparities; older LGB people were at higher risk of disability and mental distress (e.g., Fredriksen-Goldsen et al. 2013). Similar to older adults in the general US population, lifetime victimization, financial barriers to healthcare, obesity, and limited physical activity accounted for poor health, disability, and depression among LGB older adults. Internalized stigma also predicted disability

and depression for LGB older adults, but this was mitigated by social support and social network size. Cochran and Mays (2007) found no differences in physical health between lesbians and heterosexual women (ages 18–72) when psychological distress was taken into account.

The extent to which an individual is resilient in response to life stressors has been used in some research on U.S. populations as a way to assess healthy aging (e.g., Fredriksen-Goldsen et al. 2012). As previously noted, it has been suggested that lesbians may be more resilient than heterosexuals in response to traumatic, challenging, or threatening circumstances, such as illness or disability, because they routinely must cope with cultural victimization. Some evidence supports this notion. Balsam (2003) found that lifetime victimization was less highly correlated with trauma for lesbians and gay men than for heterosexuals. Lesbians also use psychotherapy and counseling at higher rates than heterosexuals (e.g., Rothblum and Factor 2001). Furthermore, Weston (1991) reported that lesbians often created "families of choice" or strong support systems in response to minority stress. Balsam and D'Augelli (2006) noted that the process of building an identity as an LGBT person requires significant self-awareness and personal growth, which may serve to increase resilience. Based on crisis-competence theory, Fredriksen-Goldsen and Muraco (2010) argued that lesbians and gay men may be better prepared than heterosexuals to accept aging because of their experience with negotiating transitions across the life course.

In summary, lesbians face unique risks due to minority stress that have mental- and physical-health consequences. A lifetime of coping with these unique stressors might prepare older lesbians to be more resilient in the face of life stressors, such as aging, but, as noted in the section below, this may be complicated by multiple minority identities (e.g., Hispanic, older, lesbian). However, studies have not yet been conducted to compare the mental or physical health of lesbians versus heterosexual women and men or gay men of different age, racial and ethnic groups, or nationalities.

Race, Ethnicity, and Social Class

The intersectionality of sexual orientation, race or ethnicity, and social class in the USA is rarely encompassed in research on lesbians or on aging. Even in cases when these demographic variables are assessed, there often are not a sufficient number of lesbians of color included to test for differences or identify patterns. Thus, the lifespan development of racial and ethnic minority lesbians in the USA has yet to be written. Development of a profile of the older racial and ethnic minority lesbian requires significant extrapolation from research on younger minority heterosexual adults, younger minority lesbians, or older white lesbians. The cultural context for each racial and ethnic group plays a role as well. Below we review and extend some research on African Americans, Hispanic Americans, Asian Americans, and Native Americans.

Black (heterosexual) family networks, for instance, are comprised of both biological family members and nonbiological members, and the members have high

levels of contact and support (Chatters et al. 1994). An interesting study by Mays et al. (1998) of black lesbians and gay men, age 18–70, showed that the women were more likely than the men to disclose their sexual orientation to their family. Disclosure to mothers and sisters occurred most often. Because women play a pivotal role in maintaining support networks in black families, it may be that confiding in one's mother and sister(s) may serve to strengthen bonds.

Family ties could be even more important to black lesbians as they age. The lesbians in the Mays et al. (1998) study reported significantly lower annual incomes than the gay men even though they were more likely to have had a graduate-level education. Midlife black lesbians were more likely than midlife back gay men to be currently involved in a same-sex relationship, to be cohabiting with a partner, and to have had children (Mays et al. 1998). Based on the Mays et al. (1998) study, it is possible to speculate that older black lesbians might have to rely more on family for financial support than older black gay men do. In old age, they also may be similar to white lesbians in terms of having strong personal relationships with partners, friends, and family.

To date, no research has been done on minority stress specifically among older lesbians of color. However, similar to younger lesbians of color, older US black, Hispanic/Latina, Native American, or Asian lesbians might experience an added degree of minority stress due to having multiple socially disadvantaged statuses (being old, lesbian, minority, and/or low income). For instance, Kertzner et al. (2009) found that Latina/o LGB respondents reported more depressive symptoms and lower ratings of well-being than did white LGB participants, but the authors attributed this to other mediators of Latina/o LGB health, such as acculturation status or family acceptance, rather than sexual identity. Black LGB participants reported levels of well-being and depressive symptoms that were similar to white participants' levels. However, when gender was examined, black lesbians had more symptoms of depression than black gay men did. The number of older lesbians (over age 60) was not reported, and the extent to which these findings held for them was not indicated.

Inequalities associated with race, ethnicity, and social class are risk factors that affect resilience and successful aging because they are associated with poorer physical and mental health among older (heterosexual) adults (e.g., Centers for Disease Control and Prevention and Merck Company Foundation 2007). For example, several studies indicate that in the USA, black lesbians are more likely than black heterosexual women to be depressed (e.g., Cochran and Mays 1994) and also more likely than heterosexual women to have no regular healthcare professional, to be uninsured, to be overweight/obese, to be a current smoker, and to drink more when they drink alcohol (Mays et al. 2002). Matthews and Hughes (2001) reported that black lesbians (average age of 43) used therapy/counseling significantly more often than did black heterosexual women. In contrast, Dibble et al. (2012) reported that midlife black lesbians (mean age = 52) attending a national conference had a high health-related quality of life despite the fact that many reported a high frequency of health problems. Black lesbians also were reported to respond to social invisibility within their families and the black community by engaging in self-validating processes and limiting access to their families (Glass and Few-Demo 2013).

Based on data from a national study of Asians and Latinas/os in the USA (mean age = 40), Chae and Ayala (2010) examined the relationship between sexual identity,

unfair treatment, and psychological distress. Both Asian and Latina/o LGB participants were significantly more likely than Asian and Latina/o heterosexuals to report unfair treatment, such as being treated with less courtesy and respect, or being feared, insulted, or harassed. In addition, higher levels of unfair treatment were associated with more psychological distress. No gender differences among LGB people were noted, and perhaps were not examined. Kim and Fredriksen-Goldsen (2012) also found that, as compared with Hispanic heterosexual women in their mid-30s, Hispanic lesbians were at elevated risk for problems related to smoking, asthma, and disability. However, these differences did not hold when age, education, and income were taken into account.

Less is known about sexual minority American Indians/Alaska Natives (AI/AN). Native American culture historically was more permissive toward cross-gender roles and same-sex sexuality (Garrett and Barret 2003). In some AI/AN societies, elder sexual minority individuals were even revered because it was believed that they were able to see the world from both a male and a female perspective (Jacobs 1997). AI/AN LGBT activists in 1990 adopted the term two-spirit to acknowledge this traditional belief that sexual minority individuals possess elements of both the male and female spirit. However, western colonization and Christian beliefs about the sinfulness of homosexuality led to the marginalization of and discrimination against two-spirit individuals in many AI/AN societies that continues today (Garrett and Barret 2003; Walters et al. 2006). Two-spirit women report greater discrimination and trauma within their tribes than do their heterosexual peers (Balsam et al. 2004) and often report distancing themselves from their traditional culture in order to fit into white lesbian communities (Walters et al. 2006). The combination of homophobic discrimination within AI/AN cultures and mainstream society and racism from within the white lesbian community have been linked to poorer health and other negative risk factors among AI/AN lesbians (Chae and Walters 2009).

