PERCEPTIONS OF WELL-BEING IN TWO GROUPS OF OLDER ADULTS: LONG TERM CARE CENTER RESIDENTS AND NON-RESIDENTS, IN CURICO, CHILE

By

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To Mamá, Papá, and Isidora
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Abstract of Dissertation Presented to the Graduate School
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PERCEPTIONS OF WELL-BEING IN TWO GROUPS OF OLDER ADULTS: LONG TERM CARE CENTER RESIDENTS AND NON-RESIDENTS, IN CURICO, CHILE

By

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May 2017

Chair: Peter Collings
Major: Anthropology

This study assesses perceptions of well-being between two groups of older adults in Curico, Chile. One group (n=25) were residents from a long-term care center (known as ELEAM), while another group (also 25) were members from clubs for older adults, who lived in their own homes. Both groups were paired according to the variables of age, educational level, socioeconomic status and physical status.

This study consisted of two phases of data collection. The first phase included participant observation and survey research, measuring five components of well-being: life satisfaction, health status, self-rated health, social support, and socioeconomic status. Data showed that both groups had similar characteristics in self-rated health and epidemiological profile. However, in social support, ELEAM residents reported scores. Regarding life satisfaction, although both groups had average scores for developed nations, the distribution of scores was completely different. Some ELEAM residents were extremely dissatisfied with their lives. Instead, most club members were in the average category. This data concludes that the sum of each one of these factors did affect the perception of well-being among ELEAM residents.
The second phase of the research involved the collection of life story narratives to explore differences in how older adults in different living situations --long-term residential care vs. independent living-- define and perceive what it means to be well in old age. Narrative data provided a context for each participant’s life, showing that during adulthood and adolescence, both groups were similar in terms of traditional roles: girls helping with house chores, and boys either working or studying. During adulthood, these gender roles are still present: women become mothers, and among those childless they stayed at home. Men spent most of their time either working or having fun with friends. Finally, during old age, both groups showed their desire to be _tranquilo_ or “peaceful”. However, both groups have different ways to reach that state: ELEAM residents focused on keeping good relationships with fellow residents and maintaining their autonomy. Club members focused on their relationships with their families, and engaging in activities such as gardening, and participating in clubs for older adults.
CHAPTER 1
INTRODUCTION

Over the past 20 years, the life expectancy for people at age 60 has improved worldwide (Cotlear 2011). Additional research (UN 2002) suggests that the actual aging patterns are unprecedented and will have different implications in populations. For this reason, the perceptions about the aging population have been changing gradually, from a reflection of social success (Roughan, Kaiser and Morley 1993) to a complex issue, mainly based on the potential implications to the society (Restrepo and Rozental 1994).

In fact, as a consequence of speculation on possible implications, aging has become part of the so-called “apocalyptic demography” (Gee and Gutman 2000), which focuses on the potential burden that a larger aged population can become on the rest of the society. Some countries perceive population aging as a problem of biopolitical governance, because of the challenges that arise at both the individual and population levels (Lamb 2009). For instance, in some countries, social security systems are under pressure, because there are not enough young people to support them. The United States has been facing this problem since the last decade. Because fertility rates have dropped, the country has had to “import” labor to meet society’s needs (Estes 2001). Although migrants are part of the solution for the shortage of work force, some sectors perceive immigration as a potential problem of biopolitical governance. However, Leeson (2013) suggests that an aging population –or any age combination- is not a threat; instead, the challenge resides in the ability of local and regional structures to adapt to the new demographic profile.

This research focuses in Curicó, Chile, a Latin American upper-middle income country, that also presents advanced levels of aging population: the dependency ratio
has changed dramatically during the last years, along with a decline in fertility rates and an increase in life expectancy.

Chile’s political/cultural history began with a diverse indigenous population (there is archaeological evidence that there were about 13 different ethnic groups), and followed a period of the Spanish Conquista in the sixteenth century, followed by European colonization in the south during the 1800’s (Montecino 1991). These events were the foundation of mestizos, people of combined Amerindian and European ancestry. In fact, a study showed that the genetic structure of Chileans reflected historical migration patterns, with ancestry being 45% Native Americans, 52% European and 3% African (Eyheramendy et al. 2015), contrasting with other Latin American countries, such as Mexico, Guatemala, Ecuador and Peru that present higher Amerindian ancestries (Salzano and Sans 2014).

However, Chile shares some similarities with its neighboring countries. For instance, Chile also experienced a military dictatorship during the seventies. Augusto Pinochet’s regime lasted seventeen years, and left legacy of abuse of human rights, several deaths, and a divided country. In addition, the reforms made during this period are still valid, especially those who encouraged a neoliberal economy.

After the dictatorship, the country faced an economic development regime, guided by neoliberal politics that opened the economy towards global trade. These policies along with sociocultural changes, gradually altered gender roles: women are entering to the labor force, yet still face the pressures of traditional expectations: doing housework, and providing family caregiving. Men are also trying to divide their roles:
they are family providers but simultaneously wish to spend more quality time with their children, and to help in parenting (Olavarría 2001).

Regarding the current demographic profile of Chile, because fertility rates have decreased and life expectancy has increased, there are an unprecedented number of older adults. Because this change has been faster in comparison to some European countries and the United States; it is expected to become a challenge to the country to keep up with this demographic transition, especially in terms of social security.

Although scientists are conducting research about aging and the aged in Chile, most it is focused on addressing the gerontological aspects of older adults, conducted in larger urban centers, and focused on delivering services. Significantly less research addresses the experience of aging or the whole spectrum of aging in Chile: from those who are independent, to the institutionalized; and from those living in urban to rural areas, because the economic and political changes mentioned above, has also changed the way in which rurality is experienced. Chilean anthropologists Roberto Hernández and Luis Pezo (2010) suggest that since 1980, there is a “new rurality” in Chile, characterized by an increase of people from urban areas moving to rural areas and a decrease in agriculture in a small scale. Information about how older adults live in these areas, and the changes that they have faced is limited (Piña 2013).

In addition, it is important to explore the sociocultural implications of a rapidly aging country, understanding the conditions in which present-day older adults live, and especially, if these conditions affect their well-being.

Although well-being has been considered in general terms as “the good life”, there is still a lack of consensus regarding its definition. Beyond achieving a consensus
in academic spheres, it is necessary to address how older adults understand this concept, and what are the factors that according to their judgment, contribute to their perception of well-being. Considering the above, this research explores the perceptions of well-being among a group of Chilean older adults, using both standard questionnaires and narrative data, in order to get, in their own words, what means to age well in Chile.

This research addresses two groups of older adults that have been understudied in Chile: those that are institutionalized and living semi-rural areas. According to estimations by Marín, Guzmán and Araya in 2004, about 2% of the population in Chile lives in some kind of collective residences. This percentage is lower than the United States 3.6% (Department of Health and Human Services 2012), but higher than in neighboring Argentina at 1.3% (Roque 2014). The fact that there are not any official (or recent) numbers available about this group in Chile, is evidence of an information gap about institutionalized older adults. In fact, Marín, Guzmán and Araya (2004) suggested the importance of the creation of a formal registry of these institutions for the next census. On the other hand, most research in Chile is conducted in its capital, Santiago, or in the most populated urban areas. For this reason, this research was conducted in Curicó, a city of 144,025 habitants with 14.5% of the population aged 60 and above, located in the central valley, that has both urban and rural areas.

This project considered two groups: residents from a long-term care center (n=25), and members of two groups of senior organizations (n=25). Both groups were paired in terms of age, years of education and physical status; hence, the main objective of this research is to find if living arrangements do influence the perceptions of well-being in these particular groups of Chilean older adults.
Because the research considers particular groups in a Chilean city, the findings are not, representative of all Chilean older adults. It is important to note that older adults are a heterogeneous group, therefore, there are several differences between them, as well as similarities.

Also, it is important to mention that in this dissertation I refer to the people aged 60 and over as “older adults” or *adultos mayores*, its homonym in Spanish. I avoided the use of the words “elderly” in English, and “*anciano*” in Spanish, because in both languages, these words have been associated with negative stereotypes about old age (Smith 2012; Sociedad de Geriatría y Gerontología de Chile 2015; Graham 2012). In Chile, the politically correct term to refer to people aged 60 and over is *adulto mayor*, in fact, it is the term used in laws and decrees. Most participants in this research preferred this term.

In addition, this research posed several challenges. For instance, I was born and raised in the city that I conducted research, therefore, I knew the language, and I could easily understand geographic or local references that participants mentioned. Simultaneously, there were some differences, such as the age gap between the participants and me. The youngest participant was 62 years old, and the oldest was 89, therefore, some participants were almost 40 years older than me. The age gap was evident especially in the way in which participants approached me: there was distance from the beginning, because many of them did not understand why a young person from Curicó, and lived in the United States, wanted to know about their lives. This has been a common issue among anthropologists. For instance, Barbara Myerhoff (1980), an American Jewish anthropologist faced similar problems. While she was conducting
research in Mexico, the Huichol people asked her “why work with us? Why do not you study your own kind?”. In that moment, she realized that she should study her own kind. Myerhoff then decided to study elderly Jews in Venice, California. In a documentary made by Lynne Litmann (1976) that won an Academy Award, Myerhoff expressed her concerns:

“An anthropologist of course, tries to feel the native’s head, that’s how, in a way, you know the culture, but in a sense that is, false, in a way as an exercise, an imagination. Because you will never be that…but I will be old, and I need to know that, there is a validity in me identifying, what that, that is nothing that I ever experienced working with Indians, or working with, you know, really exotic people I will never be…I will never be a true Indian, but I will be a little old Jewish lady”

Unfortunately, Myerhoff died in 1985, when she was 50 years old. In this quote, she expressed the importance of study her own kind, especially in anthropology, a discipline that was conceived as a way to study “the others”. Like Myerhoff, during my fieldwork I was identifying with something that I will become someday, a Chilean old lady, though in a completely different context, because some participants in my study did not have any formal education, and they were born in poor families. Instead, I have a different socioeconomic background, which has been allowed me to study abroad.

Regarding the organization of this dissertation, Chapter 2 reviews literature on the life course perspective and well-being, providing the theoretical framework for understanding what it means to be well during old age. The life course perspective delivers a way to integrate both, a snapshot of social relations, and a dynamic approach of the current—and past-conditions, to contextualize the lives of older adults, considering historical and geographical aspects of the life cycle. On the other hand, well-being is a key concept for understanding what is considered “the good life”, which can be useful to address which factors contribute to harmonious aging.
Chapter 3 investigates Chile as an aging country. First, I describe the demographic transition towards a larger population of people aged 60 and above, and the potential impacts on the Chilean society, families, households and social contract. Next, I describe the present-day Chilean older adults and the “social safety network”: pension systems, health care and the National Service for the Aged (SENAMA), institution in charge of encouraging active aging and the development of social services for Chilean older adults. Later, I address their living arrangements: independent living and collective residences. Finally, I describe the Chilean cultural views of this age group, and, how in Chile, older adults are a synonym of grandparents. Also, within Chapter 3, I address the aftermath of the military dictatorship, that “ended” officially in 1990, however, there are still implications that particularly affect access to services for older adults.

Chapter 4 draws attention to the ethnographic context in which this research was conducted. It describes how well-being in older adults has been addressed in Chilean literature and which factors have been found to contribute to it. These factors include the family as a main source for social support, volunteering and participation in organizations, home ownership, psychological perspectives, and income. Then, I provide a description about the main characteristics of Curicó: its historical background, location, geography, economic activities, demographic profile, and the population of older adults living in the city. I address the housing options for both, independent and dependent aged. For the first group, there is a description of sporadic activities, and permanent activities such as “Clubes de adulto mayor”, organizations particularly created by and for senior citizens. In addition, there is a final section including research
settings, in which I discuss how well-being is understood as an umbrella term that involves five dimensions: self-rated health, physical functioning, social support, socioeconomic status and life satisfaction.

Chapter 5 addresses the first phase of the research which focused on the collection of survey data. This phase was conducted over four months, between September and December 2015. Here, I discuss the objectives and ethical clearance, along with the main characteristics of the two groups of participants. Group 1 was comprised of 25 older adults, residents of the ELEAM Carmen Martinez Vilches. After this group was selected, Group 2 was selected to be paired with Group 1 in terms of age, years of education and physical status. Chapter 5 also addresses sample selection, the informed consent process, and the collection of demographic and socioeconomic data for both groups. Then, I present the statistical analysis for self-rated health, social support and life satisfaction. There are in-group and cross-group comparisons.

Chapter 6 discusses the results of the second phase of the study, conducted after processing the survey data. In this case, data collection was made between May and August 2016. Chapter 6 present the narrative data obtained through life stories conducted with half of the participants of the first phase, to study a few cases, in detail. In addition, this Chapter describes the data collection and analysis for the life stories conducted with 25 participants, ELEAM residents and club members.

Finally, in Chapter 7 I discuss the conclusions of this dissertation, including the pros and cons of the use of the life course perspective and well-being as main concepts, and the use of mixed methods for this research. In addition, I compare the
data obtained in Chapters 5 and 6, and I describe the differences and similitudes among ELEAM residents and club members. As a final point, I discuss the limitations of this study and provide suggestions for future research.
It has long been understood that social gerontology is rich in data, but theory poor (Birren and Bengtson 1988). Hendricks, Applebaum and Kunkel (2010) suggest that although there is a place for theory in social gerontology, it is difficult to researchers to move from the theoretical abstraction to empirical observation.

Anthropology in this sense has been no different from gerontology until recently. This research follows a shift in perspective among anthropologists interested in aging (Danely and Lynch 2013; Sokolovsky 2009a). Before, anthropologists interested in aging focused on “geroanthropology”, which considered the lives of older adults as if “they constituted a distinct and easily bounded category of persons” (Cohen 1994, 138), the anthropology of aging today employs a more dynamic approach. As Fry suggested “for those researching aging, the conclusion is, it isn’t age, per se, that is the object of study” (Fry 1990, 129). Therefore, this new approach aims to show how people grow old in different cultural and historic contexts. For these reasons, this research is based on two main theoretical approaches: the life course perspective and well-being.

The life course perspective emerged during the 1960s as a new way to assess human behavior in a rapidly changing society (Elder 1985). Before the advent of the life course perspective, there were two broad methods: “(a) a snapshot ‘social relations’ or structural approach that viewed the impact of the social surroundings on the individual and (b) a movie-like ‘temporal’ or dynamic approach that traced the story of lives over time” (Giele and Elder 1998, 6). The life course perspective arose as an option to fill the gaps within the study of aging, integrating both perspectives, an instant portrait of the current situation and a long-term approach of the life span for individuals, allowing more
comprehensive studies, that contextualizing lives, considering historical and geographical aspects of the life cycle.

Well-being, on the other hand, has been considered as a “typical catch-all term without a precise meaning” (Veenhoven 2007, 216). Well-being is often used as a synonym for “the good life”; that is, how individuals think and feel about what it is important in their lives and what makes them feel good. Because the set of values considered to judge “living well” will vary cross-culturally, it is important to consider cultural relativism when discussing factors that influence well-being among different populations.

This concept has also been confused with quality of life (Walker 2005) and wellness and health (Adelson 2000); and simultaneously, researchers tend to disengage the association of well-being as a synonym of happiness, because the latter is considered as a subjective term, therefore, less reliable (Diener and Ryan 2009). Even though well-being is related to health and quality of life, this concept has not received as much attention as other topics among medical anthropologists (Matthews and Izquierdo 2008). In fact, the book “Pursuits of Happiness: Well-Being in Anthropological Perspective” published in 2008, was considered in the Medical Anthropology Quarterly as the first book “to bring together anthropologists working on the notion of well-being” (Russell 2011, 546).

In summary, the life course perspective along with well-being, are used in this research as two theoretical orientations that will provide different approaches to address how Chilean older adults perceive well-being. Which are the factors that influence their happiness in old age, considering their current and past cultural, historical, and
personal context? The following sections provide a description of these two approaches, discussing strengths, weakness, applications in aging studies, and how employ these concepts in this research.

Life Course

Theoretical Orientation

Elder, Kirkpatrick and Crosnoe (2003) describe the life course as a theoretical orientation, because this perspective does not make predictions. Instead, this perspective serves as a framework for conceptualizing how individuals move through the life cycle, inspired by the different sets of values and beliefs provided by their cultures. In fact, this perspective helps to understand social organization.

This orientation conceives of the family as a plastic entity that gathers several interdependent individuals moving at their own pace (Hareven, 1996). Therefore, the life course perspective distinguishes between cohorts and generations. Instead of considering generations, which is a model based on the reproductive life cycle, it privileges the use of cohorts by birth, placing individuals in a historical context and considering the relationships between people of the same or different cohorts, and how membership in a cohort can influence the timing of their lives.

The life course perspective is mainly based on five principles: life-span development, agency, time and place, timing and linked lives (Elder, Kirkpatrick and Crosnoe 2003). The first principle, life-span development, assumes that human development and aging are lifelong processes; hence, each life stage is related to another. One does not suddenly becomes old. All the stages of life are part of a continuum. Every stage of the life cycle is studied in relation to the others.
The second principle, agency, states that individuals construct their own life course through choices and actions that they take to the extent allowed by biological, cultural and historical constraints. People’s motives to satisfy personal needs result in decision making that organizes their lives around goals within the options and pressures of their situations. For instance, the family of origin can influence agency. Repetti, Taylor and Seeman (2002), showed that families characterized by conflict, aggression and neglectful relationships, created vulnerabilities in their offspring, producing disruptions in psychosocial functioning, such as social competence, and emotion processing. These disruptions, in turn, lead to accumulating risk for mental health disorders and poor health.

The third principle is time and place. Time and place refers to the context in which the life course develops. Therefore, the particular time in which individual lives will significantly shape their life course. This principle also considers social hierarchies, cultural and spatial variations specific to each period. For instance, the current age-segregated life course present in most modern societies, education is reserved for young people, work for people in their middle years, and leisure for the retired. Riley and Riley (2000) suggest that an age-segregated model is becoming outdated, because it prevents intergenerational interactions. In fact, they argue for an age-integrated model, in which individuals perform these three activities simultaneously and intergenerational relationships are encouraged.

