CHAPTER 1

Social Work Practice in the Twenty-first Century

The aging of the United States poses opportunities and challenges for social workers as the profession advances in this new millennium. The ethos of aging is changing as the population of older people becomes more ethnically diverse, lives and works longer, begins second and third careers, and struggles with chronic illnesses. The age considered to be “late life” has also changed. Middle age formerly began at 35, but today many view 45 and 67 as the beginnings of middle age and late life, respectively. In the new century midlife may commence around 50 and include the years between 50 and 69, with senescence not beginning until about 70.

How people will age in the future and how these changes will affect social work are important questions that we must answer. Other, related questions include what will become the most common problems of late life, and which elderly people will be most likely to encounter them? How will these transformations affect the psychology of aging? Will they alter how we age physically? Will age norms and roles change as demographics shift? How will communities respond to these transitions? Will society legislate social policies, laws, and regulations that adequately address elders’ needs? What practice techniques will work best with which older people? These are only a few of the questions that social workers must consider.

The next four chapters describe an integrated practice model for social workers who work with older people. The model incorporates contemporary theories from gerontology and social work and reflects the changing demographics and paradigm shifts in the United States and around the world. The theoretical concepts illuminate the promises and limitations of prevailing treatment strategies and the importance of approaching clients’ needs and concerns on multiple levels. Practitioners who understand the theoretical bases of the integrated practice model can be more effective in helping their older clients than those professionals who rely upon intuition and dated assumptions.
The complexity of the problems that older adults present to social workers requires a practice framework that incorporates micro and macro interventions as well as multidisciplinary practice. Well-developed therapies are more effective for older people when they are combined with social and environmental interventions. For example, a social worker may help a new widow cope with her feelings of loss and grief and recommend that she participate in a widow support group, thereby attending to the client’s psychological and social needs. People who lose loved ones benefit from a holistic approach that encourages them to grieve and to accept support from others. Other people who are facing loss remind us of the universality of grief and loss, and people who share their suffering with others who are grieving feel empowered and less alone. By encouraging social workers to recognize multiple factors in their assessments and interventions—how a person’s physical and mental well-being as well as his social needs and daily routines might be affected—we will help older people from diverse backgrounds.

It is now axiomatic that not only do biological changes affect psychological functions but certain mental states affect physical status. Social events, such as caring for a sick relative or dealing with the loss of a spouse, can induce stress and other physiological changes. Stress lowers caregivers’ immune system and increases their susceptibility to illness. Instead of working with clients’ discrete problems, gerontological social workers must intervene on affective, cognitive, behavioral, and environmental levels simultaneously. Most gerontologists, regardless of discipline, agree that holistic treatment approaches help elderly people more than do strategies that treat cognitive, affective, or social functioning in a vacuum. The first chapter highlights demographic changes during the twentieth century that have important implications for gerontological practice.

**Demographics of Aging**

The number of Americans aged 65 and older increased tenfold during the twentieth century, from 3.1 million in 1900, when the median age was 22.9 and older people represented only 4% of the population, to 35 million in 2000, when the median age was 35.3 and older people comprised 12.4% of the United States population (see figure 1.1). The substantial increases also occurred in the group of people aged 85 and older (see figure 1.2). This group grew from 122,000 individuals in 1900 to 4.2 million in 2000. This graying of the population will continue as fertility rates decline and life expectancies, which are now at an all-time high at 77.2 years, continue to rise (National Center for Health Statistics [NCHS], 2003a).
Older women still vastly outnumber older men, especially in the oldest age groups (see figure 1.3). In 2002 the United States was home to 14.2 million men and 19.5 million women older than 65 and about 1 million men and 2.4 million women older than 85 (Spraggins, 2003). Gender differences in life expectancy (74.4 for males and 79.8 for females born in 2001) are expected to continue for at least the next fifty years.
Although most men older than 65 are married (approximately 75%), most women in this age category are single (almost 60%). Older women are four times more likely to be widowed than their male counterparts; there were 8.9 million widowed women (46%) compared to 2 million widowed men in 2002 (nearly 14%) (U.S. Census Bureau, 2003c) (see figure 1.4). Another 10% of older women were either divorced or separated, and about 4% never married. According to the Policy Institute of the National Gay and Lesbian Task Force, one to three million (3–8%) Americans older than 65 are gay, lesbian, bisexual, or transgender (Cahill, South, and Spade, 2000). Although we have minimal data from national samples, most experts estimate that the U.S. population in the twenty-first century will have a greater proportion of older lesbians than older gay men, especially among the oldest old (Barker, 2004).