This short summary of some issues that are likely to affect older lesbians of color in the USA shows that not much empirically based research has been conducted with older, ethnic, or racial minority lesbians. Large population studies that have been used successfully to reveal trends across combined groups of sexual minorities have insufficient numbers of lesbians to conduct analyses that take age, race, ethnicity, and social class into account. In addition, it is difficult to find and recruit sizeable numbers of racial or ethnic minority lesbians for research purposes. It is likely that our knowledge of older racial/ethnic minority lesbians within the USA will remain limited at least for the near future.

Older Lesbians Internationally

Cultural attitudes and laws concerning homosexuality vary widely throughout the world, and it is reasonable to presume that the status of older lesbians will be highly dependent on where they reside. In a study of homophobia in 32 countries drawn from the World Values Survey and European Values Study, Hadler (2012) found that democratic practices, societal affluence, and the presence of international organizations within a nation were associated with more social tolerance toward

homosexuality. Canada, the USA, and western European nations (e.g., the UK, France, Spain) had the highest tolerance of homosexuality, followed by the eastern European nations (e.g., Belarus, Russia). In contrast, China, India, and Turkey (the only Muslim country included in the study) were highly intolerant of homosexuality (Hadler 2012).

It is likely that older lesbians living in countries with legal protections or high social tolerance of homosexuality will have a better quality of life than those in repressive countries. For example, Canada decriminalized homosexuality in 1969, added sexual orientation to the Canadian Human Rights Act in 1996, and legalized same-sex marriage in 2006 (CBC News 2012). Canadian researchers and activists are now advocating for universal healthcare policies to reflect the diversity of older people's sexualities and relationships (Murray et al. 2011).

Legal changes concerning lesbian and gay rights both reflect and reinforce social acceptance. For example, Ireland decriminalized homosexuality in 1993 and outlawed discrimination on the grounds of sexual orientation with the Employment Equality Acts of 1998–2004 and the Equal Status Act of 2000 (Morrison et al. 2009). Young people in Ireland now appear to endorse the idea that sexual minorities should be protected from discrimination. Approximately 98 % of Irish heterosexual college students surveyed by Morrison et al. (2009) agreed or strongly agreed that "a person's sexual orientation should not block that person's access to basic rights and freedoms." This cohort is likely to accept older lesbians as they themselves age.

European Union policy also bodes well for future older lesbians. EU citizenship, in the Charter of Fundamental Human Rights, confers the right to protection from discrimination on the grounds of sexual orientation (European Union 2013). Therefore, LGB people are increasingly accepted and becoming visible within contemporary European life. A number of European countries have legalized same-sex marriage, further establishing full human rights for lesbians, including the Netherlands (2001), Belgium (2003), Spain (2005), Portugal (2010), and France (2013) among others, and most recently the UK (2014).

The global trend in decriminalizing homosexuality and extending same-sex marriage rights may be partially due to the influence of successful lesbian and gay rights movements in developed nations. For example, Encarnación (2011) posited that the legalization of same-sex marriage in the predominantly Catholic nation of Spain was highly influential in the progressive changes occurring in Latin America. Currently all Spanish-speaking Latin American countries and Brazil have decriminalized homosexuality. In 2007, Uruguay legalized same-sex civil unions, and Argentina legalized same-sex marriage in 2010 (Encarnación 2011).

Despite advances, repressive contexts are still prevalent internationally. Post-socialist eastern European states (i.e., those countries between the River Elbe and the Ural Mountains) are less progressive on the issue of lesbian and gay rights than are western European states (Takács and Borgos 2011). For instance, legal same-sex marriage is not available, and legal registered partnerships for same-sex couples are only recognized in Slovenia, the Czech Republic, Hungary, and Croatia (all of which are members of the EU).

Low social tolerance of lesbians still exists even in nations that have decriminalized homosexuality. In Brazil and Mexico, hate crimes against sexual minorities are rampant (UNAIDS 2009). Although most known victims are men, violence against lesbians often goes unreported, further reinforcing a hostile anti-homosexual cultural climate (UNAIDS 2009). China decriminalized homosexuality in 1997, and homosexuality was no longer classified as a mental illness in 2001. However, same-sex attraction is still largely viewed as deviant. For example, Chow and Cheng (2010) indicated that it is generally believed that China adopts a "3-no" policy—no approval, no disapproval, and no promotion—on homosexuality. The Confucian notion of filial duty stipulates that children have a duty to parents to continue the family line. Therefore, a woman's role is to marry a man and give birth to children, especially sons. The value of filial duty and fear of rejection from parents may contribute to the relatively high levels of shame that Chinese lesbians report (Chow and Cheng 2010).

Consensual same-sex relations are still illegal in 80 countries (Economist Intelligence Unit N.A. Inc. 2010). Older lesbians in countries with repressive laws or low social tolerance most likely have less certainty of even basic human rights protections, particularly if they are openly lesbian. They even may be imprisoned for life or put to death. Some countries such as Turkmenistan, Uzbekistan, Kuwait, Qatar, Malaysia, Ghana, and Belize only criminalize male homosexuality. Therefore, although lesbianism technically is legal, there is no legal protection from discrimination or hate crime victimization for lesbians. For example, gang rapes of lesbians in some African countries have been characterized as a "regular practice" (Awondo et al. 2012).

Some countries recently have reversed the global trend toward greater acceptance of homosexuality. In 2014, Russia passed laws that criminalized homosexuality and classified "homosexual propaganda" as pornography (Fierstein 2013). Anyone suspected or accused of being lesbian or gay can go to jail, and anyone who makes pro-lesbian or gay statements deemed accessible to someone underage can be arrested and fined. Many countries in Africa continue to criminalize homosexuality, with South Africa as the notable exception. In 2014, Uganda passed a law that defined some homosexual acts as crimes punishable by life in prison (Karimi and Thompson 2014). Robert Mugabe, the long-time president of Zimbabwe, often has compared homosexuals to pigs in this frequently repeated quote: "They are worse than dogs and pigs, yes worse than dogs and pigs" (Fisher 2013, p. 1).

South Africa was the first country in the world to ban homophobic discrimination in its constitution and the first African country to allow same-sex marriage. Even so, many South African lesbians are at risk for depression and other mental-health issues largely because of discrimination (Polders et al. 2008). Black lesbians interviewed by Potgieter (2003) felt strongly that it was important for them to have children in order to conform to social norms for women, as well as because they valued them and wanted to be seen as an adult. Black South African lesbians have also been the target of "corrective rape," a term used to describe a hate crime that is used to convert lesbians to heterosexuality—an attempt to "cure" them of being gay (Reddy et al. 2007; Strudwick 2014). The term was coined in South Africa in the early 2000s when such attacks began to be noticed by charity

workers. Although there has been international coverage of the issue, attacks have been escalating in terms of number and injury to the victim and have even resulted in deaths (Strudwick 2014).