Timing, the forth principle, refers to the variation that can produce developmental antecedents, behavioral patterns, and life transitions if they occur in a particular time. For example, same events affect persons in different ways depending on when
happened in the life course (George 1993). A study conducted by Chen (2001) in Taiwan, found that a cohort that lived during their early twenties during World War II presented in general lower levels of life satisfaction, due to their experience of the war. In addition, Elder and Giele (2009) suggest that families coordinate their lives according to the timing of external events; this is why different cohorts can have variations in their trajectories of work, because they will adapt to the time and place in which they are living.

The fifth principle is linked lives, and it suggests that there is interdependence among individuals. This means that a personal network shapes the individual life course. For instance, Antonucci (2001) coined the “Convoy Model” to explain how social relations change within the life span: each person has their own convoy, which consists of a group of different persons that can enter or leave their social network through different stages of the life course. The decisions and actions made by the people from the convoy will influence others. Uhlenberg and Mueller (2004) suggested that even the decisions made by the first generation can influence the lives of the people from the third generation.

Regarding strengths, the life course framework helps to visualize the significance of macro forces, “including the social institutions and cultural practices that organize everyday life routines, and unique historical events and periods of social change (Dannefer and Settersten 2010, 4). Likewise, the life course perspective assesses lives in motion, instead of as an “instant photo”, which was the way previous studies addressed the life course (Elder 1998). In Chile, Barros (1979), showed that in later life, men have fewer friends than women; she attributes this due to the impact of the
historical period in which they were born: men were socialized to interact with their coworkers, establishing superficial friendships. Instead, because women were educated to stay at home, during the day, they interacted with fellow female neighbors who were doing the same chores and, built stronger friendships, that were based on deeper topics such as being in charge of the domestic life.

The principle of linked lives also promotes interdisciplinary relations because it contemplates several aspects that are addressed by different disciplines. This interdisciplinary can be reached through looking for symmetry among disciplines, that is, providing a space in which each discipline can provide its own perspective, because the main goal of these relationships is to get the maximum benefits, using different approaches to avoid homogenization.

One of the weaknesses of the life course perspective is that it is not a theoretical framework, therefore it does not provide testable outcomes (Mayer 2009). And because it is a functional paradigm, intra-cultural variation is overlooked during the search for “the normative, the average, and the typical, [to] ask the larger questions of cross-group differences” (Fry 1990, 143).

Levy et al. (2005) recognize that the life course perspective lacks two basic “instructions”: data design and data collection. First, there are not standardized ideas about which kind of measurements we should use, nor is there a consensus about what kind of data we should collect. Also, most of the studies are longitudinal, which can be exhausting, especially at professional and economic level, because it is mandatory to follow people to research different time points, which is translated in overspending resources which requires sufficient funding to do so (Dannefer and Settersten 2010).
Still, longitudinal studies are highly valued because they provide time depth. For instance, a key study to life course research was based on a longitudinal study. Elder’s book “Children of the Great Depression” published in 1974 established the bases for the life course as a theoretical approach. He studied 167 individuals born between 1920 and 1921 from their childhood (they were attending elementary school in California) through their forties, during the 1960s. Using role and age-based theories he provided both, a “timeless” view of lives and generations to understand interdependent lives and a “contextualized” view through timing and agency, to explain the influence of the economic crisis on their life course (Elder 2005; 1999).

George suggests that “there is not an integrated theory of the life course; nor, I would argue, should there be one.” (George 2003, 671). This feature, which can be perceived by some scholars as a weakness, for the author is a strength because it allows the integration of the five principles to other sociological theories and research traditions, which she argues, will be the dominant form of life course research in the future. Settersten (2006) reinforces this idea, suggesting that the life course perspective reaches its full potential when it is used in conjunction with other behavioral theories.

Also, there is no consensus about the meaning of each one of the five principles that conforms to the life course perspective, which leads to misuse of concepts between different disciplines, between different studies, and even within the same paper. For example, Marshall (2005) states that the concept carrying the main problem is agency, this is in addition to all the “life” concepts, such as: life course, life cycle and lifestyle. Besides, Settersten and Gannon (2005) suggest that terms like agency and structure are not appropriately defined.
Finally, Settersten (2009) argues that the life course perspective neglects biology and development, because these aspects have been historically associated with the life span life perspective, which is perceived as a domain of psychology. In this sense, it is important to make a distinction between life course and life span.

Dannefer and Daub (2009) argue that the main difference between life span development and life course perspective is that both have different interests. For instance, life span aims to describe “age-related change in individual human beings, and to the intensive and extensive scrutiny of multiple aspects of the individual, whether straightforward or elusive, from reaction time to wisdom” (P. 16). Even though the life course perspective also addresses individual outcomes, it is not limited to that level, because it also considers collective (cohorts) and sociocultural categories. In fact, Oris et al. (2009) allude that life course sociologists consider the effect of social structure, and to which extent that affects interactions between individual, family, and historical times. In addition, they look for variations of life course by cohorts and historical context. By contrast, lifespan psychologists primarily focus on the on individual development in a “typical life course”.

Nowadays, the life course framework is applied in diverse research, and it is possible to find some regional differences in its application. For example, European studies have focused on individual biographies and in-depth interviews (Heinz and Kruger 2001). Also, one of the main challenges for the life course perspective, is to assess the great differences between one cohort and the next one (Settersten and Gannon 2005; Macmillan 2005). It is crucial to count with current descriptions about the
individual’s life course, especially for social institutions in order to create social policies that really address people’s true necessities.

The life course framework has been applied to a wide range of disciplines: for example, it has been used in nursing research. Black, Holditch-Davis and Miles (2009) used the life course perspective as a framework to evaluate the experiences of 34 women who gave birth prematurely after a high-risk pregnancy. Thus, each of the four elements were used as follows: time and place was used to understand the current “culture of technology” as the authors called it, in which during pregnancy, women are subject to a series of tests, which alienates the mother, because all the attention is focused on the fetus. Timing was helpful to understand the differences between younger and older mothers, and how most of the younger mothers’ pregnancies were unplanned. On the other hand, agency was used to address choices and actions related to pregnancy and mothering experience. Finally, linked lives showed the networks of each one of the mothers, and how some of the people from these networks became social capital, especially considering that these premature babies had to be hospitalized for a long time since birth.

Applications in Aging Studies

The life course theoretical orientation has been considered appropriate to research aging because each one of its five principles provide a different angle to understand and research old age and aging.

The first principle, the life-span development, assumes that life is a continuum, therefore, aging is not an isolated life stage, and whatever happened in early stages it does have an impact. The second principle, agency, assumes that people make choices, and that these choices will affect at the moment and/or in late life. Third
principle, time and place, helps to provide a context for an individual’s life, and also
assumes that there are cultural and historical variations. The forth principle, timing,
provides insights about the particular time in which the person is living. And finally,
linked lives recognize the interdependence between individuals, and how they can
interfere in each other’s lives.

The life course perspective has been linked to previously existing theories to
complement them. For instance, Ferraro and Shippee (2009) integrated the concept of
cumulative advantage/disadvantage, which addresses inequalities as a cumulative
process that unfolds during the life course (see also O’Rand 1996) along with the life
course perspective. The articulation of five axioms to identify how life course trajectories
are “influenced by early and accumulated inequalities can be modified by available
resources, perceived trajectories, and human agency” (Ferraro and Shippee 2009, 333).

Also, Hareven (1986) suggested that the use of the life course perspective,
particularly the use of cohorts (based on birth order) instead of generations (based on
family lineages) facilitates the study of experiences in earlier life, and how these can
influence during old age, because older adults should be not studied as a homogeneous
group, but instead as cohorts moving through history, each one with their particular
characteristics. In other words: different aspects of individual aging are often “not
ddictated by chronological age per se, but instead shaped by a host of factors that
cumulate in individuals over decades of living” (Dannefer and Settersten 2010, 3). For
this reason, the life course, as a theoretical orientation provides the guidance to
understand the meaning behind everyone’s old age experience.
In Latin America, most life course studies have been related to old age and aging, however, the popularity of the life course perspective is not as big as in other regions (Blanco 2011). For example, Oliveira and Liberalesso (2008) conducted a study about successful aging in Brazil, creating a concept that considers individuality and cultural difference, which can be achieved through setting realistic personal goals. In addition, Gastron and Lacasa (2009) conducted a study in Mexico, describing the perception of changes during the life course: they found that people perceive many changes in their youth, and then the perception of change is decreasing throughout life; reaching a point during old age when losses outweigh gains.

On the other hand, anthropologists have always been interested in the life course, from as early as Malinowski’s “Argonauts of the Western Pacific”, published in 1922; and Margaret Mead’s “Coming of Age in Samoa”, published in 1928 (Danely and Lynch 2013). However, as Bateson (2013) notes, these earlier works were focused on a childhood rather than adulthood, aiming to examine early developmental transitions, such as puberty and marriage; without considering the life course as a whole. In fact, it was not until 1945, when Simmons published his now classic work “The Aged in Primitive Society”, that anthropologist considered the aged as a particular age group to be studied (Fry 1980). Thus, early anthropologists collected data among all age groups. They had the material to analyze and describe cultures in term of what we know today as the life course perspective; in fact, some of them did research considering the different life stages as a whole. Even so, they did not use the term life course. For instance, Meyer Fortes, a South-African anthropologist, who conducted work among the
Tallensi and Ashanti in Ghana, examined kinship and family, and described how their particular social structure modified their lives (Fortes 1949).

Regarding this research, the life course perspective, serves as a link between theory and applied research, providing a way to address old age in Chile: it is important to consider the social and historical context of the present-day Chilean older adults: they were born around mid-1930’s and 1950, therefore, they were raised during a period in which Chile was a completely different country. For instance, gender roles were completely different, women were associated with the domestic sphere, raising children, taking care of their families, and doing house chores; instead men were socialized to being the breadwinners, and to have a completely different live outside home with male friends (Barros 1979). For this reason, women were not encouraged to study, as opposite of their male counterparts. Therefore, being born and raised during these years, as data analysis will show in Chapter 5 and 6, shaped the way in which both genders relate to each other during their entire life course. Also, as it will be shown in Chapter 3, the military dictatorship during 1973 and 1990 reshaped the country, affecting the lives and timing of the people alive during that period, and, future cohorts. Examples like these, reaffirm the importance of considering the historical context when it comes to study individual’s lives. Moreover, demonstrates that in aging studies, the life course perspective it is key to understand the lives of present-day older adults, because it also consider relationships with others as fundamental, to contextualize the individual as a part of a particular society, in which they have different roles.

The following section addresses well-being, the second approach used in this research, as a way to complement the life course perspective.
Well-Being

“The Good Life”

Well-being as a concept has been described as “elusive and promiscuous” (Barnes, David and Ward 2013, 474), because of the lack of consensus about what it means, its scope, and its measurements. Still, that does not necessarily mean that there is no consensus at all. Some authors suggest that its main scope it is related to what is the good life: how each individual thinks and feels about what is important in their lives. In this sense, well-being reflects “how much people are living in accord with evolutionary imperatives and human needs, abut also represents judgments based on the particular norms and values of each culture” (Diener and Suh 2000, 4). For this reason, it is important to consider cultural relativism alongside well-being, because the set of values considered to judge “living well” will vary cross-culturally. Hence, the importance of counting with models constructed from local data to address well-being in a particular context.

Moving to the different ways to address well-being, Toma, Hamer and Shankar (2015) distinguish two main approaches: hedonic and eudaimonic. The hedonic approach has two components: affective and cognitive. Affective is based on joy and the absence of negative affectivity. Instead, cognitive is constructed from a “life evaluation”, which can be about life as a whole, or a specific aspect. On the other hand, the eudaimonic approach investigates the “philosophical” aspects of life, such as purpose in life, sense of control and personal growth.

In addition, Diener and Ryan (2009) identified six different ways to approach well-being. Some of these are: telic theories, which conceive well-being as a synonym of happiness, and can be achieved when a goal or a necessity is satisfied. Temperament
and personality theories consider that personality traits are strongly related to well-being: for example, extraversion can predict positive affect and neuroticism leads to negative affect. Relativist standards are composed by two approaches, social comparison theory and adaptation theory. The first states that an individual use as standard of good life, other people’s experiences, therefore, the social context play a very important role. Instead, adaptation theory refers to the constant pursuit of happiness or what it has been called “hedonic treadmill”; this is because once the person reaches a positive goal, he/she will have a boost of well-being; however, later, the person will adapt to this new baseline, looking for more positive experiences.

For this research, I consider well-being as an umbrella term (see Chen 2001), in which individuals evaluate what it is important in their lives, according to their particular cultural context (Diener and Suh 2000). The culture in which individuals live shapes which factors are considered as the “good life”; for this reason, it is expected to find variations across cultures, and during the life course of an individual, as they move through historical times. The Centre for Health and Well-being at the University of Sheffield suggests that the factors influencing well-being are life satisfaction, health status, social support, and socioeconomic status (CWIPP 2015).

In addition, considering the fact that there is no clear consensus about a definition of the concept of well-being, this research aims to generate a definition of well-being in late life through life story interviews with participants, to record in their own words which factors they think that influence the perception of feeling well.

Well-being and quality of life have been used to assess a more holistic perspective of life, considering physical, psychological and sociocultural factors; moving
away from some -now outdated- biomedical perspectives about health as the absent of disease (Walker 2005).

Considering several factors that can influence well-being helps to provide a better understanding about how can really affect the sense of well-being. However, this relativism on which factors are considering important, can also be considered as weakness.

The main weakness about the concept of well-being is the lack of consensus on its definition and ways to measure it. For instance, for some authors, quality of life is a synonym of well-being (Bowling and Gabriel 2007). Whereas for others (Diener and Ryan), well-being is a key component of quality of life. Still, academic and lay audiences refer to well-being as a widely-known concept, supposing that everyone knows exactly what it means (Walker 2005). This ambiguity has resulted in a large number of studies about new ways to measure well-being instead of articles focused on the needed debate about the limits of the concept, to narrow down and standardize the definition. This research is a contribution to fill that gap, asking directly to older adults, to describe, in their own words, what are the factors that they consider that helps them to age well, in their context.

Additionally, there is a general reluctance to associate quality of life and well-being with happiness (Gilhooly, Gilhooly and Bowling 2005). This opens a space for a debate about how pleasure, happiness and satisfaction of needs are addressed in each culture, and why happiness is considered as more subjective than quality of life. However, this issue will not be addressed here because it deviates from the central topic of this research.
Another challenge in well-being research is the generalization of results. In a highly-globalized world, cross-cultural studies are fundamental for our understanding of different cultures. However, cross-cultural research generates diverse challenges; and well-being research is not exempt of these (Matsumoto and van de Vijver 2011). As mentioned above, because well-being refers to the good life, its definitions can vary even among members of the same culture. For this reason, it becomes difficult to create adequate mechanisms to measure well-being that incorporate all the spectrum of diverse experiences.

Finding mechanisms to measure well-being has been also a problem for anthropology, because from its beginnings, the discipline’s goal was to increase understanding about different cultures, and this research was not excluded from this dilemma. This research aims to get the perceptions of well-being among a particular group of older adults in Chile and so the results are not broadly generalizable. However, this research is also an effort to increase our understanding about the different conditions in which older adults live around the world. This dilemma was solved using mixed methods: qualitative and quantitative methods. This allows to gather comparative data through surveys, and simultaneously, this data is grounded in the particular cultural context of contemporaneous Chile.

**Applications in Aging Studies**

The concept of well-being has been key to address quality of life among the aged. Most studies focus on which factors influence the sense of well-being.

During the twentieth century, as health care expanded in western countries, simultaneous discourses on health promotion, dieting, and exercise arose, increasing the pursuit of wellness across populations. Following this trend, in the late 1980s, Rowe
and Kahn (1987) developed a model to characterize independent older persons, using three domains: the absence of disease, physical/cognitive capacity, and engagement with life. Since then, the topic became a constant topic of research in gerontological studies, using terms such as “active aging”, “healthy aging”, and “productive aging”, even these topics became so popular that crossed academic boundaries, becoming a household word and a theme for self-help books. The success of this topic was based on the idea that individuals could take charge of their old age: if they exercised enough, ate healthily, and maintained their social life, in turn, they will be autonomous for a longer time. These ideas were especially successful in countries like the United States, because this emphasis on personal responsibility concurs with neoliberal ideas about individual freedom and self-control (Estes 2001; DiPietro et al. 2012; Bülow and Söderqvist 2014).

Because the cultural views of aging have changed since this concept was conceived (Andrews 2012), the concept has become outdated. For instance, successful aging implied that older adults seeking help was a sign of failure (Barnes, David and Ward 2013), increasing the age segregation already present in western societies. Instead, researchers suggest that it is necessary to embrace old age. Liang and Luo suggest that instead of using the concept “successful aging”, gerontologists, and the general population, should move towards “harmonious aging”, inspired by the Ying-Yang philosophy. This concept argue that it is necessary to find balance instead on uniformity; recognizing the challenges and opportunities of senescence, “health the integrity of body and mind, and emphasize the interdependent nature of human beings” (2012, 327). This is similar to what anthropologist Sarah Lamb suggests: “we are all
moving toward physical decline and death. The best we can do--and it's a lot--is to accept this inevitability and try to adapt to it, be in the best health we can at any age” (Lamb, 2014, 51). In this sense, Lamb suggests a recognition of meaningful decline, as part of the enjoyment of old age.

Still, words like “active aging” are part of programs directed toward the aged. For instance, in Chile, SENAMA, the National Service of the Aged, which is the entity responsible for development of social services for older adults, states in their webpage, that one of its main purposes is to engage active aging. Although the institution does not address specifically how they define active aging, considering the descriptions of their programs, it could be deduced that they refer to programs that seek to keep older adults as healthy as they can, considering the physical limitations that some of them can present (SENAMA 2015).

Besides successful aging, the well-being literature has focused on which aspects help to reach a better life. For instance, Toma, Hamer and Shankar (2015) determined how neighborhoods (described as the distance of 20 minutes of walking, or about one kilometer from home) influenced well-being. Among older participants, those who showed negative perceptions of their neighborhood had lower levels of well-being, and it was associated with greater decreases in well-being over a four-year period. However, the authors pointed out that their results are not generalizable, because a large percentage of participants were white (about 98%). However, Elliot et al. (2014) using data from three British cohorts of older adults, found that that a high sense of neighborhood belonging correlated with higher levels of subjective well-being, showing
that even though culture determines which factors affect well-being, there are some
cross-cultural shared elements.