Every census since 1970 has found more people living alone than the previous census recorded, and older women—73 to 77% of all female heads of household older than sixty-five during this period—were especially likely to live in one-person households (see figure 1.5).

The proportion of older men living alone remained substantially smaller than the proportion of older women who lived in single-person dwellings between 1960 and 2000. At the same time the percentage of male heads of household aged 65 and older who were living alone increased in every decade (see figure 1.5). The most common one-person households included older white adults; older blacks, Hispanics, and Asian and Pacific Islanders are less likely to live alone (U.S. Census Bureau, 2000).

The number of people who are members of ethnic minorities in the United States has increased dramatically since the mid-1970s. Figures 1.6 and 1.7 show the
**Figure 1.4** Marital Status by Sex and Age, 2002 (Percentages of Population Aged Fifteen and Older)

*Source: Spraggins, 2003, figure 3, p. 2.*

**Figure 1.5** One-Person Households Within Age-Sex Groups: Percentages, 1960–2000

*Source: Hobbs and Stoops, 2000, figure 5-7, p. 157.*
changes in the minority elderly population over time. Although minorities represent larger percentages of younger age groups, the minority population in every age group was larger in 1990 and 2000 than in 1980 (Hobbs and Stoops, 2002). The older black population has grown steadily over time (see figure 1.7). In 1980 the U.S. population included 2.1 million blacks aged 65 and older, in contrast to 2.5 million in 1990 and 2.8 million in 2000, when older black men and older black women represented, respectively, 6.7% and 9% of the black population (figure 1.8).
Significant differences exist in the average life expectancies of blacks and whites. The average life expectancy for black males born in 2001 was 68.6, in contrast to 75 for white males. The average life expectancy for black females was 75.5, in contrast to 80.2 for white females (NCHS, 2003a).

The older Hispanic population has also increased. It rose from 0.7 million in 1980 to 1.1 million in 1990 to 2 million in 2002, when older Hispanics represented about 5.1% of the total Hispanic population (Administration on Aging [AOA], 2003b) (see figure 1.9). The number of these elderly people will continue to in-
crease. Older Hispanics, who will soon become the largest minority group in the cohort of people aged 65 and older, are expected to account for 16% (13.4 million) of that group by 2050 (AOA, 2003b) (see figure 1.10).

Although the numbers of Asian and Pacific Islanders in this country have also risen since 1980, the percentage increase of those older than sixty-five has remained stable since 1980 at about 7% (Reeves and Bennett, 2003). Figure 1.11 illustrates the distribution of people aged fifty-five and older by race, Hispanic origin, and age.

Although poverty rates among older people have declined since 1990 (from 12.2% in 1990 to 10.4% in 2002), many older people remain poor (see figure 1.12). About 17% of people older than 65 and nearly 20% of people older than 75 were within 125% of the poverty level in 2002 (Proctor and Dalaker, 2003). The highest poverty rates continue among older blacks: 38.5% of black women were poor or near poor, compared to 18.6% of older white women and 10.8% of older white men in 2002. Among black women older than 75, almost half (41.5%) were poor or near poor (see figure 1.12). Hispanic men and women older than 65 also have high rates of poverty: 31.1% and 33.9%, respectively, were within 125% of the poverty
level in 2002. The 31.6% of Hispanic men and 35.4% of Hispanic women older than 75 also were within 125% of the poverty level. Unlike other ethnic groups, Hispanics have seen poverty rates decline for those older than 65, but poverty rates have remained steady among all Hispanics. The Hispanic and black elderly continue to have higher rates of poverty than older white, non-Hispanic people and older Asian and Pacific Islanders, who have the lowest poverty rates (9.9%) of any ethnic group (Proctor and Dalaker, 2003).