Despite the serious challenges that still exist for lesbians of all ages in repressive countries, the global trend is toward greater human-rights protections for lesbians and gay men. International human-rights organizations are placing increasing pressure on many countries to decriminalize homosexuality (Awondo et al. 2012; Kordunsky 2013; Smith-Spark and Black 2013), and public opinion in support of same-sex marriage is increasing worldwide (Pew Research 2013). In addition, lesbian and gay communities and rights organizations continue to emerge. For example, thriving lesbian communities have been documented even in some of the more traditional countries, such as Thailand and the Philippines (Jackson 2001). In India, there are burgeoning LGBT communities in the large urban cities (Dave 2010). In sum, the quality of life for older lesbians most likely will improve as decriminalization and human rights laws and LGBT activism continue to spread internationally.

Directions for Research

Greater understanding of older lesbians' lives is important for a number of reasons. Older lesbians: (a) represent a growing percentage of the aging population; (b) hold a hidden history spanning decades of dramatic social change; (c) bring an added dimension to knowledge of older women's sexuality; (d) provide a cultural heritage for younger lesbians; and (e) provide views of hidden subcultures created by social marginalization and of lives lived successfully without men (Westwood 2013). More needs to be learned about older lesbians' health, housing, and social care needs around the world. Research on lesbians also will serve to challenge and remedy the heteronormative and gendered assumptions embedded in theories of development (Rose 2000).

Although the number of studies about older lesbians and gay men is growing, this work often has limitations (Grossman 2008). First, studies tend to over represent gay men and under represent lesbians, as is the case for psychological research on LGBT populations more generally (Lee and Crawford 2007). Theory and research on sexual minorities tend to elevate commonalities and to ignore or not test for gender differences. Because women's development, needs, and issues are different from men's, Averett and Jenkins (2012) have argued that theory, research, and practice should consider women separately or with great attention to those differences.

Large-scale, empirically based studies of older lesbians would contribute greatly to what is known but, admittedly, researchers will confront difficulties (Westwood 2013). One difficulty pertains to how to define who is a lesbian. Self-definition as "lesbian" often is used by researchers but will not capture women who do not label themselves with this term or who do not embrace a lesbian identity as a primary identity. Further, some older lesbians' experiences reflect sexual fluidity, that is, movement among heterosexual, bisexual, and lesbian identities. Others may define

themselves as political lesbians, who became lesbians due to their radical feminist stance, or those who are simply "in love with my best friend who happens to be a woman." A second challenge is in finding older lesbian participants. Older lesbians are not only a hidden population, but are a population in hiding (Traies 2012). Many older lesbians live in clandestine communities and are very careful about whom they admit to their networks. This is particularly true in countries that criminalize homosexuality. A third difficulty is that a representative sampling of lesbians is nearly impossible to obtain for the reason cited above; they are an undefined population (Meyer and Wilson 2009). Samples of racial and ethnic minority lesbians are particularly difficult to locate, partly because samples tend to reflect the identity of the (mostly white) researchers.

Participatory action research (PAR) has been proposed as a way to address some of the challenges mentioned above (e.g., Ray 2007; Westwood 2013). In PAR, the participants become co-researchers and genuine partners in the project and participate in what knowledge is produced. A collaborative research approach ensures participation by communities affected by the issue being studied (Foster and Stanek 2007). PAR is considered particularly appropriate for addressing health disparities among underserved minorities, who often have limited or negative histories with health research (Bogart and Uyeda 2009; Wells and Jones 2009). It is useful also for identifying social disparities in health for minority or disadvantaged lesbians (Northridge et al. 2007). In addition, PAR may be especially useful in providing access to those who do not identify as lesbian or who wish to remain hidden. Fenge (2010) used this strategy successfully to recruit older lesbians living in rural areas.

Information about older racial and ethnic minority lesbians or low-income lesbians is sorely lacking and is clearly an important area for future research. Intersectionality theory (e.g., Shields 2008) might provide a useful framework for research with lesbians of color. Studying each identity separately does not provide an adequate profile of these groups. The category "Hispanic," for instance, does not capture differences between Hispanic women and men. "Sexual minorities" does not reveal differences between lesbians and bisexual women or between lesbians and gay men. "Black lesbians" does not identify differences between poor and middle-class black lesbians. Thus, studies of identity intersections (e.g., poor older black lesbians) will be more informative than studies of blacks, women, poor people, elders, or sexual minorities separately (Kertzner et al. 2009). It is probable that poor older black lesbians have life experiences or outcomes (and a unique combination of disadvantages) that differ from those of blacks, women, or elders as a whole.

In summary, some features of the invisible older lesbian have begun to become visible through research that has been conducted on small samples of white, middle-class, older lesbians in the USA. However, there are many possible directions for future research. Theory has yet to be developed (or expanded) that can direct future research. Longitudinal research is required to examine what impact the changing sociopolitical environment in the USA and the developed nations has on lesbians over the life course. More knowledge is needed concerning older lesbians with multiple primary identities (e.g., race, ethnicity, social class). Cross-cultural comparisons

also will be valuable to better understand the experience of older lesbians in developing countries, many of which still have archaic and discriminatory laws and cultural standards.

Conclusion

The intersection of historical cohort and social change will continue to have a dramatic impact on subsequent generations of lesbians. One might expect that those born today in Canada, the USA , and other countries that recognize legal same-sex marriage will have different and more open life experiences than lesbians from previous cohorts. The legal recognition of same-sex marriage is a positive change that signifies the end of discriminatory practices and second-class citizenship (e.g., Lannutti 2005). Retirement communities for lesbians have been evolving in the USA and may be more available as the baby-boomer generation retires (Rabin and Slater 2005), and LGBT-specific social services are being developed in urban areas (Adelman et al. 2006; Kling and Kimmel 2006). Also, as previously noted, there remains a critical need for research with older lesbians that can inform public policy and provide greater insight into their unique needs, especially in developing nations where legal protections are not available and homophobic attitudes still prevail. As visibility, theory, research, policy, and laws progress globally in the direction of validation, older lesbians are sure to become "newer every day" (Dickinson 1986, p. 499).

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Clinical Interventions to Empower Older Women

Jennifer L. O'Brien and Susan Krauss Whitbourne

Clinical interventions for older women draw upon knowledge about mental health in later life but must be tailored to the specific challenges women face as they grow older in Western societies that typically view and portray them negatively. In this chapter, we present a model for understanding the concerns of older women and offer suggestions for mental health practitioners to follow in providing care to this population.

According to the biopsychosocial model of lifespan development, physical, psychological, and social factors interact to influence the trajectory of an individual's aging process (Whitbourne and Whitbourne 2014). This model predicts that there are large individual differences in the nature and progression of age-related changes, many of which are influenced by broad social factors. For older women in particular, societal and psychological issues related to gender play a crucial role in influencing mental and physical health (Whitbourne and Bookwala in press). In this chapter, we discuss the effect of gender on the mental health of older women. Through a feminist lens, we then explore specific clinical interventions that can improve older women's mental health. Throughout the chapter, we focus on the impact of social constraints on and cultural stereotypes of older women that can act as barriers to attaining appropriate treatment.

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Overview of Mental Health Issues for Older Women

Interaction of Gender and Aging in Rates of Psychological Disorders

Social factors interact with biological and psychological changes to influence adults' mental health throughout their later years. In the case of older women, negative stereotypes and discrimination interact with inequities in access to health care and other resources (Antonucci et al. 2010) to create particular challenges. Further, older women face specific challenges due to gender differences in life expectancy that mean they are more likely during this time period to face major life stressors such as widowhood, relocation, financial strain, and caregiving.