In addition to the debate about the importance of the person-environment in well-
being, Wahl (2006) suggests that aging research is missing the contextual factors,
which are crucial determinants of day-to-day behavior and well-being in later life.

In this sense, it is also important to consider the well-being of those older adults
who are institutionalized. In these cases, they change their familiar context for an
institution in which probably they will not be able to make their own decisions, producing
relocation stress, which affect well-being.

The life-course perceptive, described on the previous section, suggest that
events happened during younger years will have an impact in old age. In addition, a
study conducted by Chen (2001) in Taiwan, found that even after controlling
demographic and aging effects, life satisfaction decreased as age advanced, because
the participants in their earlier twenties experienced the effects of World War II. These
results are contrary to the increase in subjective well-being that is expected during old
age, because it has been found that “life satisfaction increased to approximately age 65-
70 and then declined” (Mroczek and Spiro, 2005, 197). There is an inverted-U
relationship between age and well-being, meaning that the latter improves with age.
This is possible because older adults “maximize social and emotional gains and
minimize social and emotional risks” (Carstensen 1992, 331). Besides, Baltes’ (1997)
theory of Selection, Optimization, and Compensation, states that during late years, the
elderly create several coping strategies including: selecting goals, optimizing goals and
preferences, to find a balance between the gain and losses inherent to old age.
Therefore, the decrease in well-being experienced by the Taiwanese sample corresponds to the years they lived and were exposed to World War II.

Along with the factors mentioned above, research has found that monthly income affects perceptions of well-being. However, Lloyd-Sherlock and colleagues (2012), in their comparative research suggest that although pensions and cash transfers have been considered as prime determinants of well-being among older adults of developing countries, the “reality is much more complex, and relates to wider processes of development and change, as well as older people’s own evaluations and expectations” (Lloyd-Sherlock et al. 2012, 251). This highlights the importance of considering older adults’ own perspectives and sociocultural settings to understand which factors really contribute to their perception of well-being.

This chapter provided an examination of two approaches: the life course perspective and well-being. Although these approaches have been used for many years, there is still room to improve and complement these. For instance, this literature review raises some questions, especially concerning aging studies. During the nineties, when the life course research was still incipient, yet becoming more popular, anthropologist Christine L. Fry (1990) suggested that the life course perspective needed empirical research of how the life courses vary across cultures and within cultures, to have a better understanding of the forces which shape life courses. Some twenty years later, anthropologists are still making the same call for more research across cultures, considering that most research still emerges from a very small portion of the world (Danely and Lynch 2013). If worldwide institutions like United Nations and World Health Organization reports sporadically numbers about life expectancy, population aged 60
years and above, and other characteristics, why we do not know so much about the conditions in which older adults are living? What are the factors that the aged, as a heterogeneous group, consider to “age well”? can the life course perspective help to our understanding of well-being in old age? Are there any differences or commonalities in perceptions of well-being among older people living independently, and those institutionalized?

Considering the above, this research addresses those gaps, providing information about older adults in Chile, a country with a particular political history, and it is in the crossroads of economic development, cultural changes and aging (Gitlin and Fuentes 2012). Although research has been conducted in Chile about the aged, most of focus on the health problems during old age, or are conducted in the larger cities. In this sense, this research acknowledge that these previous studies have been key to expand our understanding about Chilean older adults, still, there are gaps to fill, especially concerning older adults living in less populated areas and explore if there are any differences between individuals living in their own homes and in institutions.

Chapter 3 will expand on the contextual context in which this research took place. First, I explain the current demographic profile, and the potential impacts of an aging country in terms of the society as a whole, families and household, social contract, and older adults. Then, I will address social security, living arrangements, and cultural views of the aged in Chile.
CHAPTER 3
CHILE: AN AGING COUNTRY

During the last 50 years, Chile has experienced several cultural, political and demographic events that have changed the country. For example, the military dictatorship headed by Augusto Pinochet, lasted seventeen years. Pinochet’s regime facilitated a privatization of services but, left 1,209 individuals detained/disappeared, 8,259 tortured political prisoners, and 342,298 deceased (INDH 2011).

There is no clear consensus among historians whether the transition to democracy continues to the present day or whether it has already ended. However, most historians refer to the period between 1988 and 1990 as the end of the regime. The first refers to the year when the first democrat elections were held through the plebiscite, and 1990, when Patricio Aylwin assumed as the first president democratically elected since Salvador Allende in 1970 (Salazar and Pinto 1999). Still, Chileans are trying to reconcile the previous political/ideological postures, and looking for new ones, based on pluralism and consensus juxtaposed (Richard 2004). However, this process has been more complicated in comparison with other countries that also were military dictatorships, because almost 44 years later after the coup, “in Chile there remain many supporters of Pinochet and his regime. Chile is often likened to two nations sharing the same territory, but divided by an ideological chasm and opposing memories of the past” (Natzmer 2002, 237).

Also, what has attracted most international and national attention, is that after the dictatorship ended, center/left governments of the Concertación coalition (founded in 1988) have supported the neoliberal model (Winn 2004). In fact, Garretón (2012), argues that the Concertación –called Nueva Mayoría since 2013- have failed to
overcome or replace this model inherited by Pinochet through several measures. For instance, the first government after the dictatorship, presided by Patricio Aylwin (1990-1994), kept an open market economy. Then, Eduardo Frei’s government (1994-2000), instilled Chile’s economic integration with the rest of the world through free trade agreements (FTA), which were concretized during the next government.

In addition, there have been changes related with religion, especially among Catholics, who are the largest religious group in Chile. According to the census of 2002, among those aged 15 years and over, 70% claimed to be Catholic (INE 2003). In 2016, this percentage changed to 58% (PUC and Adimark 2016). Although the 1925 constitution officially separated Church and State, the Catholic Church remains a powerful agent in Chile, because it served as a powerbroker in the Chilean transition to democracy. Therefore, the Church “acquired political legitimacy and developed close relations with the politicians who later took control of the national government” (Htun 2003, 80). For instance, there are catholic schools for the children of Chile’s ruling classes, and the National Catholic University (a place for the elite). In addition, there are charity organizations that benefit the most vulnerable sectors of the population.

Currently, Chile faces a rapidly expanding economy and an advanced demographic transition, in which its habitants are living longer and having fewer children. This situation presents unique challenges for the country, because these changes have occurred much faster compared to Europe and the United States.

Chapter 3 assesses the essential characteristics of the country, such as identities, demographic profile, and the principal characteristics of older adults and their access to social security and services, for a better understanding of the current
demographic situation, and how that originated in the cultural, political and historical Chilean context.

**Demographic Transition in Chile**

In 2015, the estimated population for Chile was 18,006,407 habitants; 49.5% of them men and 50.5% women. Most of the population lives in urban areas, only 12.7% of the population live in rural areas (INE 2016). To reach this current demographic profile the country faced several cultural and political changes that shaped the population. One of these changes is the demographic transition.

The demographic transition theory states that societies progress from high fertility and high mortality rates to conditions of low fertility and mortality, due to economic development: on one hand, people gain access to education and contraceptives, therefore, couples start to have fewer children. On the other hand, sanitary conditions improve, increasing access to medical care and vaccinations, causing a decrease in infectious diseases (Kirk 1996). In addition, it is expected that birth rates will continue decreasing as societies become wealthy (Taucher 1997).

Because of these demographic changes, there is an increase in life expectancy and reduction in mortality. As a result, aged societies emerge.

Aged societies are characterized by a higher number of people aged over 60, and a lower number of younger people (Leeson 2013). Table 3-1 shows the similarities and differences between Chile, Latin America and the Caribbean, the United States, and the European Union in terms of total fertility rate, life expectancy at birth, and the population aged 65 and over (World Bank 2014):
Table 3-1. Total Fertility rate, life expectancy at birth and population aged 65 and over: Chile and selected regions

<table>
<thead>
<tr>
<th>Category</th>
<th>Chile</th>
<th>Latin America &amp; Caribbean</th>
<th>United States</th>
<th>European Union</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fertility Rate</td>
<td>1.8 children born/woman</td>
<td>2.1 children born/woman</td>
<td>1.9 children born/woman</td>
<td>1.5 children born/woman</td>
</tr>
<tr>
<td>Life expectancy at birth</td>
<td>81 years</td>
<td>75 years</td>
<td>79 years</td>
<td>81 years</td>
</tr>
<tr>
<td>Population aged 65 and above (% of total population)</td>
<td>11%</td>
<td>8%</td>
<td>15%</td>
<td>19%</td>
</tr>
</tbody>
</table>

Although these numbers show that Chile is experiencing an advanced aging of its population (CEPAL 2015), they do not explain the complex set of factors that have influenced these changes. For instance, regarding human fertility, factors such as socioeconomic status, religious beliefs, and nutritional status, among others plays and important role (Wood 1994).

In Chile, there was an increase in fertility rates especially within the period of 1950-1959; however, there have been several changes that have affected the fertility rates. For example, in 1960, the appearance of contraceptive methods, the incorporation of women into the workforce, and economic development initiated a decline in fertility rates. In fact, during 1961 Chile reached its highest fertility rate of 5 children per woman. During the period from 1970 to 1979 this rate declined by half, and since then the rates have been declining progressively (INE 2013).

Figure 3-1 shows the changes that Chile has experienced from 1950 to 2010 in terms of fertility rates.
The current total fertility rate, 1.9 children per woman, is a number that the Economic Commission for Latin America and the Caribbean (ECLAC) predicted Chile would reach in 2020 (Donoso 2007).

On the other hand, life expectancy at birth has also increased for both sexes: it went from 67.2 years in the period 1975-1980 to 79.1 for 2010-2015. Figure 3-2 shows these changes:
In addition, the country has an Aging Index of 80, which means that for every 100 people under age 15, there are 80 people over 60 (Ministerio de Desarrollo Social 2015). Figure 3-3 shows how the aging index has changed from 1990:

![Figure 3-3. Aging index, Chile: 1990-2013.](image)

**Impacts on the Chilean Society**

The United Nations (2013) suggests that the actual aging patterns are unprecedented and will have different implications in the population. For this reason, the perceptions about the aging population have been changing gradually, from a reflection of social success (Roughan, Kaiser and Morley 1993) to a complex issue, mainly based on the potential implications to the society (Restrepo and Rozental 1994).

In fact, because of speculation on possible implications, aging has become part of the so-called “apocalyptic demography” (Gee and Gutman 2000), which focuses on the potential burden that a larger aged population can generate on the rest of the
society. Following this line of thought, Leeson (2013) suggests that an aging population—or any age combination—is not a threat; instead, the challenge resides on the ability of local and regional structures to adapt to the new demographic profile.

One of the impacts it is the increase on the dependency ratio: the number of dependents, aged 0 to 14 and over age 65, to the total of the population, aged 15 to 64 (Harwood, Sayer and Hirschfeld 2004). In Chile, this ratio is not yet a problem, however it is expected to become a problem within the next decade. The current migration flows could help Chile to reverse, or at least, reduce the impact of the dependency ratio.

Since the return to democracy, the number of migrants has increased: according to the Department of Immigration and Migration (Departamento de Extranjería y Migraciones 2016) it went from 0.7% in 1982 to 2.3%, which is still low contrasted with the world average, 3.2%, but high for Chile's parameters. Most migrants are from the neighbor countries: Peru (31.7%), Argentina (16.3%) and Bolivia (8.8%). Nevertheless, in 2015, there was an important increase in Haitian migrants, from 3,644 in 2014 to 8,888. Most of them choose Chile because they are looking for better work opportunities and personal development (Rojas et al. 2016). Since 43.3% of the migrants are between 20 and 35 years old, it is expected to generate an increase on the work force (Biblioteca del Congreso Nacional de Chile 2016).

Another impact is the increase on public spending. According to predictions of the Ministry of Health, in 2020, about 1.5% or 2.1% of the GDP will finance healthcare for the elderly, which means a 98% increase regarding previous years (Departamento de Estudios y Desarrollo 2006).
Impacts on Families and Households

During the last twenty years, Chilean studies of families have changed significantly: as Chilean anthropologist Gonzálvez Torralbo (2015) notes, during the seventies and early eighties, there was a process of phatic imposition of a two-parent nuclear family model, where the father was the provider, and the mother was the caregiver. The Catholic church endorsed this model, and its influences crossed the religious borders to move into the academic sphere. Here, researchers that claimed to be away from a moralistic and doctrinaire position, ended up reproducing the same model of “ideal family”, especially from psychology, where academics stipulated that “family’s mission is to love” (Covarrubias, Muñoz and Reyes 1978, 19).

Later, feminist academics considered the family as a place to study gender roles (Valdés 2007) and noticed that the family was not a place of balanced gender roles, and that changes in the public spheres do not necessarily changed the power relationships within the families, which Valdés and Godoy (2008) denominate as conservadorismo fracturado (fractured conservatism), because there are modifications in certain aspects; however, in others, traditional roles still are predominant.

Yet, Gonzálvez Torralbo (2015) recognizes weakness within current Chilean family studies: although nuclear families are decreasing (Valdés, Castelain-Meunier and Palacios 2006), family studies still focus on nuclear biparental families, neglecting single-parent families, especially those by originated by adoption or the use of assisted reproductive technology, same-sex families, transnational families (where some family members live in other country, and still maintain bonds with their family), and childless families. Second, the term family is used to refer to both, kinship and households. Here I will suggest that this is not an induced error because of the language, because in
Spanish, the word for family is *familia*, and for households can be *hogares* or *viviendas*, therefore, there are different words to refer to family and households; however, Chilean researchers keep using family as a synonym for households. Third, there is a lack of interdisciplinary in family studies in Chile. There is almost no dialogue and cooperation between disciplines. Most family studies come from the health sciences, psychology, and sociology.

Moving to the current situation of families in Chile, the Ministry of Health describes the current demographic situation as characterized by small families in which couples decide to postpone pregnancies (MINSAL 2011).

In general terms, these changes altered the composition and size of the household which moved from 5.4 people on average in 1960, to 3.6 in 2002 (INE 2010). Also, the head of the household has changed: In 2000, 76.8% of the households were headed by men, whereas only 23.2% by women; thirteen years later, the number of households headed by women increased to 37.9%, higher than the 33% average for Latin America (CEPAL 2015). In addition, the household composition has changed as the number of single-person households has increased, and many couples have chosen to delay parenthood or simply prefer to remain childless (MIDEPLAN 2001).

In addition, during the last 15 years, the marriage rate (number of marriages per 1,000 people) had decreased, the age at first marriage had increased and the divorce rates reached its peak in 2013. Table 3-2 shows marriage rates, average age of marriage, and divorce rates for Chile, United States, and the Organization for Economic Cooperation and Development (OECD):
Table 3-2. Marriage rates, average age of marriage, and divorce rates: Chile and selected regions

<table>
<thead>
<tr>
<th>Category</th>
<th>Chile</th>
<th>United States</th>
<th>OECD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage rate (marriages per 1000 habitants)</td>
<td>3.5</td>
<td>6.9</td>
<td>4.6</td>
</tr>
<tr>
<td>Average age of first marriage (men)</td>
<td>30.4 years</td>
<td>26.6 years</td>
<td>32.6 years</td>
</tr>
<tr>
<td>Average age of first marriage (woman)</td>
<td>25.5 years</td>
<td>26.6 years</td>
<td>30.3 years</td>
</tr>
<tr>
<td>Divorce rate (divorces per 1000 habitants)</td>
<td>0.1</td>
<td>3.2</td>
<td>2.1</td>
</tr>
</tbody>
</table>

As shown in the Table above, marriage rates have decreased. In 1980 they remained stable at around 8.0 marriages per 1000 habitants, but today the rate has been reduced to 3.7. In addition, the average age of marriage has changed for both genders. In 2000, men married at age 28 and women at 26; eleven years later, the average age increased to 32.3 for women and 35.1 for men (INE 2014).

Divorce is legal in Chile since 2004; however, in the previous law, divorce was regulated, nonetheless, it did not put an end to marriage (because it did not dissolve the bond), therefore, it did not allow divorced people to remarry. The number of divorced couples presented a sustained increase until 2013, when reached its peak with 63,730; in 2014 this number decreased to 58,707. Divorces by mutual agreement represent 62.7% of separations in Chile (INE 2014).

Because many couples prefer to live together without being married (Salinas 2011), in April 2015 the Senate approved the Law of Civil Union, which is a contract between two people who share a household. This law allowed both heterosexual and homosexual couples to have a “legal” recognition of their status (Ministerio Secretaría...
Almost two years have passed since the enactment of the law, so there are currently no studies that describe the characteristics and motivations of those who choose this type of union over marriage.

These changes have occurred because women have greater access to education, and they have been gradually incorporated into the workforce. However, this does not mean that men and women live on equal terms. The report “Women in Chile and the labor market: women’s labor participation and wage gaps” was conducted by the Instituto Nacional de Estadísticas (INE 2015), and found that the female participation rate rises with increasing educational level. For people who only attended middle school, there are still gender differences, as reflected in employment rates that are currently 35.5 for women and 64.8 for men. In contrast, for people with graduate studies, employment rates are 88.5 for women and 91.1 for men. Additionally, the wage gap resulting from extreme differences in educational level is larger: with a primary education, women receive 42.0% less income than their male counterparts, while women with graduate studies receive on average 36.8% less income than men with the same educational level. This illustrates that in Chile, women are “punished” if they have few or many years of schooling. There is unequal access to the labor market for women and men, which results in significant differences in labor force participation rates for both groups.

It is important to note that over time, the tendency is towards a significant change in gender roles: men have been incorporated into household chores, and women have joined the workforce. Because of this, both men and women have been in conflict over how to combine their work and domestic spheres: although women are working outside
the home, this does not mean that they are delegating all domestic chores to men. On the other hand, men are also trying to divide their roles. Historically, the main role of a man was to be the family provider, and today they must continue to fulfill that role, but simultaneously they wish to spend more quality time with their children, and to help in parenting (Olavarría 2001).

These changes in Chilean families and households highlight the importance of incorporating gender analysis to family studies, because as Marx Ferree suggests “family change has continued to be seen more as a crisis than an opportunity for challenging pervasive structures of societal inequalities” (2010, 421).

**Impacts on Social Contract**

Even though most of the elderly population is autonomous, at some point older citizens will need some kind of assistance, either due to a health problem related to a disease, or just some consequence of aging (Sulbrandt, Pino and Oyarzún 2012).