Many older adults will remain productive and live in good health, free of substantial limitations on their activity. For people aged sixty-five, about 87% of white men, 83% of black men, 80% of white women, and slightly more than 72% of black women can expect to be able to remain independent (NCHS, 2003b). At the same time many older people, especially those in the oldest age categories, suffer from chronic illnesses, commonly heart diseases, hypertension, and diabetes. Chronic illnesses are especially prevalent among older women and older members of minority groups (NCHS, 2003a). While only 44.8% of sixty-five-year-old women can expect to live free of chronic arthritis for less than half of their remaining years, 58.1% of men of that age can expect to live without arthritis for the rest of their lives. Fifteen percent of women aged sixty-five and older are also more likely to require help with living independently than are men in the same age group (9%). Twenty-two percent of older non-Hispanic black women require more assistance in living independently than do older non-Hispanic white women (14%) or older Hispanic women (17%) (NCHS, 2003b). At each age and within each race, more men than women can expect to live a larger share of their lives free of any limitation (NCHS, 2003b). The difference between the white and black populations in the number of years that they are expected to live free of limitations is statistically
significant \((p < 0.05)\) at all ages, except for men aged eighty and older and for women aged eighty-five and older.

**Contemporary Aging Themes and Implications for Gerontological Social Work**

These demographic changes have important implications for social workers generally and for gerontological social workers in particular. The data indicate the need for a practice model of aging that incorporates a multidisciplinary life course perspective and recognizes the importance of heterogeneity, diversity, and inequality. An integrative practice approach is especially important with older clients, who typically present complex issues involving interactive biological, psychological, and social factors. Although older adults today are healthier than any previous cohort of elderly people, many will need help managing chronic illness, coping with loss, and meeting financial exigencies. The integrative practice approach that we present in the chapters that follow reflect these changing demographics and embraces recent concepts that have emerged in gerontology and social work. Germain and Gitterman (1996) also incorporate these concepts in their model of social work practice (see also Germain and Bloom, 1999).

The Life Course Perspective

A life course approach assumes that the past and present are inextricably linked and that understanding one stage of life is necessary in order to understand the others. The approach views late life within the context of a person’s previous choices and experiences. A central tenet of the life course perspective is to investigate and strengthen interactions between the individual and the environment, between the personal and the political, and between the micro (or clinical) and the macro (or policy) levels.

The life course perspective views the person within the context of historical, social, and individual time. Developmental and biological changes influence life experiences within the context of social and historical events as people age with others born at the same time, in other words, their age cohort. Even when they share similar historical and social experiences, however, older people will interpret events according to their subjective perceptions; personal characteristics, such as gender and ethnic background; and psychological orientations, including how they cope, feel, and react to life changes. Social time is based on age norms and expectations about how and when people should experience major life transitions. In late life the most common life transitions are widowhood and retirement. His-
Historical events or social periods affect all people and age cohorts simultaneously. Examples of historical events that affected most older people include the depression and World War II.

Historical, social, and personal time affect all adults as they age and account for certain characteristics, including attitudes or beliefs, that simultaneously affect all members of a cohort. These three dimensions also explain the diversity of views and lifestyles among older adults and the differences in their responses to various treatment approaches, such as talking therapies and informal or behavioral interventions.

Elder and Johnson (2003) have identified five major principles that underlie a life course perspective. These are the beliefs that human development and aging are lifelong processes; that the life course of individuals is embedded in and shaped by the historical times and places that they experience during their lifetime; that the antecedents and consequences of life transitions and events vary according to their timing in a person's life; that people live their lives interdependently and this network of relationships expresses social-historical influences; and that individuals construct their own life course through the choices and actions that they take within the opportunities and constraints of history and social circumstances (see Elder and Johnson, 2003, for an in-depth discussion of these principles). Settersten (2003) proposes that the life course perspective is multidimensional (individual development occurs along biological, psychological, and social dimensions); multispheral (aging occurs in family, work, education, leisure, and other spheres); multidisciplinary (it requires contributions from biology, psychology, and sociology); and multidirectional (aging is characterized by varying levels and rates of change that affect many functions and cause both gains and losses). In short, developmental, social, and historical factors affect the life course. These multidimensional and multidirectional influences underscore the need for gerontology practitioners to intervene simultaneously on micro and macro levels, using basic and specialized approaches while taking into account normal and disordered aging. The multispheral and multidisciplinary forces presume a biopsychosocial perspective on gerontological practice that assesses the multiple dimensions—individual, social, and environmental—that simultaneously affect how people age.