Research in this area has demonstrated that there are several life factors that, if present during adulthood, may predict higher rates of depression among women over 60. Kasen et al. (2010) followed a group of women over a period of 30 years and found that early life stressors, more negative life events in adulthood, and higher rates of marital stress influenced the development of major depressive disorder (MDD) later in life, independent of physical disability and the experience of prior depressive episodes. In addition to personal stressors that can accumulate over time, women's lifelong exposure to gender discrimination, combined with negative social attitudes toward aging, can create a so-called "multiple jeopardy" of ageism, sexism, and racism (Ferraro and Farmer 1996). This situation may be compounded by additional experiences of discrimination based on personal factors, such as homophobia, classism, and bias against religious practices. Such risk factors for the development of psychopathology are balanced by a number of protective factors including the accumulation of life experiences that can build resilience throughout the woman's life (Whitbourne and Meeks 2010).

Nevertheless, the balance of risk and protective factors seems to weigh against women for at least most of their lives in terms of rates of psychological disorders and symptoms. In MDD, individuals experience an extremely sad mood or anhedonia (loss of interest in usual activities) that lasts most of the time for at least 2 weeks and is not typical of the individual's usual mood (American Psychiatric Association 2013). The individual may also experience other symptoms including appetite and sleep disturbance, feelings of guilt, difficulty concentrating, and a low sense of self-worth. Recent 1-year prevalence rates indicate that 9.4% of women between 50 and 54 years old in the US experience MDD, whereas the rate is only 6.3% for men. In the next older age group of men and women 65 and older, prevalence rates are considerably lower but remain higher in women (2.6%) than men (1.5%). Rates of clinically significant depressive symptoms are higher than the rates of MDD, and the gender difference persists among women and men 65 and older. Approximately 16% of women in this age group report symptoms of depression compared to 11% of men (Federal Interagency Forum on Age-Related Statistics 2013).

Findings about the higher rates of depression among older women are particularly troubling, given the association between depression and cognitive decline,

physical illness, and functional impairment (Federal Interagency Forum on Age-Related Statistics 2013). Further, associated with their higher life expectancy, older women have higher prevalence and severity of physical illness than older men do (Kryspin-Exner et al. 2011), and cognitive decline and physical illness are stressors that can affect mental health and well-being. From the biopsychosocial perspective, there are many factors that work together to contribute to mental health issues for older women.

Similar to MDD, anxiety disorders are more prevalent in women than in men throughout much of the life course. The main feature of an anxiety disorder is a sense of dread about what might happen in the future. In addition to having the unpleasant feelings associated with anxiety, people with anxiety disorders go to great lengths to avoid anxiety-provoking situations (American Psychiatric Association 2013). Anxiety disorders range in specific symptomatology, and include social anxiety, generalized anxiety disorder, obsessive compulsive disorder, phobias, and panic disorder, among others (American Psychological Association 2013). These are the most highly prevalent of all psychological disorders in the general population with the exception of substance use disorders. They have a lifetime prevalence of 28.8% and an overall 12-month prevalence of 18.1% in the USA. Nearly 23% of all 12-month prevalence cases are classified as severe. The percentage of people who report lifetime prevalence across all anxiety disorders peaks between the ages of 30 and 44, with a sharp drop-off to 15.3% among people 60 years and older (Kessler et al. 2005). Older adults are less likely (7%) than young adults (21%) and middle-aged adults (19%) to be diagnosed with an anxiety disorder. However, as with MDD, there is a significant gender difference, as older women are nearly five times more likely than older men to be diagnosed with an anxiety disorder (Gum et al. 2009).

By the time individuals are in their 80s, these gender differences in depressive and anxiety disorders appear to dissipate (Pachana et al. 2012). It is possible that the disappearance of gender differences reflects older women's greater capacity to handle the stresses associated with the aging process due to their lifetime of experience with gender inequity (Eagly et al. 2012).

Gender differences throughout the majority of adulthood in mental health indicators may reflect, to a certain extent, unique biological factors associated with menopause (Morrison et al. 2011). Comorbidities with other diseases, physical impairment, and unhealthy lifestyle factors such as obesity and smoking also play an important role in the development of psychopathology throughout the lifespan (Byers et al. 2012). Nevertheless, physical changes must be interpreted in terms of attitudes toward older women. For example, in a study of women across European countries, postmenopausal women were found to be more likely to view their bodies in a negative way in countries that emphasize stereotyped views of older women as losing their attractiveness (McKinley and Lyon 2008).

Racial differences in rates of depressive symptoms in older women also support the notion that the demographics of mental health reflect complex biopsychosocial interactions. Spence et al. (2011) compared rates of depressive symptoms between black and white American women aged 52–81 years old in a large sample drawn

from the National Longitudinal Survey of Mature Women. Older Black women had persistently higher levels of depressive symptoms than did older White women, perhaps due to accumulated minority stress. Poverty presents another risk factor for depression in later life in general, but particularly for older women as they are more likely than older men to be poor (Kim et al. 2013). These findings highlight the importance of gender and racial inequities in socioeconomic status as contributing to the risk for psychological disorders in later life. Simply put, given that the experience of social oppression is inherently negative, it is not surprising that older women who are also social minorities are likely to encounter mental health difficulties such as depression.

In many of the studies of mental health and aging, however, researchers "control" for gender, social class, and physical health, thus preventing other researchers from gaining a full understanding of how complex biopsychosocial factors interact to influence women's experience of psychological disorders. For example, in the Sydney Memory and Aging Study, immune functioning was related to depressive (but not anxiety) symptoms in a large community sample of older Australian adults studied prospectively (Baune et al. 2012). However, all analyses were adjusted for gender. In addition, researchers may tacitly accept negative stereotypes of aging women in analyzing patterns of psychopathology in later life. Henriques-Calado et al. (2013) used the Five-Factor Model personality framework to predict the development of depressive symptoms in older women. They observed that women high in neuroticism, agreeableness, and conscientiousness tended to develop heightened levels of self-criticism, and women high in neuroticism and extraversion were higher in dependency. Both of these outcomes are related to depressive experiences; however, these may also be a product of women's adoption of social attitudes toward older women as both flawed and lacking power.

As a result of studies that do not specifically examine the impact of sociocultural factors, much less gender by age interactions, we are only just beginning to gain insight into the underlying processes that differentially affect women and men. With knowledge of the importance of studying gender, we may hope that future studies continue to provide a richer, broader understanding of the experience of aging in older women.

Impact of Psychological Disorders on the Lives of Older Women

Whatever the causes, the consequences of psychological disorders for older women not only detract from the quality of life, but can significantly shorten a woman's life as well. In the Survey of Health and Living Status in Taiwan, a study of nearly 1800 men and women aged 65 and older, chronic depression was related to higher mortality rates in women but not men. Incident depression (i.e., depression first noted in later life) was related to higher mortality for men primarily due to a higher incidence of deaths from cardiovascular disease (Teng et al. 2013). Similarly, in a 5-year longitudinal study of over 500 middle-aged and older women in the USA, recurrent MDD predicted the later development of diabetes as well as cardiovascular disease (Windle and Windle 2013).

In addition to heightened rates of morbidity and mortality, older women with depressive symptoms experience sharper rates of cognitive decline than their non-depressed counterparts. In a prospective study, Spira et al. (2012) observed steeper rates of decline in cognition and working memory among women with a greater number of depressive symptoms.