Since the resources to provide elderly caregiving are limited, Bengtson and Achenbaum (1993) suggest that to determine the organization of a care structure requires an implicit agreement between generations, which dictates who deserves care and who is the adequate person to act as the caregiver. This symbolic understanding is known as a social contract, which provides a set of norms concerning what it is expected from each participant. Because the assumptions regarding what constitutes support differ across cultures, this social contract will be unique from one culture to another (Hashimoto 1996).

There are two kinds of support available: family caregiving, and formal caregiving. The first is also known as informal caregiving, and refers to kin and non-kin relationships (Tessler and Gamache 2000). The other option is formal caregiving, which
can be provided by the State or a private institution (Walker, Pratt and Eddy 1995). However, both options are not exclusive, and can be used simultaneously, since formal caregiving should not be considered as a substitution: “formal services do not encourage families to reduce or withdraw the amount of care that they provide, nor does home care substitute for nursing home care” (Kane and Penrod 1995, 16). Accordingly, it is important to consider both options as complementary rather than exclusive, because elderly caregiving should be a shared responsibility between the family, the State, and the society (Huenchuán 2010).

Although the current demographic transition implies some challenges to the family, this does not necessarily lead to family decline (Hareven 2000). As Popenoe (1988) suggests, the family has always been subject to change, and this plasticity has allowed the family to survive as an entity.

Presently, family caregiving is one of the multiple responses to demographic shifts, and can be considered an example of familiar solidarity and the fortitude of family ties (Abellán and Esparza 2009). However, the consequences for family caregiving have become a concern, especially when the number of people aged 65 and over increases. In addition to the economic costs, there is an academic interest on the health of caregivers and their elderly care-receivers (Van Durme et al. 2012, 491), with evaluations focused on caregiver burden and mental health (Mosquera et al. 2016).

These consequences are attributed to the notions of individualist personhood, such as independence, productivity and self-maintenance, that are prevalent in western cultures and have been “exported” to other cultures (Lamb 2014). In fact, most of the contemporary welfare policies are conceived on the basis that “to be dependent is bad
and to be independent is good” (Robertson 1997, 435), although no one is completely independent.

These notions about independence can also influence well-being in older adults. Although is possible to find some cases where the elderly parents expect to receive attention from their adult children, most of them do not want to become a burden and desire to stay active as much as their physical and mental health allows them (Beyene, Becker and Mayen 2002; Zhang and Goza 2006; Sokolovsky 2009b).

In Chile, when older adults become dependent, family care is still the most prominent option: 44% of elderly caregivers are their adult children, and 83.7% of those are women. The average woman caregiver is between 40-60 years old (Jofréd and Sanhueza 2010), is of a lower socioeconomic status, has poor social networks and does not possess or have access to any caregiving training (Jofréd and Mendoza 2005).

Even though gender dynamics are shifting in Chile, the traditional gender roles still prevail. Women are socialized to develop specific skills and abilities to help others (Herrera and Kornfeld 2008). So, because it is considered a “duty” that women should provide care, the role of women as caregivers is taken for granted and not appreciated (Vaquiro and Stiepovich 2010).

Some statistics show that in Chile there is reciprocity between parents and their adult children, which is expressed in the exchange of resources throughout the entire life cycle, and with a greater emphasis on times of greatest need (Herrera and Fernández 2013). Simultaneously, additional data from the National Survey on Older Adults’ Quality of Life suggest that ideas about filial obligation are slowly changing: in 2010, 45.9% of the respondents believed that it is always mandatory for adult children
to take care of their parents when they can’t be independent any longer, and in 2013, only 41.9% believed so (PUC, SENAMA and Caja Los Andes 2011; PUC, SENAMA and Caja Los Andes 2014).

In previous research (Salazar, forthcoming), a study explored social scientists’ perceptions about the changing social contract for elderly caregiving. The research found that although latest national surveys have shown that the sense of filial responsibility is decreasing among the Chileans, there is still a sense of intergenerational solidarity within the families. The challenge then, resides in how to extrapolate that solidarity to the rest of the aged population, because stereotypes of the elderly as a frail and dependent group, and the privatizations of services, are leading some sectors of the Chilean population toward individualism. However, some data also showed that other sectors will be willing to pay an extra tax to guarantee adequate care in old age.

**Chilean Older Adults**

As mentioned above, 16.7% of the Chilean population are people aged 60 and over, and 55.5% are women (Ministerio de Desarrollo Social 2015). Once people reach age 60, their life expectancy is 24 years for both sexes (WHO 2014). The parent support ratio, which is the relationship between people aged 80 and over (potentially dependents, and care receivers) and people between 50-64 years (who are more likely to assume as caregivers for dependent older adults) went from 11.5 in 1990, to 16.4 in 2013. This means that although the population of the aged has increased, it also has increased the population of potential caregivers. Evidently, this index is based on suppositions, therefore, the real situation can be completely different.
Regarding socioeconomic status, the percentage of older adults in poverty has decreased from 2006, it went from 15.3% to 6.5% in 2013. Concerning location, Valparaíso Region and Maule Region concentrate the highest number of population aged 60 and above. Regarding their health, 68.3% of older adults have a normal nutritional state, 81% are independent. Concerning education, 9.3% are illiterate, much higher than the national average, which is 3.7%; in addition, they have 8 years of education in average; whereas the national average for people aged 19-59 is 11.8 years. Women have 0.6 years less than men in average among older adults; instead, among people aged 19-59 years the difference is 0.1 years. Finally, 9.9% of older adults participate in a religious organization, 8.9% in neighborhood council, and 6.5 in clubs for older adults (Ministerio de Desarrollo Social 2015). It is important to note that most older adults are Catholic: among people aged 55 and over, 68% are catholic, 20% Christian and 10% do not belong to any religion or identify as atheists/agnostics (PUC and Adimark 2016).

Although Chile was considered as the best Latin American country in which to age (HelpAge 2013), was the second Latin American country to become a member of OECD (OECD 2010), and the GPD during the period 2009-2013 was relatively stable (World Bank 2014), Chilean academics, especially from the Social Sciences, have criticized these achievements. Montecino (2004) for example, explains that many of these achievements are measured in indexes but not in quality; therefore, these “successful numbers” may be missing the real impact that each one of these achievements has on the Chilean population. The GINI index measures the degree of inequality in the distribution of family income, the value ranges from 0 (equal distribution
of income) to 100 (unequal distribution). Chile has a GINI index of 50.2, which defines Chile as the most unequal country of the OECD (World Bank 2014).

Aging and the Social Safety Network

For the last forty years, Chile has faced several cultural and political changes. As mentioned in the beginning of Chapter 3, the most important agent of change was the military dictatorship. This started with the coup led by Augusto Pinochet against the socialist government of Salvador Allende on September 11th 1973, and ended when Patricio Aylwin assumed the presidency after the first democratic election in almost eighteen years (Bitar 1990).

In 1970, Salvador Allende was elected president of Chile, becoming the first socialist to become president of a Latin American country, elected through a democratic election. During his government, Salvador Allende nationalized large-scale industries such as copper mining and banking, and increased social spending on education and health care system, moving the country towards socialism. This, in change, produced an increase of enrollment in kindergarten, primary and secondary schools, and improvement in sanitary conditions of rural and low-income areas (Ruiz 2005; Salazar and Pinto 1999). The increase in public spending, caused a deficit in fiscal resources, generating inflation that affected business. In turn, companies tried to sabotage the state, through hoarding of basic resources such as food and cleaning supplies. For this reason, the government was losing support among the population, different groups such as health practitioners, small business, transport and mining showed their rejection (Memoria Chilena 2016).

In September 11th, 1973, the Military Junta, aware of the economic inflation, executed a coup d’ etat against Allende’s government. This group headed by Augusto
Pinochet, commander of the army, was also composed by the commanders of navy, air force and police. Years later, the Central Intelligence Agency of the United States (CIA), revealed in a declassified report that they “sought to instigate a coup to prevent Allende from taking office”, in 1970, through three plans; one of them included provision of tear gas, submachine-guns and ammunition to one group of Chilean plotters. Although “CIA did not instigate the coup that ended Allende’s government on 11 September 1973, it was aware of coup-plotting by the military”. Still they assumed that during the dictatorship, the CIA influenced news media in Chile, as an effort to improve Pinochet's public image (CIA 2007) despite the fact that during his regime, there were 1,209 individuals detained/disappeared, 8,259 tortured political prisoners, and 342,298 deceased (INDH 2011).

The military regime facilitated the transition to a neoliberal country. An analysis made to the discourses made by Pinochet during the military regime (Saavedra and Farías 2014) showed that these neoliberal policies were directed towards privatization, deregulation, free trade and reductions in government spending. These changes were achieved mainly through the reforms imposed on seven sectors, which per the Military Junta were the most vulnerable: social security, education, workplace, regional decentralization, agriculture, judiciary and health sector (Danus, Silva and De la Cuadra 1982). These reforms were executed through the reorganization of the government functions: instead of investing in social policies, the State favored the creation of funds for private resources, imposing a perception that public services were inefficient, and that only through free choice of private services could Chileans access quality services (Tetelboin 2003).
Pension Systems

There are two reforms made during the dictatorship that affected directly the elderly population: the privatization of the pension system and the health care system.

In 1980, the military regime privatized the previous pay-as-you-go (PAYG) scheme to a defined contributions (DC) scheme that was based on individual capital accounts, which were managed by private companies, or pension fund managers (AFP) (OECD 1998). Chile was the first country to privatize the pension system (Quintanilla 2011).

The PAYG system was based on “social solidarity”, since each pension was financed in part by the contributions made by the active workers and the State, the money collected went to a common fund. Furthermore, pensions were based on the taxable remunerations registered by the worker in the last years before retirement, and included allowances for maternity, widowhood, hard labor, and work in toxic environments (Arellano 1985). However, this system was criticized for the lack of uniformity, because of the “series of parallel systems for different groups of workers, with broad heterogeneity of eligibility rules and benefits” (Fajnzylber and Paraje 2014, 130).

In the current system, each worker has a personal account where their contributions are deposited, and they will earn the profitability of the investments that the AFP made with those funds (Superintendencia de Pensiones 2014). Under this system, women are at a disadvantage: most older women did not have a paid job during their adulthood, or if they did, they possibly got maternity leave, or constant absences due to childbearing or taking care of another family member, resulting in less investment in an AFP, and therefore, obtaining a lower pension.
Considering the above, in 2008, the government of Michelle Bachelet undertook a reform of the DC system to introduce a solidarity pension system designed to promote gender equity and reduce the inequities that the individual capitalization system was generating (Larrañaga, Huepe and Rodriguez 2014).

Despite these efforts, the average old-age pensions are lower than the minimum wage, and there is still a gap between genders. In November 2016, the minimum wage was USD$390 for adults aged 18 to 65 years (Dirección del Trabajo 2016), and the average pension for men was USD$292, and for women USD$ 172 (Superintendencia de Pensiones, 2016a). Figure 3-4 shows the difference of income between men and women:

Figure 3-4. Minimum wage and average pension, both genders, November 2016 (in USD).

The financial situation is even harder for the retirees who have a basic solidary pension (Pensión Básica Solidaria-PBS). Only people aged 65 and over who belong to the poorest 60% of the population can gain access this benefit. In November 2016, the amount was USD $156 monthly (IPS 2016), which is equivalent to 40% of the minimum
wage, and 45% of the total of retirees received this benefit (Superintendencia de Pensiones 2016b). Also, the National Socioeconomic Profile (CASEN) surveys showed that within the 65-75 age group, at least one in five adults is still working; which shows that the actual pension system “does not allow adults over 65 to retire from the job market” (Fajnzylber and Paraje, 2014, 129).

**Health Care**

During the dictatorship, the healthcare system also was privatized. In the early seventies, before the coup, the Chilean healthcare system comprised four agencies: Health Ministry (Ministerio de Salud, MINSAL), National Health Service (Servicio Nacional de Salud, SNS), National Employees’ Health Service (Servicio Medico Nacional de Empleados, SERMENA), and the private sector (Aedo, 2000). In 1973, the reforms to the healthcare system began, concluding with the creation of the new health system in 1981. Health reforms consisted of several phases: elimination of staff linked to the previous government, separation of the agents who developed the main functions, and finally, a change in the axis of power in the health sector (Tetelboin 2003).

The actual healthcare system is a mixed one, consisting of public and private sub-systems. The public system is called FONASA (Fondo Nacional de Salud), which is funded through State contributions, mandatory contributions from workers (7% of taxable income), and co-payments. FONASA beneficiaries are divided into 4 groups according to their income, from category A: indigents, vulnerable people and basic solidarity pension beneficiaries, to category D: people who receive a monthly taxable income higher than USD$ 495 (Superintendencia de Salud 2015). The private system,
ISAPRE is funded using the same 7% of taxable income, plus an additional amount which will depend on the plan of each beneficiary (Arteaga 2008).

Today a worker must earn at least the equivalent of USD$ 565 to enroll in the ISAPRE system if they do not have dependents; otherwise, the baseline will rise (Superintendencia de Salud 2015). Considering the current minimum wage, this means that only a small group of the population can afford healthcare services through the private sector, and some age groups, such as older adults are discriminated against, because as stated above, the average pension and basic solidary pensions are below the minimum wage. In fact, 86.1% of older adults are enrolled on FONASA; instead, 7.4% of them it is enrolled on ISAPRE (Ministerio de Desarrollo Social 2015).

**National Service for Older Adults (SENAMA)**

In Chile, the aged were not a target population for social policies (except pensions) until the military dictatorship. During previous decades, there were two kinds of institutions that cared for the elderly: state-owned, and faith-based organizations, such as ANIPSA, a conglomerate of catholic institutions which includes international partners such as Caritas (Aldunate and Gutierrez 1985).

Then, in 1995 the National Committee for the Aged (CONAMA) was created to make a diagnosis of the current situation of the elderly population and suggest ideas to address issues and concerns related with aging. In 2003 SENAMA was created. Currently, SENAMA is the institution in charge of encouraging active aging and the development of social services for older adults. For instance, SENAMA offers several programs. Along these programs stand out *Voluntariado Asesores Senior*, a program in which retired teachers can volunteer to teach the poorest children in the country (from elementary and middle school); *Fondo Nacional del Adulto Mayor*, which provides
funding to organizations of older adults; *Programa de cuidados domiciliarios*, a service of home assistants trained to deliver socio-sanitary support to older adults in their homes; *Centros de Día*, centers that provide day care to 1,200 low income older adults who are at risk of dependency, and also provides support to their families (Kornfeld, Abusleme and Massad 2016).

In addition to these programs, SENAMA has a unit of studies that is responsible for generating and systematizing information, and providing technical assistance when required.

**Living Arrangements for Older Adults**

In Chile, there are different housing options for *adultos mayores*. As previously mentioned, in Chile the family is still a strong institution, therefore, most older adults live in their own homes or with their relatives. However, this reliance on the family seems to be challenged by the demographic transition and cultural changes that the Chilean society has been faced since the seventies. Although the country has been engaging a neoliberal agenda, “market-based solutions to elder care have not been, nor are they likely to be the answer” (Pereira, Angel and Angel 2007, 2097), because institutional care is still too expensive for most families, but most of them are middle class, they are not “poor enough” to apply for public long term care centers, and not “rich enough” to pay for a private option (Horton 2004). Because of this, a small percentage of *adultos mayores* live in collective residences such as long-term care centers.

The following sections address in detail each one of the current housing options for Chilean older adults.
**Independent Living**

The most popular option among *adultos mayores* is living in their own home. According to the National Socioeconomic Characterization Survey (CASEN), 81.8% of the population aged 60 and over lived in those conditions; 6.0% in leased houses, 9.4% in a house transferred from someone else; 2.4% in usufruct houses and 0.4% in other categories. Although most of them share their home with someone else, only 3.9% live on homes with overcrowding (Ministerio de Desarrollo Social 2015).

**Collective Residences**

In Chile, there is not an official classification for collective residences for older adults besides *Hogar de Adultos Mayores* (Vergara 2008). According to the last census, conducted in 2002, in Chile there were 1,668 residences for the elderly; from those, 624 (37.4%) were informal residences: that is, they did not comply with the minimal sanitary regulation to be considered officially as residences for *adultos mayores*. And 1,044 (62.6%) were formal residences (INE 2003).

In order to be selected to live in a collective residence for *adultos mayores*, potential applicants are usually ranked through their capacity to perform activities of daily living (ADL) and/or instrumental activities of daily living (IADL). And, according to the kind of institution, public or private, socioeconomic information is also collected.

In Chile, most of older adults are independent. CASEN measured the percentage of dependent *adultos mayores* through ADL and IADL. The smallest age group with dependency is 60-64; then it is followed from the group ages 65-69: only 9.7%, then 11.5% of ages 70-74, 16.3%, ages 75-79, 23.3%, and the largest group is among those aged 80 and above: 44.6%. Of course, the number increases with age, because of natural aging (Ministerio de Desarrollo Social 2015).
However, according to estimates made thirteen years ago, about 2% of the *adultos mayores* were living in some kind of institution (Marín, Guzmán and Araya 2004); nevertheless, these estimations do not specify which kind of institutions they were referring to: nursing homes, long term care centers, assisted or independent living residences, active adult communities, senior apartments, continuing care retirement communities, or hospices. The percentage in Chile is lower than the United States 3.6% (Department of Health and Human Services 2012), but higher than its neighbor country, Argentina: 1.3% (Roque 2014). In meetings with SENAMA, they were asked if there is any official data about the percentage of *adultos mayores* living in nursing homes; yet, until today, the only data available is the study previously cited.

**Predictors of institutionalization**

Before describing the options for collective residences, it is important to understand who lives in these kinds of institutions. For this reason, these section approaches the predictors of institutionalization among the aged.

Luppa et al. (2010), through a systematic review of research published between 1989 and 1995, found that the predictors with strong evidence were: advanced age, not having one’s own house, low self-rated health status, functional impairment, difficulties with ADL and IADL, cognitive impairment, and number of prescriptions.

Additional research found that the existence and quality of kinship ties is important. For instance, childless older adults have a higher risk of institutionalization (Johnson and Catalano 1981; Pezzin, Pollak and Schone; Zhang and Hayward 2001; Aykan 2003). Also: being unmarried, living alone, having lower family-care resources, lower socioeconomic status, lower social support and loss of spouse (Freedman 1996; Bowling 1994; Gu, Dupre and Liu 2007; Nihtilä and Martikainen 2008; González-Colaço
et al. 2014; Hakeck 2015; Stephan et al. 2014; Pimouguet et al. 2015; Wergeland et al. 2015).