Heterogeneity

People become increasingly differentiated as they grow older. Heterogeneity within a given birth cohort tends to increase during the lifetime because gender, race, religion, sexual preference, ethnic background, and individual characteristics all influence adult development. Carl Jung suggested it first: as people age they
become increasingly individuated—more different from others in personality, income, education, health, and cognitive functioning. In her book *At Seventy: The Journal of May Sarton* (1987) the author May Sarton explained why she enjoyed growing older: “Because I am more myself than I have ever been. There is less conflict. I am happier, more balanced, and . . . more powerful” (p. 10).

Characteristics that distinguish a person earlier in life often become exaggerated with age. Cohorts also become increasingly variegated over time. Intracohort variability is as complex and multifaceted as intercohort differences (Dannefer and Uhlenberg, 1999; Dannefer, 2003). Practice models that are based on heterogeneity and individual differences enhance our understanding of aging and improve the efficacy of our interventions.

The marked individual variations inherent in older cohorts caution gerontological practitioners about inappropriately applying theories or interventions based on selected subgroups. On one hand, we must use best practices in social work. At the same time if social workers fail to tailor interventions in accordance with individual clients’ circumstances and unique characteristics, social workers will be ineffective in treating many older adults. This is particularly important when gerontological practitioners use standardized assessments, especially those developed from research on younger or homogeneous populations. Social workers can take into account the heterogeneity among older people by using more subjective assessment techniques to supplement the objective assessments. Standardized instruments help social workers diagnose specific conditions, such as dementia or depression, while subjective assessments, such as narrative approaches, often yield valuable information from clients that might otherwise remain concealed. These more subjective approaches also work well when the goal is to help an older client find meaning or benefits in his life. Gerontological social workers should balance subjective and objective methods and tailor them to a client’s circumstances.

**Diversity**

Calasanti (1996) distinguishes heterogeneity and diversity in her discussion of aging. She contends that the former focuses on individual variation and the latter applies to groups relative to their structure in society: “Incorporating diversity, then, ultimately means broadening our knowledge of all groups; uncovering and exploring the power relations constitutive of social reality stems from examining the similar and different experiences of a variety of groups. This comparative process is rendered even more complex by the dynamism and simultaneity of various power relations. That is, individuals experience their race/ethnicity, gender, class, and sexual orientation at the same time” (p. 149).
Calasanti argues that gerontologists must conceptualize diversity in terms of five factors: context, agency, dialectical processes, oppression and liberation, and historical influences. Context involves an examination of the circumstances surrounding a person’s situation and automatically requires taking into account biological, psychological, social, and political factors. An older person seeking help with a problem does so within the context of diverse influences. These often include a person’s physical and mental health, living arrangements, social supports, social class, and ethnic background. When social workers encounter an elderly person who is seeking help for depression, for example, the initial assessment should occur on multiple levels. Social workers must arrange for the person to have a complete medical evaluation because many illnesses result in depression, and depression can compromise a person’s immune system and increase her susceptibility to disease. In addition, the person’s living arrangements and social supports provide social workers with information on at least two fronts, helping them to determine which resources might be useful in intervention at a later time, as well as factors that may be contributing to the depression, such as social isolation and problems with transportation. The older person’s social class and ethnic background expose some of the obstacles that she struggles against as well as norms and customs. Elderly people’s sexual preferences are also important, although members of the current older cohort conceal their sexual identity more often than do their younger counterparts (Fullmer, Shenk, and Eastland, 1999).