Older women's higher rates of depression are associated with a host of other difficulties that may erode their quality of life. Among the nearly 2000 women included in the USA Women's Health Initiative study (Vahia et al. 2010), the 20% with subthreshold depression were lower on measures of successful aging, optimism, personal mastery, and self-efficacy, and they reported more anxiety and hostility than their nondepressed counterparts. In other words, one in five women in that sample not only showed depressive symptomatology, but was unable to achieve virtually all components of successful aging as defined in this study.

Despite the factors that can increase older women's risk for developing depressive symptoms throughout their lifespan, there are many ways in which older women can be empowered to improve their well-being. These include both individual considerations and specific clinical interventions. For instance, research has shown that women who suffer from depressive symptoms for years, if not decades, can benefit at any point in life from psychotherapy. As studies of older women show, however, such interventions are particularly important in the later years of life when these symptoms can place them at risk for both physical illness and normative age-related changes.

Perspectives from Successful Aging on Older Women's Resilience

Up until this point we have emphasized unfavorable outcomes in understanding the experiences of older women. There is also ample evidence of the resilience of older women, and their ability to resist negative stereotypes about aging, avoid being hampered in their enjoyment of life by physical changes, and maintain healthy and rewarding relationships with family and friends. In two large-scale studies intended to document gender, class, and racial/ethnic differences in the prevalence of successful aging, women were found to have higher successful aging scores than men both in objectively- (McLaughlin et al. 2010) and subjectively- (Strawbridge et al. 2002) rated indices.

According to the standard definition offered by Rowe and Kahn (1998), older adults are considered to be "successful agers" if they meet the criteria of being free of disease and disability, high in cognitive and physical functioning, and engaged with life. Critics of this definition maintain that it places undue emphasis on being disability- and disease-free and, therefore is overly restrictive (Vahia et al. 2012). Moreover, it fails to incorporate social context, such as the economic challenges and discrimination faced by older individuals, particularly those from marginalized groups.

By contrast, the World Health Organization (WHO; 2002) suggested the use of the term "active ageing" and in its definition incorporates social and contextual factors as well as the potential for individuals to have objectively-defined poor

health but high subjective well-being. Noteworthy is the fact that WHO makes explicit the role of autonomy and independence, placing greater emphasis on the individual's ability to get around in the environment, rather than on whether or not the individual needs physical accommodations due to disability. Moreover, at the broadest levels, the WHO model proposes that gender and culture influence the direct determinants of external factors that can impinge on older individuals from their immediate environment. Thus, the WHO approach to understanding successful aging explicitly provides a role for gender, unlike the Rowe and Kahn model.

Using the WHO criteria for active ageing, López et al. (2011) observed higher proportions of active agers among men (38.4%) than women (21.9%). They related this gender difference to those broad social and contextual factors including gender inequalities in the workplace, economic and personal autonomy, and cultural images of attractiveness in which older male celebrities enjoy more favorable status than their female counterparts. It is possible that as current cohorts of middle-aged women grow older, they are embracing positions of greater power, replacing traditional stereotypes with images that reflect more favorable attitudes toward age, gender, and broader lifestyle options (Muhlbauer and Chrisler 2012). At present, however, these redefinitions of traditional gender roles are more likely to prevail among women who enjoy higher socioeconomic status and its associated benefits including the ability to take advantage of prevention measures that enhance their physical and mental health.

The WHO definition of active ageing overlaps well with the biopsychosocial perspective by bringing sociocultural factors into a position of central prominence. Researchers interested in sociocultural factors have examined the role of support from a woman's social network in helping her to maintain a healthy and independent lifestyle. Netuveli et al. (2008), using data from the British Household Panel Survey, found that women over 50 who had high levels of social support in the form of friends and close family relationships were more resilient to sources of adversity including functional limitations, bereavement, marital separation, and poverty regardless of their socioeconomic status. Similarly, in the Australian Longitudinal Study of Women's Health, women with larger social networks, including widows and caregivers, had more favorable mental health outcomes than those with smaller networks (McLaughlin et al. 2011). Within a small, focused sample of women living alone with a form of neurocognitive disorder, Frazer et al. (2012) found that having close interpersonal relationships served to bolster the women's ability to cope with their loss of independence.

Social discrimination may make it more difficult for older women to identify and then find sources of social support (Fawcett and Reynolds 2010). Women who adhere to the traditional view that support should come from either their spouses or close relatives may fail to be able to take advantage of more extensive friendship networks. Heterosexual married women are more likely to outlive their husbands, which means that they could potentially lose their only source of social support when they become widows. Similarly, women who rely extensively or exclusively on family members may place themselves at risk of social isolation as those relatives die or move away.

Nevertheless, the fact that the majority of older women are able to overcome the many obstacles to successful or active aging suggests that they possess an inner resilience that protects them from the potential ravages of exposure to ageism and sexism. According to Skultety and Whitbourne (2004), older women are more likely than men to engage in "identity assimilation" in order to protect themselves from frequent threats to their identity, particularly in the context of gender stereotypes and discrimination against older women. This means that they define themselves in positive and healthy ways and do not allow experiences related to aging to alter their core sense of self. Further, as pointed out by Sneed and Whitbourne (2003), older women may engage in denial as a self-protective mechanism against these stereotypes of aging, thus they do not see themselves as in need of intervention.

These findings suggest that, from a feminist perspective, in order to capitalize on their potential for resilience, women must overcome traditional stereotypes and redefine gender roles to encompass positive attitudes toward both aging and gender (Muhlbauer and Chrisler 2012). On the one hand, as suggested in the concept of identity assimilation, women must buffer their sense of identity as they get older by building a protective barrier between their experiences and their internal self-definition. Using a more proactive approach, they can question and challenge the negative portrayal of older women in contexts ranging from the workplace to the media. However, such a transition may be difficult for women to achieve, particularly if they are living in societies that continue to reinforce the frailty, unattractiveness, and vulnerability of older women. This is precisely the area in which mental health interventions can be most useful for older women. We argue that, by operating from a distinctly feminist framework, mental health professionals should work with their clients to build on their potential for resilience to define themselves in ways that actively maintain their positive sense of identity.

Interventions to Promote Mental Health for Aging Women

Psychological interventions that build on older women's potential for resilience can improve mental health outcomes by helping clients to bolster their personality strengths. This may be achieved by concentrating on their lifetime experiences of successfully coping with personal stressors, exposure to negative stereotypes about women, and discrimination in the public sphere. It is important to acknowledge that women who are chronically depressed or anxious, or who first seek treatment in later life, may possess these strengths even as they have struggled with other issues that impinge on their mental health.

Unfortunately, the process of building on older women's resilience is made more difficult by the many mixed signals they receive not only from health professionals but from society in general. According to Lips and Hastings (2012), older women are encouraged to become more engaged in leadership roles that take advantage of their seniority and experience; however, they are simultaneously presented with images that emphasize the limitations associated with aging (such as the greater

risk for dementia and osteoporosis) and visions of the later years as involving rest and retirement. For example, if women decide to retire early, they place themselves in economic jeopardy, which, in turn, increases their risk of mental and physical illness. If they decide to continue working, they are less likely to be able to find fulfillment in other domains, such as engaging in hobbies and spending time with their families and friends. In the area of physical activity, women are encouraged to maintain their health by exercising; however, they are also warned against the risks they present to themselves of physical injury.