Because in Chile family ties are important, and a small percentage of *adulto mayores* live in institutions, being institutionalized is perceived as a synonym of abandonment, rejection, and loneliness. It is equivalent to being rejected by family, lacking a place to live, and having nowhere to go (Barros 1979).

In the next section, there is a description of the main characteristics of the faith-based institutions that own collective residences for older adults in Chile.

**Faith-Based institutions**

In Chile, the Catholic Church has played an important role. Just in the nineteenth century, the State emancipated from the Church (Serrano 2003). Even though, during the last ten years the number of Catholics in Chile decreased significantly from 70% in 2006 to 58% in 2016 (PUC and Adimark 2016), the Catholic church still offers several services.

Catholic and other Christian Churches have been responsible for creating different kind of institutions (Romieux 1988), to fill the gaps “born of state neglect and retraction by designing and delivering social services and development programming” (Hefferan, Adkins and Occhipinti 2009, 1). In the context of Chile, neoliberal reforms encouraged, since the military dictatorship, to NGO and faith-based institutions to take on responsibilities such as older adults care.

The main Faith-based institution (FBO) in Chile is *Hogar de Cristo* (Christ’s Home) a Jesuit’s institution founded in October, 1944, (Fernández 2008) by Father Alberto Hurtado. From its beginnings, *Hogar de Cristo*, offered help to people of lower socioeconomic status. Today, this Catholic institution offers a continuum of care for
older adults that address the full range of needs for senior care for 5,216 adultos mayores:

- Programas de atención domiciliaria (in home assistance): directed to older adults with some dependency level. Currently there are 89 programs that serve a total of 3,172 older adults through the country.
- Centros de Encuentro (day care centers): intended to prevent or delay cognitive and/or physical dependency on older adults. Nowadays, there are 44 centers, serving 1,195 older adults.
- Residencias larga estadía (self-managed long term care centers): in these facilities, they provide care to older adults with some level of dependency, and socioeconomic vulnerable. Today, there are 17 residences through the country, serving 849 older adults.

Hogar de Cristo counts with high levels of specialization and expertise, training staff and volunteers. For this reason, the institution offers a professional environment. Although it is a FBO, the institution does not receive direct funding from the Catholic church, because they provide services such as administration of long-term care centers for older adults, they receive State funding (Hogar de Cristo 2016). In addition, another portion of its funding comes from donations, and services, such as coronas de caridad (crowns of charity) which are memorial cards that have expression of love for a departed love one, and serve as replacement for traditional funeral wreaths; and Funeraria Hogar de Cristo, a funeral home located through the country that offers paid services as well as free services for the poorest (Pereira, Pereira and Angel 2009).

Although this FBO has a “faith background”, it does not include religion as part of its programming, nor require religious affiliation for staff, volunteers or clients.

In addition to Hogar de Cristo, there is another Catholic-based institution that provides services of care for older adults: Fundación Las Rosas (The Roses Foundation). This FBO, founded in 1967 by Santiago Tapia, a bishop who was in charge of Cáritas. Most of its funds also comes from donations, and alliances with
companies. For instance, during October and December 2016, they had an alliance with Upa! a convenience store part of 51 gas stations (Shell) located throughout the country. In these stores, it was possible to donate one breakfast for a resident of Fundación Las Rosas for CLP$200 (USD$0.30). The campaign collected in total, 114 days of breakfast for their 2,200 residents.

Today, they offer their services to 2,200 older adults in 30 residences located throughout the country. They provide shelter, palliative care, food, occupational therapy, and spiritual guidance for their residents. To apply for their centers, the potential members had to fulfill the following requirements: have at least 60 years, having a pension, and demonstrate social, familiar, and economic vulnerability (Fundación Las Rosas 2016).

**ELEAM: long-term care centers**

Considering the need to update the rules governing long-term care centers for older adults, in 2010, was created the Decree 14. This section refers to the centers that are ruled by this decree (Ministerio de Salud; Subsecretaría de Salud Pública 2010).

These centers are aimed to provide shelter for people aged 60 and over, and because biological, psychological, or social reasons, they require a protected environment and specialty care. However, potential residents cannot suffer from ailments that require continuous or permanent medical assistance.

ELEAM must follow a series of minimum requirements for its operation. And once they show evidence that they follow these procedures, they will have authorization from the local ministry of health bureau to operate. Among the minimum requirements are: an office that allows a private space for interviews with residents, their relatives or other visits; aisles wide enough that let people with wheelchairs move with confidence, along with bars in which older adults with limited mobility can support to walk with ease; rooms
big enough to shelter all residents at once, these rooms must have natural lighting, furniture and recreational items for residents, such as music, magazines and books; an external zone such as a patio; dining rooms big enough to shelter at least 50% of residents at once; at least one nurse call button in every room; adequately labeled escape routes; and at one bathroom every five residents.

Regarding human resources, the decree recommends that each ELEAM has at least the following professionals: nurses, a nutritionist, a kinesiologist, an occupational therapist and a social worker.

There are different requirements for older adults with severe physical or cognitive dependency: nurses with a shift of 12 hours and one with a night shift; a caregiver for every seven residents during the day, and one every ten at night. On the other hand, those with moderate to mild physical or cognitive dependency requires a nurse during two hours (day) and one on-call 24/7; and a caregiver every twelve residence during the day, and one every twenty at night. Instead, independent older adults require one caregiver every twenty residents 24/7.

In 2007, previous to the creation to Decree 14, SENAMA investigated the functioning conditions of ELEAM (Morris et al. 2007). They found a total of 419 centers authorized by the ministry of health to operate. Most of them are located on the central part of the country, especially in the Metropolitan region (56%) and the Valparaíso Region (16%). Also, they are relatively new; in fact, 68% of them were founded less than 20 years ago; are small, because 64% had less than 20 residents, and 66% of ELEAM got less than 10 staff members.
In addition, these centers are oriented to treat older adults with low levels of dependency, only 15% treated bedridden adultos mayores. On average, 55% of ELEAM charged CLP$123,786; about USD$188. This is a high amount considering that the average pension in Chile in 2016 was USD$232, and that 45% of Chilean older adults in November 2016 received the basic solidary pension, which was USD$156 (IPS 2016).

Moreover, Morris and colleagues also found the following deficiencies: deficit in development of human resources, because only 47% of the interviewees indicated that they did not have any training for administration; and multifunctionality of staff (they were doing directive, administrative and caregiving functions during the day). Also, directors pointed that was extremely hard to found potential workers, because it was hard to find people with vocation, item that they found indispensable for providing care for older adults, because it demands a lot of hard work and it is exhausting from a psychological point of view.

Finally, most ELEAM imply in their mission statements that they are the “last station” or the place where older adults spent their last years before death. In the opinion of the authors of this report, that perspective is wrong because ELEAM lost their focus on providing high standards to maintain well-being in older adults, especially among those who are not terminal patients.

A most recent study (Sepúlveda et al. 2010) explored the socio-familiar profile of ELEAM residents in three southern cities: Temuco, Padre Las Casas and Nueva Imperial. They found that most of them lack social support; in fact, 40.5% of them did not have any kind of contact with their adult children. Also, 33.7% of them felt “loneliness, hopelessness or confusion in their lives” almost daily.
Chilean Cultural Views of Older Adults

Chilean Identities

Chile is unique in Latin America due to its geography, political history, actual economic rise, and its multicultural essence. The sum of these aspects has shaped individual Chilean identities, because one of the characteristics of the country itself is that it has no single identity.

Bengoa (2004) explains that one of the underlying reasons is the cultural diversity that Chile has had from the beginning; there is anthropological evidence that suggests that at least thirteen different ethnic groups existed in the geographic zone of what it is known today as Chile. Throughout history indigenous people have always been regarded as an extension of the country “The chronology of the indigenous history of Chile is not necessarily the same as the history of Chile” (P. 14). For this reason, the relationship between the indigenous people and the Chilean State has historically been regarded as problematic because it is a story of meetings and disagreements.

Larraín (2001) describes the Chilean identity as dynamic, because it is subject to constant changes. For this reason, it is has become difficult to identify which aspects constitute the Chilean identity. Despite this, in a recent study, Mayol, Azócar and Azócar (2013) identified two main layers that constitute the Chilean identity: Hacienda and Neoliberal models.

Haciendas were large landed estates located on the countryside in most of Latin American countries. These were established during the Spanish colonial era in Latin America, and were characterized by the hegemonic relationship between the Spanish and the indigenous/mestizo population (Lyons 2006). The second layer is composed of the value system associated to the neoliberal model, which was imposed during the
military dictatorship. The result is that the elite group responsible for the socioeconomic reforms during Pinochet’s rule is deeply conservative in matters of morality, religion, and democracy, but simultaneously advocates for total freedom in the economic sphere.

Montecino (1991) describes that among the first Spanish who arrived in Latin America during the Conquista. Most were men; therefore, relationships between Spanish men and indigenous women were facilitated, resulting in a large group of "illegitimate" children, which later would be known as mestizos. A genetic study (Eyheramendy et al. 2015) demonstrated that among Chileans, the chromosome X presented predominant Native-American ancestry; whereas chromosome Y confirmed a predominant European ancestry.

These hegemonic relationships created an imbalance between men and women, in which men enjoy a better social status than women because they are associated with the public sphere, while women develop in the domestic sphere, the family care environment.

Even though the factors mentioned above come from different historical contexts, the sum of them “promote, explain, justify, and legitimize existing inequalities [in Chile]” (Mayol, Azócar and Azócar 2013, 20).

**Abuelitos: Older Adults as Synonym of Grandparents**

Despite the creation of policies and programs mentioned above, it is still possible to find stereotypes and prejudices associated with old age, which often generate exclusion and fragmentation of intergenerational ties.

In Chile, there are several ways to refer to people aged 60 and over. The commonly used words are adulto mayor, anciano/a, and abuelito/a. Adulto Mayor (Older Adult in English) it is the politically correct way to refer to them, according to previous
interviews conducted with aging Chilean specialists (Salazar, forthcoming) because that is the way that SENAMA refers to them, and also how the Law N° 19,828 defines people of age 60 and over.

*Anciano/a* was a commonly used word years ago; however, during the last years, this word has acquired a pejorative meaning, since most people use it to refer to old people with high levels of dependency (Sociedad de Geriatría y Gerontología de Chile 2015). On the other hand, *abuelito/a* refers to grandparent, therefore, it is not appropriate to call all older adults this way, because not all of them are in fact, grandparents.

However, one of the main stereotypes of the elderly population presented in media and books is still the *abuelito/abuelita* (grandparent). A study conducted by Jorquera (2010) showed that in the official textbooks provided by the ministry of education, the predominant conceptions about the old age and aging are: aging as a biological phenomenon and isolated from other life stages; older adult as a synonym of grandparent; and the elderly as a passive citizen, retired from work.

SENAMA conducts regularly surveys and studies at a national level to measure how older adults are included within the larger population. The latest “National Survey of Social Inclusion and Exclusion of Older Adults in Chile” and “National Survey about Quality of Life of Older Adults in Chile” showed that 73% of the respondents perceive the elderly as a frail and dependent group. However, the statistics show that only 25% of the elderly have some degree of dependency (SENAMA and FACSO 2015; PUC, SENAMA and Caja Los Andes 2014).
In addition, older adults are mostly represented in media as grandparents. For instance, during 2016, there were several events that highlighted older adults. Different sectors of the population in the whole country were reflecting about the pension system, because it began to show deficiencies to keep up with the current aging country. In June, the vice president of the Association of Pensioners of Concepción chained herself to the front of an AFP branch in Concepción, southern Chile, to protest the announcement of the fall of pensions by 2%.

Within eight national news, channel and journal websites that covered that event, six of them used the word *abuelita* (grandmother) to refer in their headlines to the 82-year-old woman (Publimetro 2016; Chilevision 2016; Mega 2016; El Mostrador 2016; BioBio 2016; El Dinamo 2016); whereas one used *anciana* (elderly) (El Desconcierto 2016) and one used *jubilada* (retired) (Cooperativa 2016).

These facts show that despite the progressive inclusion of older adults, and the efforts to create policies to integrate them to the population, still there are some strong stereotypes against older adults.
CHAPTER 4
WELL-BEING IN ADULTOS MAYORES: CURICÔ AS A CASE STUDY

In Chapter 2, I described the factors that international literature considers as principal to well-being in older adults. These factors include self-rated health, physical functioning, social support, socioeconomic status, and life satisfaction.

Chapter 3, made the case for the country as an alternative case study for well-being of older adults in modern societies. As Gitlin and Fuentes (2012, 297) aptly state, Chile is “an upper middle-income country at the crossroads of economic development and aging”

Even though the study of the aged in Chile has a lengthy, interdisciplinary history, most studies are firmly rooted in gerontology. Scielo Chile (www.scielo.cl), a State-founded Chilean scientific electronic library online, includes a selected collection of Chilean scientific journals, of different areas of knowledge. A quick exploration in its search engine including only Chilean journals, using keywords such as envejecimiento (aging), adulto mayor (older adult) and anciano (elderly) found articles that addressed the following aspects of aging and the aged: bioethics (Mercado 2001), hospitalizations (Riquelme et al. 2008), medication management (Marzi et al. 2013), linguistics (Véliz, Riffo and Arancibia 2010), cognitive aspects (Sánchez and Pérez 2008), physical environment (Sanchez, 2015), anthropomorphic indicators (Arroyo et al. 2007), nursing (Ortiz and Castro 2009), social functioning (Zavala et al. 2006), and clinical studies, such as myocardial infarction (Ugalde, Ugalde and Muñoz 2013), risk of falling (Gonzalez, Marín and Pereira 2001; Gac et al. 2003), glaucoma (Salgado and Castro 2008) and depression (Hoyl, Valenzuela and Marín 2000). These geriatric aspects are
important to the study of the aged, but it is also important to address the sociocultural implications of an aging country, especially considering the particular history of Chile.

Considering this, it seems that anthropology in Chile is being held by the “bystander effect”, that is, when individuals do not offer any means to help a victim when other people are present. We, as anthropologists, are discussing and criticizing about how aging studies are being conducted in Chile, and how it is necessary a new approach, including concepts like culture, gender, cohorts and generations; however, we are not doing any contributions to change this situation, or engaging in interdisciplinary studies.

Chapter 4 focuses on the factors that influence well-being in adultos mayores (older adults), focusing especially on the family as the main source for social support, the importance of volunteering and participate in social activities, owning a house and socioeconomic status.

Following a discussion of the social science literature on the aged in Chile, I will turn my attention to the ethnographic context of this study. I focus especially on the city of Curicó – it’s historic background, geography, economic activities– and the demographic profile of older adults in Curicó. Also, I provide information about the housing options for dependent adultos mayores, and I focus on one long-term care center (known as ELEAM), Carmen Martinez Vilches, in which I conducted research. I explain how I approached the ELEAM, the history of this center, location, capacity, administration and the admission process.

In addition, I describe the options for independent older adults. First I describe the sporadic activities that the Adulto Mayor Program from the Municipality offers, and
then, I explain the characteristics of the clubs for older adults (*Clubes de adulto mayor*). In particular, I describe two clubs “*Estrellitas del Vaticano*” (Vatican’s Little Stars) and “*Campo Lindo*” (Beautiful Countryside). As in the previous section, I also explain how I approached them, and the main characteristics for each one of these clubs.

**Well-being in Chilean *Adultos Mayores***

**Family as a Main Source for Social Support**

For Chilean older adults, family is the most important factor in assessing well-being. A study conducted in Antofagasta, one of the largest cities in the northern part of Chile, found that social support provided by their families was the first item that older adults mentioned in a survey about well-being (Urzúa et al. 2011). In fact, the main source for social support among *adultos mayores* is family. Barros and Muñoz (2001), working in Santiago, found that 75% of the aged relied on their families for support. Spouses and domestic partners (43%) were the first person they turned to for help, followed by adult children (21%). This is because Chileans, just like other Latin Americans, consider it necessary to “count” with potentially available people who will provide material, instrumental, emotional support, companionship, and advice when needed (Montes de Oca 2001).

In addition, Barros et al. (1979) found that, for men from older generations, family relationships are more important than friends; whereas for women, both are equally important. This is a product of gender differences in socialization, because many contemporary older women were housewives, therefore they spent most of their time at home, having spontaneous and daily encounters with neighbors that were in the same situation. Only with her friends could women behave as they wanted, because within the family context they were expected to behave rigorously. On the other hand, men
created more superficial friendships with co-workers, because in the intimate family context they could act as themselves. The above resulted in the fact that women had stronger relationships with friends, which they could keep until their later years, having greater well-being in that aspect in comparison with their counterpart. Although this study was conducted years ago, it seems that this is still true for the current cohort of *adultos mayores*. However, because of the changes in gender roles that Chile has been experienced during the last years, it’s expected that the situation will change for future generations of older adults.

In conclusion, the kind of social support that Chilean older adults need (and want) could be described as: wanting to remain as active/useful citizens during the longest time possible, participating in different activities, both within and outside the family, and simultaneously, keeping their autonomy, and avoiding “becoming a burden” (*volverse una carga*), which is one of the main concerns of *adultos mayores* according to the last National Survey on Older Adults’ Quality of Life conducted in 2013. In this sense, Chile does not seem to be that much different than any other society. For instance, Simmons (1945, 1946) generally found in cross-cultural surveys that the ideal old age seems to be physically healthy, productive and functional, and socially connected.

**Volunteering and Participation in Organizations**

In general, when discussing social support among older adults, the tendency is to emphasize the benefits that originate to *adultos mayores* from the support received by younger generations, such as their adult children or grandchildren. However, it’s important to emphasize that in Chilean families, adultos mayores are a key component that also offer social support when needed. A previous study (Salazar, forthcoming)
showed that Chilean social scientists consider *adultos mayores* as the foundation from which many families have been built and developed, due to the help that they provide: sometimes they act as caregivers for grandchildren, especially women; they also provide economic help to their adult children; and because most of them are home owners, they offer their houses when the rest of the family is in need. In this sense, for *adultos mayores* is important to feel that the familial support is reciprocal.