The second factor affecting diversity is agency, which involves structural forces that are imposed upon individuals, often at an institutional level. These include economic systems, welfare institutions, and ideologies. Approaches that consider the effects of agency probe the ways that macro forces affect the lives of elders. Social Security regulations are examples of macro-level influences that affect many people and discriminate against those who worked intermittently for low wages. Advocates for elderly people can encourage older clients to lobby against such oppressive policies. Encouraging collective actions among older people increases others’ awareness of ageism and sexism and, concomitantly, enhances older people’s feelings of empowerment and emancipation. Other macro forces include the media’s obsession with youth and youthful appearance (see Calasanti and Slevin, 2001, for more discussion of the social significance of the aging body).

The third concept underlying diversity, according to Calasanti (1996), is the dialectical nature of aging. By dialectical Calasanti means those processes that are dynamic as well as contradictory. An older person who struggles against ageism, for example, confronts both liberating and oppressive forces. On one hand, proponents of “productive aging” believe that most older people can work and remain in the labor force much longer than many people previously assumed. On the
other hand, new policies, including changes in the age at which people will receive Social Security benefits, may increase poverty, especially among older women. The elimination of mandatory retirement laws is an important victory over ageist policies that forced people to terminate their employment prematurely. Yet in a society that offers limited opportunities to invest in pensions and other retirement benefits, some elderly people must work even though they are disabled or ill. The dialectic underlying diversity takes into account the complexities and ranges of motivations, desires, and feelings involved in growing older.

The fourth dimension recognizes the unequal power relations that the dominant population often displays toward minority groups. Theoretical assumptions that are based on majority populations and homogeneous samples can unfairly discriminate against older people who are homosexual, childless, or otherwise culturally different. Erik Erikson’s model of psychosocial development (Erikson, 1963) exemplifies how practitioners can inappropriately apply concepts to older people who have not accomplished certain psychosocial tasks. According to Erikson (1963), adults who fail to master intimacy, generativity, or integrity face isolation, stagnation, or despair (see chapter 2 for a more in-depth discussion of Erikson’s stages). Carol Gilligan and others now question the applicability of many established developmental theories, such as Erikson’s, to women, various ethnic groups, and other minorities (Gilligan, 1982; Sands and Richardson, 1986). For example, Sands and Richardson (1986) found that many women wrestle with intimacy and identity and intimacy and generativity at the same stage instead of at different stages.

The fifth concept that Calasanti (1996) has identified as underlying diversity is historical context. This concerns the confluence of various power relations at a specific point in time and requires, “comparisons of similarities and differences in diverse aging experiences over time” (p. 154). Each person belongs to a birth cohort and is influenced by historical events. These cohort and historical events often become permanent markers that interact with aging. Current cohorts of older people who lived through the Depression view money and investments differently than members of subsequent cohorts; the “Depression babies” typically are more thrifty and economically cautious. At the same time, intracohort variations preclude practitioners from generalizing to all cohort members, each of whom idiosyncratically experiences the effects of age, cohort, and period.

Last, Calasanti (1996) emphasizes the fluidity of events and interactions: “Social reality neither consists of deterministic structures nor is it the result of random processes. Rather it is constituted by simultaneously dynamic and patterned processes that reconstitute and are shaped by permeable structures” (p. 155). She adds that “losing the rigidity that more static notions of social reality assume means that we cannot derive immutable ‘truths’ about the social aspects of aging” (p. 155).
The increasing diversity of the population requires practice approaches that consider the variability within and between groups that results from differences in gender, ethnicity, religion, social class, and sexual orientation. Gerontological social workers must know how older people from different ethnic groups differ from one another, but practitioners must also avoid inappropriate generalizations or stereotypes about individuals who have unique characteristics pertaining to culture, worldview, and level of acculturation. Gerontological social work must use a culturally competent practice model that integrates heterogeneity and diversity and individual and structural variations. Social work scholars, such as Geron and Little (2003) and Maramaldi and Guevara (2003), underscore the need for more culturally sensitive assessment instruments in gerontological social work to effectively evaluate older people from culturally diverse backgrounds.

Multidisciplinary Perspective

No single discipline can effectively meet the myriad of issues that emerge in later life. Practitioners need knowledge and skills from multiple disciplines to adequately care for older people. Biological and social processes interact as people age. Longevity, for example, is affected both by genes and by social factors, such as vigorous exercise, positive outlooks, diets low in animal fats, and moderate tobacco and alcohol use (Palmore, 1995; Leventhal et al., 2001). People with strong social supports typically live longer than socially isolated people. Social supports mitigate daily stresses by providing elderly people with confidantes with whom they can exchange information and share feelings (Chiriboga, 1995; Krause, 2001; Lubben and Gironda, 2003).