From a feminist perspective, obtaining adequate interventions necessarily entails that older women are not only able to access those services, but must overcome powerful sociocultural messages that lead them to perceive themselves as powerless or invisible. After a lifetime of socialization to accept stereotypical views of women, particularly in more traditional cultures, it may be difficult for women to acknowledge the impact that these messages have had on them.

Nonpsychotherapeutic Approaches to Mental Health Interventions with Older Women

A number of existing approaches to the mental health treatment of older women are based on traditional models that do not question social attitudes or directly address discrimination, yet can have beneficial outcomes. As we discussed above, women traditionally derive social support from within their own families. However, when other family members become infirm, these older women, who are now their caregivers, may find themselves in a position of needing to look outside the family for both emotional and practical help. Support groups for caregivers as well as mental health treatment specifically focused on caregiving issues can, therefore, become critical psychosocial interventions (Smith 2007).

Organized religion is a second source of support for older women. Attendance at religious services can help to increase resilience by way of accessing spirituality (which has long been found to improve well-being) and providing social support within an individual's community. Vahia et al. (2011) measured variables related to positive psychological functioning (including self-reported optimism and depression) in a large sample of older women. They found that spirituality and attendance at organized religious services and rituals was significantly associated with higher resilience. Membership in a spiritual organization might also have an indirect positive effect on mental health for older women who endure stressful life events, by not only offering a source of emotional support, but by providing a sense of meaning and context for life events.

Beyond social support, increasing research attention has focused on studying positive effects of mental activity on improving aging-related decline in older women. Liddle et al. (2012) found that participating in artistic endeavors, such as painting and playing musical instruments, was associated with improved cognitive functioning and emotional well-being. Further, they found that women who had stopped partaking in these activities tended to report greater decline in mental health-related quality of life.

Research on cognitive activity in general has shown that older women appear to benefit from challenging mental engagement regardless of the specific type of intervention. Such benefits include improved memory and decreased cognitive decline (Evers et al. 2011). Carlson et al. (2012) found that older women's resilience (defined as reduced risk of cognitive impairment) increased with participation in a wide variety of activities, as did their performance on measures of neurocognitive decline and dementia.

Video game interventions are perhaps the newest area to be examined as methods of promoting cognitive functioning in older adults (Bavelier et al. 2012). Because older women appear to be drawn to so-called "casual" (vs. hardcore) video games such as Bejeweled Blitz and other tile-matching online games (Whitbourne et al. 2013), these provide an opportunity for mental health practitioners to include them in interventions. Not only do these games promote cognitive functioning, but they also help older women overcome social isolation by allowing them to maintain contact with family and friends outside of their homes and communities when they participate in online interactive games. Playing board games or card games also has beneficial impact on cognitive functioning, and may be preferable to online games as they can be more easily accessed.

Physical exercise plays a vital role in promoting older women's well-being. Indeed, researchers have proposed that one major factor associated with the higher prevalence of Alzheimer's disease in older women is that they are less likely than older men to engage in physical exercise. Exercise, when combined with control of dietary intake of fat and sugar, was found in one controlled study to show improved levels of beta-amyloid, known to be a risk factor for Alzheimer's disease (Baker et al. 2012). Direct benefits of exercise on psychological functioning have also been shown in numerous investigations of older adults. Even a minimal level of exercise involvement, such as walking for 60 min four times per week, can reduce depression (Legrand and Mille 2009) as well as improve memory (Evers et al. 2011). Klusmann et al. (2012) found that, in a sample of women over 70, participating in an exercise program lowered their "aging dissatisfaction."

In a study of the effect of exercise on self-esteem and depressive symptoms among Korean elders, Sung (2009) compared a group of older adult women under and over the age of 75 throughout a 16-week group-oriented exercise program. Both groups of women experienced benefits from the exercise program, but the women over 75 showed significantly greater improvement in self-esteem than did those under 75. Further, Sung found that both groups of women showed improvements in body strength, flexibility, and static balance. Interventions such as these not only benefit women's mental health, but also reduce the likelihood that they will suffer injuries from falling, which are a major source of disability and, ultimately, mortality in older adults (Tinetti and Kumar 2010).

The type of exercise recommended to an older woman should take into account her current level of physical ability. For older women with mobility limitations, less rigorous forms of exercise are best; these might include swimming or water exercise. Rica et al. (2013) found that a water-based exercise program benefited heavy-weight older women in physical fitness, muscle strength, and overall quality of life.

From a biopsychosocial perspective, these studies on the benefits of exercise show that, ideally, interventions targeted at older women should address mental health issues from a variety of approaches. However, older women may not spontaneously seek out such interventions, at least not the present cohorts of those 65 and older. They may need to be empowered to see themselves as having the potential to engage in such "masculine" activities as weight-lifting, use of the treadmill, or other activities in the gym. In addition, adherence to an exercise regimen requires commitment and persistence in situations that might feel physically uncomfortable, particularly for women who did not spend their lives playing sports or being physically active. These older women might become frustrated with a new exercise program and discontinue before they receive much benefit.

It is important to note, then, that many different types of exercise activities have been found to be beneficial for older women. As such, older women should be advised to seek out multiple forms of physical activity and establish their own preferences for engaging in regular exercise. Keeping in mind their varied physical abilities, an exercise routine for older women should incorporate both their mobility limitations and their preferences for activity type. For example, some women may prefer only one type of physical activity, such as walking, and might choose a routine where they go on 60-min walks around their neighborhood each week. Other women might prefer a more varied routine, for example, attend one water exercise class per week, walk 2 days per week, and attend one yoga class per week. Women with limited access to resources such as a gym or fitness classes can still find many opportunities to enhance their physical fitness. Activities, such as dancing, playing with children or pets, and work around the home, such as gardening, lifting, and cleaning, can also be valuable sources of exercise. Finding the right "fit" for an exercise routine and creatively seeking out resources and opportunities for physical activity can help older women to overcome the barriers we have mentioned.

Exercise can also have social benefits. Group classes offer the opportunity for older women to meet other participants and, in this way, expand their social support networks. In addition, by being part of a group effort, class members may feel more motivated than they otherwise would if they were exercising on their own. Such opportunities may also enhance feelings of community and renewal (Peters 2012).

From a biopsychosocial perspective, then, healthcare professionals can encourage older women to incorporate changes into their daily routines that promote their physical and cognitive functioning. Given the intimate link between body and mind, these interventions can provide benefits not only by alleviating symptoms of depression and anxiety but by helping women become mentally and physically stronger.

Barriers to Mental Health Interventions with Older Women

Despite the potential for mental health treatment to succeed in providing older women with beneficial interventions, there remain challenges relevant both to clients and to professionals alike. These challenges stem from negative stereotypical

views of older women that regard them as weak, ineffective, dependent, frail, and incapable of change (Martin 2012).

First, geographical location plays a large role in creating barriers for older women living in rural areas with regard to access to professional mental health services. However, the benefits derived from mental health services can be obtained for these women through other sources, such as increased community involvement with neighbors and relatives by sharing their experiences and knowledge, such as by passing down stories and traditions, recipes, and cultural rituals. Older women living in rural areas can also empower themselves through active involvement in volunteer work or by socializing in community centers and religious congregations.