Chapter 2 addressed the programs that SENAMA offers to older adults. One of its programs, “Senior advisors”, seeks to provide educational support for low-income/highly vulnerable children through retired teachers. Ferrada and Zavala (2014) conducted a study in Concepción, the second largest city in Chile, comparing subjective well-being between two groups: “senior advisors” volunteers and non-volunteers. They found that volunteers reported higher levels of subjective well-being than their counterpart: the mean was 181 for the first ones and 156 for non-volunteers; in fact, among volunteers their scores were evenly distributed; rather, the non-volunteers showed high standard derivation.

*Adultos mayores* benefit from interaction with younger generations as well with their peers. This is important because they share their experiences, spending time together that can result in an increase of their well-being. Sociologist Carmen Barros (1991), who is one of the pioneers in social research on aging, suggested that older adults who participated on organizations reported high levels of well-being, because they felt able to exchange support and “health tips”, causing them to feel more independent.
Home Ownership

Another important factor for well-being in the Chilean context is housing arrangements. As mentioned in Chapter 2, most adultos mayores are home owners, hence, that is the only real state that they possess. Simultaneously, that is the only valuable good that they can pass on to their adult children or even grandchildren. In July 2015, conservative representatives proposed a reverse mortgage for adultos mayores. Reverse mortgage are loans for older homeowners that did not require monthly mortgage payments. That means that owners do not pay until they die, sell, or move out of the home (Consumer Financial Protection Bureau 2012). According to the representatives, this would hypothetically, result in an increase in the pensions for older adults, because they would be handing over their homes to an insurer in exchange for a monthly fee. This idea generated debate about the squalid pensions that most older adults receive once they retire (El Mostrador 2015). Also, for some people, this mortgage was considered a way to increase pensions, whereas for most of the people - including the president Michelle Bachelet - this was a sign of disrespect towards adultos mayores, because many them paid a mortgage for about 20 years to purchase a house, and because of that, they were now proud homeowners. Finally, the project was rejected (La Nación 2015). This was an example of how important is home for the majority of Chileans, and not only considering a house as a synonym of real state, but also considering the several meanings it has for many people.

Psychological Factors

In addition to the factors mentioned above, research shows that psychological factors such as self-esteem are crucial for well-being. Ortiz and Castro (2009) suggested that for adultos mayores in Chile it is crucial to keep a high self-esteem
during late adulthood, because of the physical and psychological changes they face, esteem is considered as a coping strategy that helps them to adapt to old age daily.

It seems that in general, the Chilean older adults keep high levels of self-esteem. Zavala et al. (2006), recruited people aged 60 and over from a health clinic. A high percentage of the sample (52.6%) showed high self-esteem, which was compared with caregivers’ perspective, who also agreed with that.

Time perception also influences well-being. Güell et al. (2015) found that a particular combination of time perspective helped *adultos mayores* to keep high levels of subjective well-being: low orientation towards present and past-negative, a high orientation towards past-positive and a medium orientation towards Future. This means that older adults who are focused on the “good things” about the past, and just a little concerned about the future, will have a better well-being, at least in Chile. Because the authors empathize that for each country there is a different combination of time perceptions that will work; hence, they do not consider that their results can be considered as normative parameters.

It is fundamental to note that most of the studies conducted in Chile about well-being or quality of life among older adults are biomedically oriented, and only consider people who are currently living with families or alone, ignoring the approximate 2% of *adultos mayores* who live in nursing homes or long-term care centers. As mentioned in Chapter 3, this number is low compared with the United States, but high than Argentina and Peru. Maybe the reason why researchers do not consider institutionalized older adults it is because it is harder to get permission to conduct research on those centers,
and some of them have cognitive impairments that will make responses harder to obtain.

**Income**

In this domain, there are many things to improve for older adults. However, one of the worst indexes of well-being among older adults in Chile is, according to Urzúa et al. (2011), the fear of death and dying. Older adults are afraid to experience a painful death. Although this has been found to be common in other countries (Wink and Scott 2005; Depaola et al. 2010), the authors attribute this to the fact that in Chile, death is such a strong taboo, that people avoid talking about it.

This becomes evident in the low percentage of people who are organ donors: just 123 people donated their organs in 2014 (Corporación del Transplante, 2015). According to the transplant corporation, families do not discuss about what will happen if some of the members die; and in other cases, families do not respect the will of the deceased, who sometimes want to be organ donors.

Finally, is important to note that although there is research about well-being and quality of life among Chilean *adultos mayores*, there is still a huge gap. There is a need for a Chilean perspective about these problems: not only is necessary to have data, but also theoretical models. Actually, the lack of a local academic perspective about aging is not an exclusive Chilean problem: Westerhof and Barrett (2005) used Carstensen’s socioemotional selectivity theory to explain some findings from a study about older adults in the United States. They discussed how a model originally developed in Germany could be “exported” and applied in very different countries from where it was made, because obviously, there are cross-cultural variations.
For this reason, this research contemplates to explore how the previous aspects mentioned in this literature review applies or not to the case of Curicó. The following section will focus on Curicó as a site to study well-being in older adults.

**Curicó**

This section explores the main characteristics of Curicó: its historic background, location, geography, economic activities and demographic profile. In addition, there is also a description of the sociodemographic data of *adultos mayores* of Curicó, to understand why it is important to conduct research in this city located in the central valley of Chile.

**Location**

Curicó is located on the central valley, about 195 kilometers south of Santiago (see Figure 4-1). Curicó belongs to the Maule Administrative Division, a first level administrative division. In 2015, the city had a total of 144,025 habitants (INE 2015).

![Curicó location map](image)

Figure 4-1. Curicó location map within administrative region, Chile, and South America. Source: Centro de Competitividad del Maule.
Curicó also is part of the Curicó Province, a second-level administrative division, governed by a provincial governor, who is appointed by the president. The province of Curicó is composed by nine communes, and each has a municipality consisting of an alcalde and a municipal council. Figure 4-2 shows Curicó from its hill Carlos Condell:

![Curicó, view from hill Carlos Condell](image)

Figure 4-2. Curicó, view from hill Carlos Condell. Source: photo courtesy of author.

**Historic Background**

The city’s name means “Muddy waters” in Mapudungún (Mapuches’ language, an indigenous group), and it comes from Kurü = black, and Ko = water. As mentioned in Chapter 3, in Chile, there is archaeological evidence that there were about 13 different ethnic groups; Mapuches being the most numerous group.

According to historical records, around the eighteenth century, when the Spanish Conquistadors settled in the Central Valley, south of Mapocho River (today in the area
of Santiago, Chile’s capital), Curicó, was occupied by an indigenous group named “Kuris”, whose main activity was agriculture, because of the fertile soil.

In 1743 the city was founded under the name of Villa San José de Buena Vista, (in honor of Chile’s Governor), over five kilometers from its current location. Four years later, the city was moved to the east, near a hill where a Franciscan priests’ convent was located. This change created favorable conditions for an increase of different convents, which in turn, was attractive to aristocratic families who oversaw the city. Finally, in 1890, Curicó obtained its title as a city (Guevara 1997).

**Geography and Economic Activities**

The city has a Mediterranean climate, with a prolonged dry season in summer (December to March). These conditions are favorable for agriculture, which is the city’s main economic activity. Among its principal products are: apples, cherries, kiwis, tomatoes, sugar beets, wheat, maize, legumes, and wine. The city export most of its products to different countries, including the United States, Canada, Iran, Turkey, Taiwan and China, through fruit companies such as Unifrutti, Dole, Del Monte, Copefrut, Agrozzi and wineries such as Concha y Toro, Santa Rita, Viña San Pedro, Los Robles, and Viñedos Puertas.

During the last decades, the city has undergone several changes that have notably modified it. Because of the incipient economic development, there has been an increase on the secondary and tertiary economic activities including financial institutions, transportation, department stores, universities, health, and entertainment have all grown over the last several decades.

For example, because of the increase on the demand for educational options, Curicó now has three campuses of regional universities: Universidad de Talca,
Universidad Católica del Maule and Universidad Tecnológica de Chile. Also, there are five campuses of professional institutes (Municipalidad de Curicó 2015).

Another agent of change has been earthquakes. Chile is known for its seismic activity and frequent earthquakes. The last important one, in February 2010, magnitude of 8.8 $M_W$, severely affected the historic center of Curicó, and several buildings collapsed, mainly because its construction materials and design that was not suited for withstanding earthquakes.

Among the most vulnerable structures were the oldest Catholic church, *San Francisco*, constructed in 1758; the headquarters of Curicó oldest newspaper, *La Prensa*; a care center for the elderly and homeless *Hospedería del Hogar de Cristo*; and the Hospital, constructed in 1973 (Rojas and Rojas 2015). The latter resulted with structural damages, therefore, it was declared an unsafe area, and local authorities recommended its evacuation as soon as possible. Because of this, the city received help from several sources, the most important, came from a neighboring country, Argentina. An Argentinian field hospital was located near the damaged hospital, which was active for about six months. After that, a temporary solution was offered, a modular hospital (La Tercera 2011) nevertheless, it was expected that in 2014 a new hospital will be constructed (MINSAL 2011). However, only in January 2017, did construction of the new hospital begin (Vivimos la Noticia 2017).

**Demographic Profile**

According to projections made by the National Institute of Statistics, in 2015, the city had a total of 144,025 habitants, 49% are men and 51% are women, representing a 14% of the population of the Maule Region, and 0.8% of the country. It is expected that in 2020, the city will have 150,024 habitants (INE 2012). In 2011, 14.2% of the
The communal population was considered in poverty situation, almost the same percentage that the national average: 14.4% (Ministerio de Desarrollo Social 2014).

**Adultos Mayores in Curicó**

As previously mentioned, Chile has an advanced aging profile. In the case of Curicó, the population aged 60 and over also constitutes an important part of the population. The aging population has grown from 9.74% of the population in 2002, to 14.9% in 2015, and it’s expected that the city reaches 17.3% in 2020. Figure 4-3 shows the population of *adultos mayores* in relation to the country and the Maule Region (INE 2012):

![Graph showing percentage population aged 60 and over: Country, Maule Region and Curicó, 2002-2020.](image)

**Figure 4-3. Percentage population aged 60 and over: Country, Maule Region and Curicó, 2002-2020.**

As previously mentioned, SENAMA it is the institution responsible of *adultos mayores*’ policies at a national level. In addition, there are 15 regional offices, one in each administrative region.

The regional office for the Maule Region it is located on Talca, 66 kilometers south of Curicó. In addition, the municipality of Curicó has *Programa Adulto Mayor*, a
program aimed to “encourage active aging and the development of social services for older adults, strengthening their participation in society, promoting self-care and autonomy” (Programa Adulto Mayor, 2015).

This program oversees both dependent and independent older adults in Curicó. However, from the human resources point of view, for the municipality it is easier to maintain the program for independent older adults, instead of dependent older adults, because it is assumed that they are active and that they can do more things on their own. The following section explores options for dependent and independent adultos mayores in Curicó, using data gathered through interviews with local authorities during October and December 2015.

**Options for Dependent Adultos Mayores**

As mentioned above, there are different options for older adults in Curicó depending on their ability to perform activities of daily living or instrumental activities of daily living. For adultos mayores with higher levels of dependency there are two options: home-based care and ELEAM. The first option is financed by Hogar de Cristo, and consists on visits to adultos mayores with socioeconomic vulnerability. Because this section is focusing on the public options, the second option, ELEAM, will be discussed in greater detail.

**ELEAM in Curicó**

Although there is not official data about the living arrangements of adultos mayores in Curicó (INE 2013). It is known that at a national level, most of them live with their families, and a small percentage live in institutions.
According to the registry of long-term care centers conducted by the National Service for Older Adults, SENAMA, in 2012, there were three collective residences in the city:

Table 4-1. Long-term care centers in Curicó.

<table>
<thead>
<tr>
<th>Name</th>
<th>Institutional affiliation</th>
<th>Number of residents</th>
<th>Capacity</th>
<th>Established</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carmen Martínez Vilches</td>
<td>Operated by Hogar de Cristo (Catholic institution), State owned</td>
<td>54 (34 men and 20 women)</td>
<td>70</td>
<td>June 2011</td>
</tr>
<tr>
<td>San Vicente de Paul</td>
<td>San Vicente de Paul (Catholic institution)</td>
<td>63 (only women)</td>
<td>68</td>
<td>June 1990</td>
</tr>
<tr>
<td>Hogar Betania</td>
<td>Pentecostal Church</td>
<td>17 (9 men and 8 women)</td>
<td>20</td>
<td>July 2011</td>
</tr>
</tbody>
</table>

Although there are few options, this is an example of the current situation about ELEAM across the country: there are limited choices, and most of them are for people with high vulnerability. The next section explores the largest ELEAM in Curicó, the Carmen Martínez Vilches, and how it was possible to conduct research in this institution.

**ELEAM Carmen Martínez Vilches**

**Approach**

To gain access to this ELEAM in 2015, a year before, in October 2014, it was necessary to ask online through OIRS (Office of information, complaints, and suggestions) of SENAMA for authorization to conduct a research in this center.

First, the assistant manager of territorial coordination, indicated that the request was derived to the national manager of the housing program, department in charge of ELEAM. After a series of emails explaining the project, a meeting was scheduled to
discuss the research in Santiago de Chile in October 2015. After getting the authorization and total disposition of the national manager, the project was sent to the regional manager of SENAMA through the national manager. Once more, after communication through emails, a meeting was scheduled to meet the regional manager in Talca, a city located 255 kilometers to the south of Santiago. After this meeting, the regional manager contacted the director of the ELEAM Carmen Martínez Vilches, to schedule a final meeting with them, so the researcher could explain to them the project and discuss about logistics. Finally, on October 2015, it was possible to gain access to the ELEAM located in Curicó, 67.2 kilometers north of Talca.

The data that follows was gathered through interview with staff members between October and December 2015.

History

The ELEAM originally was owned by Hogar de Cristo, a faith-based institution with facilities across the country. The ELEAM, at that time was a hospedería (hostel) that offered temporary housing for older adults and hosted a kindergarten for children from vulnerable families. Back then, the hospedería was in a historic building in Trapiche avenue, in northwest Curicó, and had over 25 years of experience providing care for older adults. This house was destroyed in the earthquake of February 27th, 2010; hence, the center was forced to close due to the structural damages that the earthquake caused to the building. However, it was necessary to relocate the residents, and during this process, the director noticed that most adultos mayores did not have any contact, nor support networks.

Temporarily, in the backyard was constructed a wooden room to locate the bedridden adultos mayores, whereas the rest lived all together in one of the rooms that
survived the earthquake; this situation was extremely stressful for both, residents, and staff members, because the beds were located so close to each other that staff members have to move all the beds to one side of the room to take care of one resident, and so on.

Simultaneously, in 2010, SENAMA announced that three ELEAM would be constructed in the Maule Region, in the cities of Curicó, Cauquenes and Licantén. This announcement seemed the perfect solution for the hospedería: they could have a place to relocated their residents.

With state funding, the construction of a new ELEAM for Curicó, in Río Teno street, in northeast Curicó, was finished in 2010. However, because SENAMA can’t run their centers, they called for bids aimed to non-profit institutions and the Municipality. In this case, two bids were offered: one was made by the Municipality of Curicó and the other one was from the Hospedería through Hogar de Cristo. The new building was inhabited during two years, because of all the bureaucracy that implied the creation of the new ELEAM. Finally, Hogar de Cristo won the call for bids, because they already had experience with caregiving for older adults.

After the adjudication, it was mandatory that all former residents from hospedería applied to this new center, because although the new ELEAM was going to oversee the same staff of Hogar de Cristo; now it was state-owned, and the capacity was updated to 70 residents, therefore, they have to start from scratch.

A committee composed by SENAMA, and Hogar de Cristo, looked for applications, analyzing their health reports and socioeconomic background. Finally, the
25 former residents of the *hospedería* were admitted to the long-term care center (ELEAM) in May 2012, two years after the earthquake that destroyed the historic house.

**Location and Capacity**

Currently, this long-term care center is on *Río Teno* street, in northeast Curicó. The ELEAM is near *Sol de Septiembre*, a neighborhood of low income. Currently, the center has a capacity for 70 residents (men and women).

Because this center is State owned, 10% of its capacity, or 7 quotas, are reserved for domestic violence victims.

In the ELEAM there are several staff members who fulfill different functions: a director, a technical director (nurse), social workers, nurses, psychologist, occupational therapist, kinesiologist, doctor, chiropodist, and nutritionist. In addition, because this is a *Hogar de Cristo*, there are volunteers, such as a retired professor who teach residents to read and write. Also, because there are technical schools in Curicó, and the neighbor cities, Romeral and Teno, students from the health disciplines do their professional practices in there, even, once their finish some of them can be hired in the ELEAM.

Regarding the interior of the ELEAM, the building has 30 rooms, some of them are shared between 4 residents, 2 residents or in some cases, there are individual rooms. The center has a dining room, a common room (with chairs, and TV), bathrooms for men and women; bathrooms for visitors, bathrooms for staff members, an office for administration, office for social workers, office for kinesiologist, a medical office, nurse station, pharmacy, small chapel, hairdressing, chiropodist office, nutritionist/psychologist office, kitchen, pantry, occupational therapy room and library.

In addition, the entire center has air conditioning, which is uncommon in public offices in Chile. Also, the center has a backyard, with a roofed section to perform
several activities during sunny days, such as the anniversary of the ELEAM in May, and in October, the of the “older adult month”, in which they divide the entire ELEAM staff and residents in two teams that compete with each other.

In addition, the backyard has a small vegetable garden with tomatoes, lettuce, chard, chives, cilantro, and parsley. Residents along with some staff members are in charge of it. The long-term care center Carmen Martínez Vilches extends for a half square, and has controlled access, monitored during 24 hours, seven days a week. The building is surrounded with bars, to avoid escape of residents with cognitive problems.