Most mental health experts now acknowledge the physiological contributions to many mental illnesses. Some medications, such as drugs for high blood pressure, can induce depression (Swartz and Margolis, 2004; Margolis and Swartz, 1999; Stevens, Merikangas, and Merikangas, 1995). Elderly people with auditory impairments sometimes become isolated or paranoid when extraneous noises prevent them from hearing well.

According to Light, Grigsby, and Bligh (1996), “Environments exert an effect on personality, and… genes do also (how directly is at present largely unknown); but most important, genes also affect environments” (p. 167). Environmental factors, such as poverty and access to health care, can influence how genes are expressed. Conversely, genetic influences may be passive (when individuals are exposed to environments created by the behaviors of their relatives); reactive (when people create social environments by eliciting reactions from other people); or active (when individuals select appealing environments) (Light et al., 1996). Gold (1996) concludes that theories of aging “cannot capture the social
or psychological parts of aging without incorporating—at some level—the biological as well” (p. 224).

In the final report of the 1995 White House Conference on Aging, the authors warn that “individual issues must not be looked at in a vacuum but must constantly be viewed as part of the whole, having an impact on each other in a variety of ways” (1996, p. 24). The delegates at the conference recognized the importance of personal and social roles and responsibilities and endorsed a biopsychosocial perspective: “A national aging policy must be sensitive to the interrelatedness of the myriad of issues that surround aging” (p. 24).

The authors of *A National Agenda for Geriatric Education: White Papers* advocate a similar position: the complexity of older adults’ lives requires knowledge, skills, and delivery of services on multiple levels (S. Klein, 1996). The task force of the Association for Gerontology in Higher Education (which evaluates gerontology education) also emphasizes a comprehensive approach: “The study of aging occurring at both the macro- and micro-levels [is] built on an understanding that the underlying biological processes of aging unfold within an environment and are manifest as a result of the person-environment interaction. The outcomes of this interaction are affected by diverse dimensions, including, but not limited to, culture; demography; ethnicity; economy; geography; gender; history; political and social environments; and mental, physical and social status” (Wendt, Peterson, and Douglass, 1993, p. 11).

Multidisciplinary approaches have emerged in many areas. According to Birren and Schroots (1996), for example, “The psychology of aging may increasingly adopt an ecological point of view toward human aging that will embrace major modifications of our behavioral characteristics as we change our environments and styles of life” (p. 18). By “ecology of aging” they mean that “organisms not only express their genome but the expression is done in interaction with particular physical and social environments” (p. 18). Gold (1996) agrees: “In stark contrast to the narrowing fields of expertise in sociology, the study of aging relies upon a multidisciplinary approach. In fact, as we learn more about the processes of aging, it becomes even clearer that multiple disciplines and various methods are necessary for the study of aging. We cannot capture the social or psychological parts of aging without incorporating—at some level—the biological as well” (p. 224).

Gerontologists are increasingly involved in interdisciplinary teams that include nurses, physicians, dentists, allied health professionals, lawyers, psychologists, and social workers. Gerontological social workers understand, for example, that they often must work with physicians, who may prescribe antidepressants to supplement individual counseling, or with nurses and other allied health professionals to coordinate long-term care. Increasing numbers of social workers, especially
those involved with health care, understand the need for multidisciplinary and interdisciplinary perspectives in gerontological practice (Berkman, Maramaldi, Breon, and Howe, 2002; Damron-Rodriguez and Corley, 2002). By focusing on multiple dimensions of an older adult from multiple viewpoints, gerontological social workers will more successfully address the myriad problems that most elderly clients present.