From the client's point of view, barriers to treatment may exist because this cohort of older adults tends to attach a stigma to people who seek psychological interventions. As noted by Smith (2007), older adults tend to underutilize mental health services in the USA, and typically favor seeing primary care providers rather than mental health professionals. Although older women may have higher rates of diagnosed depressive and anxiety disorders than men due to their greater willingness to report mental health symptoms, they may nevertheless believe that they should be able to resolve their problems on their own. Their tendency to use self-protective mechanisms such as identity assimilation and denial with regard to age-related changes may lead older women to resist seeing themselves as in need of outside intervention. As a result of marginalization, older women may also come to feel that they are not deserving of the potential benefits of therapy.

Other limitations relate to access to mental health services. If older women do not have sufficient insurance coverage and have limited financial resources (a situation that is more likely to affect older women than older men), they may not be willing or able to pay for treatment. As noted by Davidson and a team of international collaborators (2012), organizational factors with regard to policies about healthcare, for instance, often dismiss the specific needs of older women in the area of cardiovascular disease. In the area of mental health care, older women are more likely to be exposed to gender-based violence, which can have obvious negative effects on their physical as well as mental health. Health professionals who provide services to older women, particularly widows, are relatively unprepared to offer appropriate treatment (Davidson et al. 2011).

Adding to these structural problems, there are attitudinal factors that compromise the services offered to older women. Mental health professionals themselves may hold negative attitudes toward older women that can interfere with the progress of therapy. As Muhlbauer and Chrisler (2012) pointed out, healthcare providers who interact with older women are "just as likely as anyone else to hold stereotypes, biases, and misconceptions" against their patients, which negatively impact the quality of the healthcare older women receive (p. 141). Although women may face these challenges more often in primary care settings than in the context of psychotherapy, there is still reason to believe that, due to limitations in the numbers of trained geropsychologists, older women might experience ageist attitudes as they seek out mental health professionals.

To begin to overcome these barriers, then, geropsychology needs to be incorporated into professional graduate and postlicensure training (Karel et al. 2012; Qualls et al. 2010). By familiarizing themselves with the special concerns of older adults (American Psychological Association 2014), and the combined influence of ageism and sexism, mental health providers can recognize that it is possible to empower older women by working to break down societal barriers to achieving wellness. One type of mental health intervention that focuses on empowering clients through examining the impact of sexism on well-being is feminist psychotherapy.

Principles of Feminist Therapy with Older Women

Feminist therapy developed in the context of the feminist movement of the 1960s, when feminist psychologists first began to conceptualize psychological distress as originating from the discrimination faced by women in contemporary Western societies. This view, much like the sociocultural approach to psychological disorders, contrasts with traditional views of psychopathology that view distress as arising from within the individual. According to Brown (2008), the central notion of feminist therapy is that the construction of gender impacts the individual and is what leads to emotional distress in women. Correspondingly, feminist psychotherapy emphasizes the individual's autonomy and capacity for insight, rather than imposing conceptualizations that are based on nomenclature from the mainstream culture.

From the standpoint of feminist therapy, traditional psychological terminology derives from a paternalistic, hierarchical culture that, in itself, creates distress for minority individuals who exist within it. In keeping with its refusal to impose these hierarchies on their clients, feminist psychotherapists do not act as "experts" in the therapeutic relationship; instead they approach therapy from an egalitarian framework, where both client and therapist are equals in the relationship and in the treatment.

Feminist therapy functions more as a conceptual or meta-theoretical framework than a set of techniques and, therefore, can be integrated with many existing, evidence-based, psychotherapeutic modalities. For instance, a cognitive-behavioral therapist working within the feminist tradition would not so much assign "homework" as "invite" the client to explore ways to access her own ability to be powerful. Brown (2008) wrote that almost any type of therapeutic intervention can be "feminist" if it focuses on creating a feminist consciousness through a collaborative, egalitarian relationship that ultimately serves to empower the individual client.

Psychotherapy with older women from a feminist perspective, then, should focus on exploring the impact of the marginalization of older women in the larger society and how it impacts the particular client. Lips and Hastings (2012) pointed to the importance of therapists addressing their own biases about older women in order to create a safe environment in the therapeutic relationship. Ultimately, by addressing the various biases and their impact on the individual, the client can become

empowered to overcome at least some of the structural and attitudinal barriers she faces and work proactively to seek resources that will enhance her well-being (such as exercise and social support). From a feminist psychotherapeutic perspective, this attitudinal shift will, in turn, help to reduce the woman's experience of distress and level of behavioral dysfunction. Further, when older women feel that they have a trusting and safe relationship with their therapist, this perception in itself can help them to feel less isolated and helpless (Rondon 2005).

Feminist therapists working with older women can enhance the well-being of their clients by providing consultation about the issues of access to healthcare, social support, and self-esteem. Travis et al. (2012) suggested that feminist therapists working with older women can empower their clients by improving their ability to navigate around the gender disparities they face in the healthcare system. McHugh (2012) proposed that feminist therapists help their clients to build social support by encouraging them to reflect on the multiple strengths they have gained throughout their lives. She suggested that older women can gain the social support benefits to mental health by joining organizations and engaging in the life of their communities. Similarly, Rondon (2005) discussed the role that therapists can play in helping older women to capitalize on their strengths by seizing the opportunity for growth in older age. Instead of viewing their status as essentially an insult to their ego, older women can be helped to focus on their life skills and experiences, which can, in turn, enhance their sense of self. Such work would build on the tendency of mentally healthy older women to minimize the impact of aging on their sense of identity through the process of identity assimilation.

In addition to giving priority to those essential themes, therapists working from a modern feminist perspective must specifically address the client's adoption of stereotyped vs. liberated attitudes toward women in society (Muhlbauer and Chrisler 2012). Within the Baby Boomer generation alone, there is a split between those who are "empowered and politicized" and those who, due to financial limitations and cultural background, remain "marginalized and silenced."Thus, in keeping with the feminist therapy tradition, feminist therapists working with older women should explore with their clients their attitudes toward themselves as older women and encourage them to feel both more integrated into their communities and more positive about their position within society as a whole. Women from the Greatest Generation are, by contrast, more likely to ascribe to traditional norms, and so this older group of older women may require even more orientation in order to benefit from a feminist perspective.

Incorporating Feminist Therapy into Evidence-Based Treatments with Older Women

As a meta-therapeutic approach, feminist therapy does not provide recommendations for specific interventions but instead is integrated into existing frameworks for treatment. From this model, feminist psychotherapists should, as is true for

all mental health professionals, follow recommendations for evidence-based approaches (Gaudiano and Miller 2013) based on the nature of the client's symptoms, available knowledge, and cultural considerations. Given that feminist therapy focuses on the impact of sociocultural factors on the individual, it is entirely consistent within the evidence-based practice framework to incorporate its principles into treatment with older women (Trotman and Brody 2002).

Some theoretical frameworks are more amenable to feminist therapy than are others. One of these is Interpersonal Therapy (IPT), a highly effective time-based treatment for MDD that incorporates elements of psychodynamic and cognitive-behavioral approaches to help clients feel more in control of their symptoms in the context of the therapeutic alliance. Traditional IPT works by helping the individual to utilize mechanisms such as social support, managing emotions, improving interpersonal skills, and assuaging stress related to interpersonal factors—all of which are techniques that could promote wellness in older women.