During May 2015, I took pictures of the exterior of the center. Figures 4-4 and 4-5 shows the exterior façade of the center:

![Image](image-url)  
Figure 4-4. External façade, ELEAM Carmen Martínez, Curicó. Photo courtesy of the author.
Administration

As mentioned above, the center is owned by SENAMA and run by Hogar de Cristo. SENAMA provides an amount for every resident, and Hogar de Cristo run the day-to-day operations. This center was the first “hybrid” ELEAM in the country: an alliance among state and a faith-based organization. This was defined as a “model of how partnerships between civil society organization and the state can cooperate towards a common good: provide caregiving for older adults” (Hogar de Cristo 2012). Although the other two ELEAM located in the Maule Region are also run by Hogar de Cristo, the Curicó ELEAM is the only one that obtained their bidding through a bid call, the other two ELEAM got their status through direct assignation, because they were the only ones who presented bids.
The ELEAM must report continually their expenses and interventions to SENAMA. Every two months they do a report concerning the activities that they did with residents, and every month they do a financial report. In addition, because this center is part of *Hogar de Cristo*, they also must report to the national offices of *Hogar de Cristo*, in Santiago; and to keep functioning, they also have to report to the regional office of the ministry of health, showing that they met the sanitary requirements.

**Admission**

Because there are 7 quotas for familial intra-violence victims, there are only 64 spaces for regular admissions. To apply, usually family members of the potential residents go to the ELEAM to ask for information. The secretary hand out an informative booklet. This booklet describes the main requirements that applicants must fulfill:

- Being at least 60 years old
- Having a *Ficha de protección social* (social protection report, made by a municipal social worker)
- Belong to the poorest quintiles: 1,2 or 3
- Show lack of social support (through another report made by a social worker)
- A medical certificate, that states that the applicant does not have any critical condition that requires constant medical care.
- Having a family member, or in default, an adult, who will act as the “representative” of the applicant
- Having some dependency level (assessed through the Short portable mental status questionnaire, known as the Pfeiffer scale and the Activities of daily living scale, ADL)
- Informed consent (in the case the resident can’t give consent, their representative must sign)
- ID
- Copy of their last two monthly pension

All this information must be presented in Talca, located 67.2 kilometers south of Curicó, because the application process is in charge of SENAMA. *Hogar de Cristo* assumes the responsibility once the resident is admitted to the center.
For the intra-familiar violence victims, the process is different. A court derives the cases, or SENAMA through their “Good practices” department. In the hypothetical situation that the 7 quotas for violence victims are already covered, the ELEAM must decide which of the previous cases admitted can be transferred to the “common” resident category. The parameter to decide who can be transferred, is the intervention that the ELEAM has already done with their residents. Once victims of violence are admitted as residents, an interdisciplinary group works take care of them.

**Options for Independent**

In addition to the programs mentioned, there are others aimed to independent *adultos mayores*, or to those who have lower levels of dependency. There are temporal activities, and permanent activities. The following sections explores both options.

**Sporadic Activities**

As the name suggests, these are activities that are conducted in short time. One of the most known is the “Verano entretenido” (fun summer), a tourism program funded by the municipality. This program is aimed to people from lower socioeconomic status, and they get to spend about 2-3 days in municipal bungalows in Iloca, a beach located 119 kilometers from Curicó. The program is free to their beneficiaries, and they get access to transportation, foods and activities. Although this program is for the entire community, the first weeks are exclusively for different organizations of *adultos mayores* (Municipalidad de Curicó 2016).

**Clubes De Adulto Mayor in Curicó**

The Law Nº 19,418 states that older adults can create their own organizations. To act as an official organization, the group must register on the local Municipality. One of the most common organizations of older adults are the Clubes de adulto mayor, clubs
that are only composed by older adults, who often live in the same neighborhood. Usually, these clubs are created for cultural interests, and the necessity to participate in activities in a common base.

The *adulto mayor* program of the Municipality of Curicó, is in charge of these clubs in the city. Currently, there are 107 organizations. This program also promotes social participation through classes and recreation activities. For instance, there is a walk in which about 200 older adults do around the Alameda (an avenue surrounded by trees). Also, there is a program called *Adultos mayores en movimiento* (active older adults), in which every week, an affiliated physical education teacher goes to every club, and conduct activities aimed to keep older adults active. At the end of every year, usually in October, there is a public activity in the municipal gymnasium, in which *adultos mayores* show what they learned through the year (Municipalidad de Curicó 2015).

These clubs can create a communal union, known as UCAM, and this organization, categorized as a second level, is composed by the presidents of each club. In Curicó, the president of the UCAM is Carmen Martínez Vilches. She is an active community member, who advocates for the rights of her fellow *adultos mayores*. In fact, she worked hard to get the new ELEAM in Curicó. That is why the ELEAM carries her name.

**Approach**

To approach *clubes de adulto mayor* in Curicó, the same approach described for the ELEAM was carried out. After getting the authorization from the regional manager of SENAMA in Talca, this office contacted the *adulto mayor* program coordinator in Curicó. A meeting was scheduled with him. The research objectives and procedures were
explained to the coordinator, and he agreed to give the phone numbers of three club presidents. During the same week, I contacted each one of the presidents and explained the research. Two agreed to have an additional meeting, and one could not accept because her club was closing their activities for the year. Therefore, from 2 Club de Adulto Mayor potential participants could be recruited: “Campo Lindo” and “Estrellitas del Vaticano”.

**Club De Adulto Mayor “Estrellitas Del Vaticano”**

The “Estrellitas Del Vaticano” (Vatican’s Little Stars) club is composed by members of the Vaticano neighborhood. This sector is located in northwest Curicó.

Today, this club has about 50 participants, however, according to its members, around half of them participate periodically. They met biweekly, from March to December; however, they take a summer break during January and February, due to most of its members being on summer vacation with their respective families.

The club meets in a communal office, located in the middle of the neighborhood. This office is shared with the neighborhood council. This office is located along a basketball court, that the neighbors built with municipality funds.

**Club De Adulto Mayor “Campo Lindo”**

Members of the “Campo Lindo” (Beautiful Countryside) club are from Isla de Marchant, a sector located northwest Curicó. Because this in a semi-rural area, looks completely different than the rest of the city: for instance, most of its habitants have their own vegetable garden.

This club has also about 50 participants, and they meet every two weeks, from March to December. They also take a summer break during January and February. The
club meets in a small cabin built especially for them, located in the backyard of its president’s house, señora Carmen Martínez. Figure 4-6 shows the cabin:

![External view, Club de adultos mayores Campo Lindo, Curicó. Source: photo courtesy of the author.](image)

Figure 4-6. External view, Club de adultos mayores Campo Lindo, Curicó. Source: photo courtesy of the author.

This club participates from the workshops that the municipality through its adulto mayor program offers to clubs. These programs follow SENAMA’s recommendations about encouraging physical activities among older adults, allowing them to keep their autonomy as much as they can. To participate from these workshops, the president of the club contacted the coordinator. Finally, the club participates in two workshops: physical activity and laughter therapy. Every Friday a physical education teacher goes to the club, and does a 1-hour class to keep the club members active. Every two Tuesdays, the laughter therapy coordinator goes to the club. He makes the members do
little exercises that include meditation, walking around the room, stretching arms and legs, playing with balls, and of course, laughing at each other. Figure 4-7 shows a class of laughter therapy during June 2016:

Figure 4-7. Older adults during a laughter therapy class. Club de adultos mayores Campo Lindo, Curicó. Source: photo courtesy of the author.

After I have presented the main description of Curicó and its older adults, Chapter 5 will focus on the first phase of data collection, conducted between September and December 2015.
CHAPTER 5
ADDRESSING WELL-BEING IN CHILEAN OLDER ADULTS THROUGH SURVEYS

Admission of a New Resident at the ELEAM

In October 2015, I was conducting an interview with the social worker and Mrs. C., the technical director when a staff member interrupted us to inform us that the new resident arrived.

Out of courtesy, I took my things and I left the office. At the lobby, there was an older couple: he was about 70, and he was using a hat, one of those classics among *adultos* mayores that are not so common today. In Chile, generally when one saw an older man using this kind of hat one assumed that he was from *el campo* -countryside-. His companion looked a little bit younger than him, but it was evident that she had medical problems: she was using a cane, and half of her face was paralyzed. She was upset, crying.

Mrs. C. approached them and asked the woman, “what happened? Are you ok?” the woman, tearfully, said she was sad because she will be leaving her husband forever. The nurse tried to console her, saying that she will be able to have visits, so his husband can come when he wants.

I said hello to the couple, and along with Mrs. C we went to the commons room; the ELEAM was celebrating the “*mes del adulto mayor*” or older adult’s month. There were additional recreational activities every day for both, residents, and staff members. That day was the talent contest, and almost everyone was participating. Some residents sang songs, others read poems, and staff members were dancing. Nobody would guess, hearing that music and the laughter that only a few meters away, in the lobby, there was a woman crying because she will become a new resident at the ELEAM.
While we were watching the talent show, Mrs. C. made some random comments about the presentations -- it is almost like a trivia for every participant. I told her that during our next interview, I would like to discuss about the admissions process, and how it functioned. Mrs. C. suggested that if I really wanted to know how things worked, she, would give me permission to follow the admission process for the couple in the lobby.

We returned to the social worker’s office, and Mrs. C. notified to the couple and the social worker, that I had permission to be there during the whole process. The social worker had already been questioning the couple asking about their socioeconomic status. Both were hard of hearing, so the social worker repeated the questions, as part of admissions. I asked to the couple if they were comfortable with my presence, and they agreed. I entered the office and took a seat in a corner.

The social assistant continued, but I quickly became clear that, some of the questions were complex to the couple -they did not understand the jargon. Mr. L. answered most of the questions, until “health assessment” questions, during which the questions are directed to the soon-to-be resident. “Mrs. F, do you know which day it is? Who is the president of Chile? Do you remember what did you eat today?” all the questions seemed to assess Mr. F’s cognitive functioning. Mrs. F answered very clearly: Michelle Bachelet Jeira is the president of Chile. She used her the full name, when most Chilean just refer to the president more familiarly.

When she was answering what she ate today, Mrs. F. almost broke into tears. “Yes, I ate beef, the leftovers from yesterday, my husband did a barbecue for my farewell”. Mr. L. also talked about it, saying that they have been married for 51 years, and on every occasion, he said that he knew this process would be so hard for him,
because they have been through so much together. Despite of the additional emotional comments of the couple, the social worker tried to keep them in track, back to the questionnaire. She explained each time, “I know, this paperwork is silly, but we must do it”.

The couple is finished the interview process with the social worker, and Mrs. F. was asked to sign her permissions for admission. Because she has hemiplegia, she could not sign, so she used her fingerprint instead. In the meanwhile, Mr. L. reflected on his new situation: “I don’t know how my life it’s going to be…. after so many years together, after all we went through”. The sadness of the moment contrasted with the music that played in the background from the commons room. We heard voices singing a cheerful folk song. Mr. L notices it, and says to Mrs. F: “see? You will have a great time here!”

The social worker completed the interview, and we moved along toward the nurses’ station and the health interview with Mrs. C. While we are walking Mr. L. tells that he is worried about the time (it was around four o’clock) and he is from a small town located to the south of Curicó, around a two-hour drive. He knows that he must be with Mrs. F during this whole process, but he is worried that will not arrive on time to the bus station on the other side of the city, because he must take two buses to get home. As it is early spring, so dusk was falling rapidly, and he does not like being out after dark. O told to Mr. L that I would leave the ELEAM at five, and I can give him a ride to the bus station.

The nurse is busy, so she excuses herself and tells the couple that she will be back in a few minutes. The social worker leaves us alone. Mrs. F. still seems a little bit
scared, she is looking at the walls, in the background still we can hear the music from the commons room. I tell the couple that October is *mes del adulto mayor*, and that in the center they are celebrating with activities, so Mrs. F. will enjoy her stay from the beginning. After hearing this, they smile to each other, keep talking about their life before coming here: their house, their small farm, the rural livelihood, waking up early, having a great breakfast, and “going to town” to go shopping.

The nurse returns, and it is evident that she has a different way of treating the residents than the social worker. She seems a little bit closer, she speaks loud but clearly, without sounding too forced. The couple seems to understand, and they seem more relaxed. Mrs. C. asks about the epidemiological profile, simplifying the medical jargon to lay terms. When she hears the couple’s answers, she “translates” the narrative to medical terms out loud and writes them in Mrs. F’s chart. The nurse explains that Mrs. F will be kept in observation during the next 48 hours, so she will be sleeping in another room. However, she will show them Mrs. F’s future room, so Mr. L will have an idea of where her wife will be living.

Another staff member enters the room, introduced as “one of the persons that will take care of Mrs. F”. She begins an inventory about Mrs. F’s belongings. I have never been in a prison, the inventory of Mrs. F’s belongings felt similar to what I have seen in films.

The nurse and I left Mr. L and Mrs. F alone, so they could say their goodbyes. Mrs. F does not look as sad as she did when she arrived.

While walk to the lobby, Mr. L told me that he is more relaxed right now, because he saw that the center is very different to what he thought it would be in he beginning.
He thought it would be a place full of sick people, a sad place, and that the staff will be less empathic. Finally, we left to the bus station.

**Foreword**

Although *adultos mayores* are treated as a homogeneous group, the vignette makes it clear that there are considerable differences among the residents. Hence, it becomes a priority to research individual experiences to understand how older adults live, especially considering that also are cross-cultural variations about what it means to age well.

As mentioned in Chapter 2, for this research, well-being is understood as an “umbrella term” (Chen 2001) because there are several factors that influence how individuals feel about having “a good life”. Based on the literature review, this research considers five items that influence well-being: self-rated health, physical functioning, social support, socioeconomic status and life satisfaction.

This mixed-methods research integrates two approaches to understanding perceptions of well-being among two groups of older adults in the city of Curicó, Chile. The first approach is survey data, and its objective it is to measure, through standardized questionnaires each component of well-being. The second approach, narrative data, seeks to complement and compare the information previously gathered through life-stories. This chapter addresses the survey data.

I focus here on perceptions of well-being in two groups of 25 older adults each, in the city of Curicó, Chile. As mentioned in previous chapters, there are five aspects that literature has been found to influence well-being in older adults: self-rated health, physical functioning, socioeconomic status and life satisfaction. This first phase of the
study, focuses on the self-evaluation of each one of these five aspects through structured surveys and questionnaires.

The statistical analysis showed that both groups had similar epidemiological profiles, presenting the same health problem as previous research has found among older adults in Chile and other populations. However, in terms of social support, I found clear differences. Participants from club members felt that they had a safety net, but ELEAM residents did not feel that way. Finally, in terms of life satisfaction, although mean scores from both groups were in the same category of “average”, the variability within each group was different. Among ELEAM residents, there was a higher variability; even there was a person dissatisfied with her life. Among club members, most scores were in the average category.

In conclusion, it was found that the sum of each one of these factors did affected the perception of well-being among ELEAM residents. Therefore, in this sample of 50 older adults living in Curicó, the living arrangement did make a difference in perceptions of well-being.

**Addressing Well-Being in Adultos Mayores**

Although there is not a consensus defining well-being, most academics agree that this concept involves a series of factors. For this reason, this concept has been called an “umbrella term”. Using the literature review addressed in Chapter 2, this research considers that well-being is composed by five principles:

- Self-rated Health
- Physical functioning
- Social support
- Socioeconomic Status
- Life Satisfaction
The merging of these five principles constitutes perceptions of well-being. To address well-being in older adults, it is key to consider the life course perspective. This means that it is necessary to understand that personal, sociocultural, structural, and historical factors in childhood and adulthood affect the later course of people’s lives. Therefore, anything that happen before it does have an impact in late life, therefore, will influence older adult’s perspectives of well-being.

The main goal of this research is to address the perceptions of well-being in older adults through mixed methods. The particular objective of this first phase is to measure each one of the five principles that conform well-being through standardized questionnaires.

**Recruitment of Participants**

**Ethical Clearance**

This research was reviewed and approved in four circumstances. First, in United States, the Institutional Board Review (IRB) of the University of Florida (IRB protocol #2015-U-1162) reviewed the project. In Chile, my research was approved and revised at the national, regional and local levels. First, it was approved by SENAMA (National Service for Older Adults), through the national manager of the housing program in Santiago; then, it was approved by the SENAMA’s regional Manager of the Maule Region in Talca, and finally, it was approved at local level, in Curicó, by the communal manager of the “Adulto Mayor” program, in the municipality, and the ELEAM Carmen Martinez director and technical director.

**Sample Selection**

Two groups of 25 older adults each were recruited through non-probability sampling, paired according to variables of age, education, income and physical health.
Group 1 was integrated by ELEAM residents, while Group 2 were members of two *Clubes de adulto mayor*.

**Group 1: ELEAM residents**

In terms of the parameters considered for the selection of both groups, there were some commonalities for ELEAM residents and club members. First, participants should be at least 60 years old. This parameter was considered because of the Decree 14, that created the ELEAMs, states that legally, in Chile, *adultos mayores* are those aged 60 years and over.

Second, participants should not have any major cognitive impairment, because it was necessary for them to be able to answer several questionnaires. In the case of ELEAM residents, this aspect was checked with staff members.

However, there were some differences regarding parameters for selection for the two groups. For instance, ELEAM residents had a parameter regarding their resident status: participants should be resident for least five months. This parameter was selected to recruit residents that already had some time living in the center.

To reach potential participants from the ELEAM, during October 2015 the director along with the technical director offered to create a list of potential participants who meet the three requirements. The result was a list with 23 residents. In addition, participant observation was conducted during the first two weeks to identify additional participants. Each one of the residents in the list generated by the staff were approached.

First, either the director or the technical director introduced the researcher, and then, I spoke alone with residents to explain the purpose of this research, what was expected from them, and then, they were asked if they wanted to participate. Twenty-
one residents agreed to participate in the study, and two disagreed. In addition, as a product of the participant observation, four residents agreed later to participate of the study. Generating a total of 25 participants for Group 1 ELEAM residents.

Beginning in October 2015, I visited the ELEAM in a regular basis, three or four days a week, for about four to five hours each day. During this time, I engaged in informal talk with staff and residents, to gain rapport, and getting to know the staff and residents before conducting the surveys. Because October it is the month of *adultos mayores* in Chile, the ELEAM has several activities, including dance competitions and sketches. I considered the timing of these activities before reaching residents to start the interview process.

Residents were asked where he/she preferred to do the interview. The staff provided a small chapel located in the ELEAM. This place offered both privacy and a place in which *adultos mayores* with hearing impairments could easily hear the questions. However, every respondent was asked where he/she preferred to do the survey. Nineteen participants chose the chapel, two interviews were conducted in the residents’ bedroom because the respondents were bedridden, one was conducted in the commons room, and three were conducted in the backyard.