Power and Empowerment

Practice models of aging must also address unequal power relations in light of growing evidence that many older people lack access to adequate health care, live in poverty, and are socially isolated. Although older adults are better off on average than they were in the past, some experts, such as O’Rand (2001), have shown that inequality within and across age groups increased during the 1990s. Similarly, Gregoire, Kilty, and Richardson (2002) found that the economic status of older married white people improved during the 1990s, but the impoverishment of older single women, especially those who were members of racial minority groups, increased. Inequalities in health and life expectancies also continue despite advances in medical care (O’Rand, 2001). Hendricks (1996) argues: “Mythology notwithstanding, equality of opportunity is not inherent in the organization of life. Nor is it an intrinsic aspect of what it means to grow old. Not all of us resemble white, middle-class males. Not all of us grow old in families with loving spouses and attentive children. We do not come from optimal circumstances that ensure maximally successful aging. If they are to be useful, our conceptual models cannot afford to be myopic” (p. 142).

Hendricks also believes that “if we are to disentangle structural and ideological constituents of the way we age, we need to develop a better grasp of the real impact of power and prestige” (1996, p. 142). Similarly, Light and colleagues (1996) observe that “individuals whose social status characteristics afford them relatively high social rank (e.g., white, male, upper-class) will have more and better environments to choose from (or to choose them)” (p. 170). O’Rand (1996) explains that “patterns of inequality within and among cohorts emerge over time as products of the interplay between institutional arrangements and individual life trajectories…. In short, structural and temporal factors interact to produce inequality over time” (p. 230–31).

Traditional theories of aging have inadequately addressed diversity, power inequities during the life course, and oppression based on age, gender, ethnicity, religion, social class, and sexual preference. Practice perspectives that ignore these influences lead to ineffective interventions that benefit only the most privileged
elderly people. According to Berkman and Harootyan (2003, p. 2), “The biopsychosocial frame is not sufficient without addressing economic, political, social, and environmental factors.”

An integrated practice framework for aging embraces ideas that will empower older clients and free them from personal and social oppressions. It must synthesize practice dialectics, such as micro and macro practice, basic and advanced interventions, subjective and objective assessments, and normal and disordered aging in order to provide culturally competent solutions for the problems that elderly people will face in this new century.

Social work practice models that incorporate emancipatory agendas are important in working with older clients, many of whom have suffered the consequences of lifelong inequities. These models assume that social workers understand how social structural factors and social policies affect individual lives and that social workers advocate for more just social policies that will empower their clients. These models also emphasize clients’ strengths and suggest ways to enhance their resilience and coping strategies. Social workers can empower older clients by working with others to change oppressive policies or by buttressing clients’ skills and helping clients to use them. In social work these models are best exemplified in the empowerment-oriented models articulated by E. O. Cox and Parsons (1994) and J. Lee (2001), and in the strengths-based models described by Fast and Chapin (1997) and Chapin and Cox (2001).

Chapter 2 reviews theories of normal aging that were developed late in the twentieth century. Practice concepts based on the themes of the first two chapters are discussed within the context of an integrative aging practice model in chapter 3. In chapter 4 we apply these concepts to the listening, assessment, and intervention stages of practice. Parts 2 and 3 examine specialized direct practice interventions for specific aging problems, focusing on psychological issues, such as depression and dementia, and on social-psychological processes involving aging families, bereavement and end-of-life care, and work and retirement. These more specialized interventions supplement basic gerontological social work interventions. Although many advanced interventions are used to treat more serious problems in late life, social workers can also use them to address more typical aging problems. In part 4 we discuss economic policies, with particular attention to Social Security and poverty in late life; health policies, such as Medicare and Medicaid; and social services and aging, specifically, the Older Americans Act and the aging network.

Gerontological social workers must understand how various health policies affect individual clients and advocate for more just policies that will empower aging people. As Estes (2001, pp. 39–40) articulately explains, “The state and economy (macrolevel) can be seen as influencing the experience and condition of aging, but individuals also actively construct their worlds through personal interactions (mi-
crolevel) and through organizational and institutional structures and processes
(mesolevel) that constitute their social worlds and society.”

**Discussion Questions**

1. How is the current cohort of older people different from younger cohorts?
2. What are some experiences of the current cohort of older people that influence their views on getting professional help?
3. How will the increase in the number of older people from diverse ethnic backgrounds influence gerontological social work?
4. How will demographic changes affect current aging policies?