By focusing on contextual life factors, IPT practitioners strive to explore how a central problem or issue impacts an individual's ability to utilize available supports and coping skills. IPT also emphasizes the importance of the therapeutic relationship as a means of promoting safe exploration of interpersonal factors and ultimately fostering change (Lipsitz and Markowitz 2013). According to Rondon (2005), IPT is a highly effective therapeutic modality for older women, particularly for those older women whose mental health symptoms originate during periods of stressful transitions to new life roles, such as widowhood. Although typically short-term in nature (i.e., 12–16 sessions), IPT has also been found to be a beneficial long-term intervention due to the focus in this therapy on managing dynamic life factors. As such, this type of therapy can help older women adapt to physical and psychological changes in later life. Therapists working from this modality can help to empower older women to enhance their independence as well as negotiate how to accept a need for help from others.

Therapeutic interventions that address pain and anxiety management through relaxation and mindfulness are another approach that can be used in both individual and group settings (Smith 2007). Mindfulness-based interventions are based on Buddhist meditation practices, and strive to enhance an individual's mindful awareness with the purpose of improving overall well-being and satisfaction (Baer and Huss 2008). Mindfulness is considered both a therapeutic framework and a specific type of intervention, and it can be practiced through various exercises that often incorporate relaxation. This can be beneficial for older women with issues related to pain as mindfulness-based exercises in themselves can serve as a psychological intervention for pain and can help to balance clients' attention so that they are less fixated on their physical symptoms.

Structured reminiscence therapy is a cognitive-behavioral intervention that has demonstrated effectiveness in reducing depression among older individuals. Reminiscence therapy was founded on the principles of Erik Erikson (1963), who emphasized the importance for older individuals to achieve a sense of ego integrity by looking back on their life and gleaning a sense of purpose and meaning. In the protocol developed by Stinson et al. (2010), older women engage in various

activities within a group setting, including remembering old songs, sharing photographs with the group, discussing their families and friends, and talking about their careers. They found that women living in an assisted living facility who participated in the group for twice weekly sessions for 6 weeks showed significant improvement in depression scores. Such an approach is not only effective in promoting positive mental health, but, because it can be administered in a group modality, can be particularly cost-effective for mental health professionals working in healthcare facilities.

There are unfortunately only limited data on the effectiveness of alternate psychotherapeutic approaches specifically focused on older women. This paucity of information reflects both the greater tendency for older adults to seek mental health treatment from primary care physicians (which in turn is more likely to result in their being prescribed medication rather than psychotherapy), lack of access to mental health services, and to what we have conceptualized as social barriers against seeking treatment for older women. It seems to follow from the research on evidence-based mental health treatments that have shown effectiveness among older adult populations in general, such as cognitive-behavioral therapy (CBT), that there is no reason older women cannot benefit from what might be considered best clinical practices for mental health providers. It is crucial, however, that mental health care providers working with older women are cognizant of the difficulties older women face in their lives that result from negative cultural stereotypes and social biases and address these in any treatment protocol.

CBT is a commonly utilized treatment modality that has shown effectiveness in treating a multitude of psychological disorders including depression and anxiety (Hofmann et al. 2012). Research has demonstrated that CBT has the potential to provide a benefit to individuals with moderate-to-severe depression equal to that of antidepressant medications (DeRubeis et al. 2005). Therapists who practice from a CBT approach focus on shifting problematic thoughts (cognitions) and behaviors in order to reduce psychological symptoms. CBT is typically tailored to meet the specific needs of the individual client, and there are many techniques from the CBT literature that can be applied in therapy with older women. CBT practitioners are able to choose from a multitude of available treatment protocols based on the disorder with which an individual presents. Specialized or adapted protocols have demonstrated significant improvements for individuals with unique needs, such as older adults (Karlin 2011). Bhar and Brown (2012) discussed some important components to a CBT approach with older adults, including promoting hope and reasons for living, expanding social support networks, enhancing problem-solving skills, and creating a suicide safety plan. They also emphasized the utility of helping patients to conceptualize problematic cognitions through a CBT lens. This strategy can use specific techniques such as cognitive restructuring, which promotes balanced and rational thinking as a means of improving one's perspective on life and thus reducing the experience of distress.

From a feminist perspective, CBT with older women could focus on promoting positive behavioral shifts based on the client's preferences, such as engagement in social support and physical activity. This modality can also be helpful by examining

not only the client's irrational beliefs and dysfunctional attitudes that stem from individual life experiences but also on the beliefs that she has incorporated through exposure to negative cultural characterizations of older women. The client could be helped to recognize that she holds these negative views of herself because she has adopted the prevailing cultural stereotypes. From that point, the therapist can help her question her own beliefs and adopt views of herself that are more accepting and positive. However, within the framework of feminist therapy, the therapist would be less challenging of her client's views than is typical in CBT and more likely to engage her in a dialogue.

Additional adaptations that mental health professionals might need to consider for working with older women relate more generally to the needs of this specific client population. For example, Stewart (2005) suggested that older women might need more reassurance about their progress in therapy than younger women do. The clinician should also be well versed in the specific themes that might be more common in working with older women, such as role transitions, bereavement, and changes in physical and cognitive abilities. Regardless of therapeutic approach, clinicians need to consider the sociocultural factors that impinge on their older women clients. Unfortunately, current mainstream psychological interventions rarely incorporate social factors, such as attitudes, stereotypes, economic limitations, and the need to cope with the practical exigencies of daily life associated with the roles of caregiver.

Another adaptation that mental health professionals need to consider when working with older women is, as is true for working with women in general, the importance of avoiding a paternalistic approach to clients. Current cohorts of older women may be particularly likely to show deference to their "doctor," but this tendency should be countered with an approach that emphasizes collaboration between client and therapist.

Finally, younger therapists themselves might have to confront not just their attitudes toward aging but the ways in which these attitudes might be reflected in counter-transference toward their aging women clients. Such counter-transferential reactions may lead the therapists to avoid discussions about sexuality (because the clients remind them of their older female relatives) or to regard their clients as less than capable of undergoing positive change because they are "over the hill." Even if they have no specific training in geropsychology, mental health professionals can improve outcomes with older women by exploring their own biases about this population and how these might affect the therapeutic relationship. These biases can also be addressed through consultation and supervision.

The reality is that with a growing number of older individuals in the population, comes a higher demand for mental health services. It is our hope that training programs in geropsychology will continue to expand along with the population of older individuals and that these programs will acknowledge sociocultural factors, such as sexism and discrimination in the healthcare system, in order to provide treatment that benefits their older women clients.

Conclusion

Research has demonstrated that older women appear to be at a higher risk for depression and anxiety than older men. Depression in itself has been linked with increased mortality risk for older adults and other psychological and physical disorders for older women in particular. Mental health issues can exacerbate cognitive decline, and not only for biological reasons. A common symptom of depression is anhedonia, or lack of interest or motivation to participate in activities. Given the findings about the positive impact of engagement in mental and physical activities on cognition for older women, the data about depression are particularly troubling. By overcoming barriers to accessing resilience-boosting activities and mental health treatment if needed, with a provider who emphasizes empowerment, older women can enhance their quality of life and live longer, more fulfilling lives.

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