Once the sociodemographic data was collected, average were calculated, and participants for Group 2 were recruited.

**Group 2: club members**

During December 2015, participants for Group 2 were recruited. In addition to not have any major cognitive impairments, it was required that participants from Group 2 shared their homes with at least one more person, since participants from Group 1 were
residents from a collective residence, this was an effort to equate their living arrangements.

Also, to pair both groups, as mentioned above, scores from the demographic interview were considered to recruit participants for Group 2. For instance, age changed from 60 years and over to being close to 74 years, because that was the average age of ELEAM residents. Years of education was not required for ELEAM residents, however, now the requirement was being close to have 5 years of education in average. For income, because all ELEAM residents received a basic pension, it was necessary that all club members had the same source of income. Finally, regarding the score for ADL, ELEAM residents did not have a parameter, although, future participants should have a score of 4.72 points.

To reach participants, the same procedures were used in both clubs. As mentioned in Chapter 4, through the communal manager of the *Adulto mayor* program, I obtained contact numbers of the presidents of clubs for older adults. First, I reached the president of the Club, and through phone, I told them about the objectives and procedures of the research. Once they agreed to participate, we scheduled a meeting for the next time club members will meet. I went to the Club, and first, had a meeting with the president, to answer potential questions and comments, about 30 minutes before the beginning of the club meeting.

During the meeting, the president introduced me, and I explained the details of the research and the participation requirements. After that, I approached club members and individually asked them, informally, about their demographic and sociodemographic information, to see if they fit the requirements for participation.
After participants decided to participate, their contact information was gathered, and a potential date for data collection was scheduled. The day before the scheduled interview, I called the participants to remind them about the interview. In some cases, participants had forgotten the interview, and made other plans, or some of them got unexpected new plans, and it was necessary to reschedule the interview. Then, the same day of the interview, an hour before the scheduled time, I called the participants to ask if they were still available for the interview. Just a few cases had to be rescheduled. Finally, the interviews were conducted in the participant’s homes.

From the first Club, “Campo Lindo”, 12 participants were recruited: 7 women and 5 men. From “Estrellitas del Vaticano” 13 participants were recruited: 8 women and 5 men. As explained in Chapter 4, women are more likely to participate in these activities, because the traditional gender roles, in which women are more comfortable doing these social activities. That is why women are overrepresented in this sample. Also, this can be attributed to the fact that women live longer than men, therefore, there is a higher probability to found women in these kinds of clubs that concentrate older adults.

Informed Consent

For both groups the consent procedure was the same. An oral informed script approved by the IRB office was read to the potential participants. This kind of informed consent was chosen for two reasons: first, some older adults were reluctant to sign papers, mainly because of the distrust generated during the military dictatorship. Second, a significant percentage of Chilean adultos mayores are illiterate, hence, it was appropriate to offer a verbal consent.

The script included the background of the researcher, the purpose of the study, and the procedures to collect information. Regarding their rights, the script included the
following information: their participation was completely voluntary; they did not have to answer every question if they did not want to; there was no compensation to them as participants, and that had the right to withdraw consent and discontinue at any time without penalty. In addition, they were told if they agreed, their interview could be recorded to transcribe it later, after the audio would be destroyed. Finally, they were told that their participation was anonymous and their names would not appear in any publications.

Data Collection

There were two phases of data collection for both groups. Each subsection addresses the collection procedures for each phase.

Socioeconomic-Demographic and Self-Assessment of Functionality

The same collection procedures were applied for both groups, however, as mentioned above, data for ELEAM residents was collected first, during October 2015. Then, the data was processed in the statistical software SPSS v.20, and means were calculated for each variable: age, education, income, and ADL. Once these means were calculated, data for Group 2 was collected in December 2015.

The collection of sociodemographic data was done through a paper survey. This survey aimed to collect information such as age, gender, marital status, years of education, income, and source of income. This procedure took about five to eight minutes on average.

In addition, the Activities of Daily Living (ADL) questionnaire was applied (see Katz et al. 1963). This instrument is used to assess functional status, and the ability to perform activities of daily living independently in six categories: bathing, dressing,
grooming, physical ambulation, toilet and feeding. Scores ranged from 0 points, independent person, to 12 points, a completely dependent person.

Still, this index does not assess more advanced activities of daily living such as shopping, managing finances and telephoning. To assess those items, there are additional scales, like the Instrumental Activities of Daily Living (IADL). However, this scale was not considered because this research also included residents of a long-term care center, therefore, some of the activities considered in the IADL were not possible to perform in the ELEAM. For that reason, the study only considered the Activities of Daily Living (ADL) for assessing functionality.

The Spanish version of the Activities of Daily Living, tested in Chile by Díaz et al. (2003) was applied. This procedure took about three to four minutes in average. However, in some cases, this procedure was faster with club members, because some ELEAM residents had hearing impairments. However, because for club members, the interviews were conducted at their homes, there also were more potential distractions, such as other people in the same place, pets, phone calls, or in some cases, grandchildren.

**Well-Being Survey**

As mentioned earlier in this Chapter, and in Chapter 2, this research considers five factors that influence well-being: socioeconomic status, self-rated health, physical functioning, social support, and life satisfaction. Since socioeconomic status data was collected during the first phase of data collection. Table 5-1 summarizes the procedures of each one of the remaining well-being factors:
### Table 5-1. Methods used for measuring well-being factors

<table>
<thead>
<tr>
<th>Well-being factor</th>
<th>Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-rated health</td>
<td><em>Escala de salud autopercibida</em> - Self-perceived health scale (MINSAL 2011)*</td>
</tr>
<tr>
<td></td>
<td><em>Salud autopercibida en relación a sus pares</em> - Self-perceived health scale compared to peers (MINSAL 2011)</td>
</tr>
<tr>
<td>Physical health</td>
<td><em>Perfil epidemiológico</em> - Epidemiological profile (MINSAL 2006)</td>
</tr>
<tr>
<td></td>
<td><em>Percepción de apoyo social</em> - Perceived social support (PUC, SENAMA, and Caja Los Andes 2010)</td>
</tr>
<tr>
<td>Social support</td>
<td><em>Percepción de reciprocidad de apoyo social</em> - Perceived reciprocity (PUC, SENAMA, and Caja Los Andes 2010)</td>
</tr>
<tr>
<td>Life satisfaction</td>
<td>Satisfaction with life scale - SWLS Spanish version (Diener et al. 1985)</td>
</tr>
</tbody>
</table>

### Self-rated health

Two surveys were used to assess self-rated health: a self-perceived health scale and a self-perceived health scale compared to peers (MINSAL 2011). These two scales are part of the National survey of employment, health, and quality of life of Chilean workers, that the Ministry of health applies. The first one is a Likert-type scale that asks participants in general, how they would to rate their health. The scores are:

- 1 = Very poor
- 2 = Excellent.
- 3 = Less than regular
- 4 = Regular
- 5 = More than regular
- 6 = Good
- 7 = Excellent

In the case of Chile, most Likert scales use seven points instead of five because that is the customary grading scale, especially in the academic context. Hence, in general, the population it is used to rating things on a scale from one to seven.
The second instrument to measure self-perceived health aimed to get information about how individuals rated their general health status compared to other people of their same age. The scale went also from 1= very poor to 7= excellent. This second scale was used to see if there were any variations in self-rated health compared with their peers.

In addition to the scores, if participants made additional comments about the reasons why they rated their self-health with that score, those were written as side notes in the paper survey at the time they mentioned.

**Physical health**

The second variable to analyze was physical health. During the first phase, the ADL questionnaire was applied. For this second part of Phase I, an epidemiological profile was made for every participant. This profile was achieved through a survey made by the Chilean Ministry of health (MINSAL 2006) and summarizes the most prevalent health problems among *adultos mayores* in Chile. This survey included the following health problems:

- Cavities and/or missing dental pieces
- Cholesterol >200 mg/dl
- Chronic Respiratory Disease
- Diabetes
- Emotional Problems/depression
- Eye Disorder (cataracts, glaucoma, low vision, etc.)
- Hearing Problems
- High Blood pressure
- Bone Problems
- Obesity
- Overweight
Each participant answers if they had these conditions. Hence, this is procedure can be defined as a self-assessment, because no evidence was requested to prove whether they had any of these ailments.

**Social support**

Social support is considered a protective factor of great relevance to well-being in older adults. Family and friends can provide the necessary support and care when needed (Barros, Fernández and Herrera 2014)

Social support was assessed using two surveys taken from the “National Survey of Quality of Life in Older Adults”, conducted in Chile every three years since 2007 (PUC, SENAMA, and Caja Los Andes 2010).

As with other surveys applied in this research, if participants made additional comments about the reasons why they answered yes or no, those were written as side notes in the paper survey at the time they mentioned.

The first survey, aimed to address perceived social support included five questions, which directly asked if people had someone to turn up in different situations: sickness, when in need, if feeling lonely or sad, share joys and sorrows and borrow money.

The second survey to assess perceived social support was shorter than the first one, and aimed to get information about perceived social support reciprocity. That is, if *adultos mayores* felt that they were given equal, more, less of what they received in their relations with others. Usually, studies about perceptions of social support in older adults highlight the benefits to them, instead of the other way around. Thus, *adultos mayores* are recognized as active agents of society, capable of providing social support to other generations, or to their peers.
Life satisfaction

In addition to the factors mentioned above, life satisfaction has been considered as a key item of well-being (Toma, Hamer and Shankar 2015; CWIPP 2015; OECD 2013). Life satisfaction refers to self-avowals of happiness, and involves “judgments of one’s needs, goals, and wished” (Sirgy 2012, 13). For measuring life satisfaction, the Satisfaction with life scale-SWLS (Diener et al. 1985) was used. The SWLS is a short 5-item instrument designed to measure “global cognitive judgments of satisfaction with one’s life” (Diener 2005). The scale had five questions and seven options as answers, which go from one, strongly disagree to seven, strongly agree. Scores goes from 5 points (extremely dissatisfied) to 35 (extremely satisfied).

Results and Discussion

This section addresses the results of each one of the procedures mentioned above, along with discussion about the principal findings. First, I will explore the results from the demographic and socioeconomic data, and then, the results for the remaining four factors of well-being.

Demographic and Socioeconomic Data

Although both groups, ELEAM residents and club members were paired in terms of age, years of formal education, monthly income, and self-assessment through the Activities of Daily Living (ADL) questionnaire, still there were some differences between the two groups.

Table 5-2 summarizes the socioeconomic and demographic profile of ELEAM residents:
Table 5-2. Demographic and Socioeconomic Data, ELEAM residents

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Mode</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>74</td>
<td>72</td>
<td>7.0</td>
</tr>
<tr>
<td>Education (years)</td>
<td>4.8</td>
<td>0</td>
<td>3.94</td>
</tr>
<tr>
<td>Monthly Income</td>
<td>USD $121</td>
<td>USD $121</td>
<td>0</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>4.72</td>
<td>6</td>
<td>3.48</td>
</tr>
</tbody>
</table>

On the other hand, the sociodemographic profile of club members was slightly different in some aspects. Table 5-3 summarizes that information.

Table 5-3. Demographic and Socioeconomic Data, Club members

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Mode</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age (years)</td>
<td>73.84</td>
<td>77</td>
<td>8.7</td>
</tr>
<tr>
<td>Education (years)</td>
<td>5.08</td>
<td>3</td>
<td>3.4</td>
</tr>
<tr>
<td>Monthly Income</td>
<td>USD $121</td>
<td>USD $121</td>
<td>0</td>
</tr>
<tr>
<td>Activities of Daily Living</td>
<td>4.08</td>
<td>0</td>
<td>3.2</td>
</tr>
</tbody>
</table>

Means from selected demographic and socioeconomic data from ELEAM residents were considered to pair with club members: age, years of education, monthly income, and activities of daily living.

For the first parameter, age, ELEAM residents had 74 years in average, for club members, the average was 73.84. Years of education were also similar, 4.8 years for ELEAM residents, and 5.08 years for club members; however, among ELEAM
residents, 6 participants did not attend school; whereas among club members, only 2 participants did not.

Monthly income was the same for both groups: they received a basic solidary pension of USD $121 approximately. Finally, in scores of Activities of daily living (ADL), ELEAM residents had 4.72 points out of 12, and club members had in average, a slightly lower score, 4.08 points, with similar standard deviation.

In addition to the data described, there was additional demographic data collected that was not considered to pair both samples. Still, this data provides insights about the demographic profile of the participants. Table 5-4 includes additional data for both groups.

Table 5-4. Marital Status, ELEAM residents and club members

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>ELEAM-Men</th>
<th>ELEAM-Women</th>
<th>Club Members-Men</th>
<th>Club Members-Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never Married</td>
<td>8</td>
<td>5</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Married</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Widow/Widower</td>
<td>2</td>
<td>7</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Within ELEAM residents, 12 of the participants were male and 13 were female. Although it was expected that the sample would feature half of the participants from each gender, the actual result was coincidence. Most male participants were never married; instead, the most common marital status among female residents was widow. Also, no one was currently married, because most of the residents were widows/widower. In addition to marital status, participants were asked if they had any
children. Among men, 50% of them were childless, 17% had one child, 25% had two children and 8% had three children. Instead, among women, 46% were childless, 23% had one child, 46% had three children and one participant had nine children.

Instead, among club members, there were 10 men and 15 women. 9 male participants were married, and one was widower; among females, the two most common marital statuses were married and widow. Regarding having children, 100% of male participants had at least one child. Of the female club members, 26% of them were childless, and among the remaining participants, most of them had two or three children, and one participant had six children.

Research has found that married older adults have about half the risk of institutionalization as unmarried persons, and having at least one daughter reduces an 

Adulto mayor's chances of institutionalization by about 25% (Freedman 1996). Additional research (Zhang and Hayward 2001) suggests that the correlation of childlessness in older adults and institutionalization must be understood in the context of marital status and gender.

Among club members, unlike ELEAM residents, most men were married. In fact, during surveys, they mentioned that they participated in clubs because their wives participated first, and then invited them. In the case of the only widower, his late wife was a club member, so after she died, he kept participating on the club. On the other hand, almost the same number of women were married and widows. The latter participated in clubs because their female friends encouraged them to participate. This coincide with findings from a Chilean study, which found that among households of adultos mayores, if there is one member participating in some kind of activity, that
significantly increased the odds of participation of another household member (Herrera, Elgueta and Fernández 2014).

**Self-Rated Health**

Regarding self-rated health, scores went from 1: poor, to 7: excellent. Here there were two questions: one asking for their general self-perceived health, and the second aimed to get how they perceived their health in relation to people from their same age. Figure 5-1 shows the average scores for both groups:

![Figure 5-1](image_url)

**Figure 5-1.** Average scores self-rated health and self-rated health in relation to peers, ELEAM residents and club members

Regarding ELEAM residents, the average score for self-perceived health (SPH) was 5.1; whereas self-perceived health compared to others (SPHO) was slightly higher, 5.4. Most participants at the moment of rate their health compared to others made comments like “I’m by far, better than the rest”, “Look at the other residents, I’m fine” and “They [other residents] are not so active as me”; suggesting that they feel that they have a better health status that the rest of the residents. In fact, during participant
observation, I noted that the group selected to participate were in better health and cognitive conditions than the rest of the residents. Also, they participated more in the activities that the center offers to them.

Instead, for club members, the mean score for SPH was 5.1, the same as ELEAM residents. However, the score for SPHO was 0.4 points lower than ELEAM residents. The mode score in SPH was 4, also lower than the mode for ELEAM residents.

Unlike ELEAM residents, club members felt that they were in worse health than their peers. They made comments like: “I’m not so active as I used to be”, “When we have recreational activities, she [another club member] moves more than me” and “Now I need help to do certain tasks”. This is because they participated in Clubes de Adulto Mayor, and in this kind of groups the more active older adults are the ones who participate. Therefore, they have different expectations: active members surround them. Instead, ELEAM residents live in an environment in which “the norm” is people with different ailments.

Comparing these “subjective” scores with the “objective” scores of ADL, there should not be any significant difference, because the difference between the average scores of ELEAM residents and club members was 0.64 and the standard deviation for both groups were also similar: 3.4 for ELEAM residents and 3.2 for club members. This demonstrates that in this context, in this two groups, the people that adultos mayores interact frequently, it does interfere in their perception of health.
Epidemiological Profile

After the epidemiological profile was made, the data was processed using the statistical program SPSS v.20. Frequencies and percentages of each health problem were calculated, and then, sorted from less frequent to more frequent.

Table 5-5 shows the results obtained for both groups, ELEAM residents and club members (CM):

Table 5-5. Epidemiological Profile, ELEAM residents and club members (CM)

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Frequency ELEAM</th>
<th>Percentage ELEAM</th>
<th>Frequency CM</th>
<th>Percentage CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cavities and/or missing dental pieces</td>
<td>25</td>
<td>100%</td>
<td>24</td>
<td>96%</td>
</tr>
<tr>
<td>Bone Problems</td>
<td>21</td>
<td>84%</td>
<td>22</td>
<td>88%</td>
</tr>
<tr>
<td>Cholesterol &gt;200 mg/dl</td>
<td>8</td>
<td>32%</td>
<td>16</td>
<td>64%</td>
</tr>
<tr>
<td>Chronic Respiratory Disease</td>
<td>6</td>
<td>24%</td>
<td>3</td>
<td>12%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>5</td>
<td>20%</td>
<td>11</td>
<td>44%</td>
</tr>
<tr>
<td>Emotional Problems/Depression</td>
<td>6</td>
<td>24%</td>
<td>7</td>
<td>28%</td>
</tr>
<tr>
<td>Eye Disorder</td>
<td>16</td>
<td>64%</td>
<td>20</td>
<td>80%</td>
</tr>
<tr>
<td>Hearing problems</td>
<td>9</td>
<td>36%</td>
<td>9</td>
<td>36%</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>8</td>
<td>32%</td>
<td>11</td>
<td>44%</td>
</tr>
<tr>
<td>Obesity</td>
<td>1</td>
<td>4%</td>
<td>1</td>
<td>4%</td>
</tr>
<tr>
<td>Overweight</td>
<td>3</td>
<td>12%</td>
<td>1</td>
<td>4%</td>
</tr>
</tbody>
</table>

For both groups, the more frequent problem were cavities and/or missing dental pieces, bone problems and eye problems. In general, club members reported most frequently health problems such as cholesterol, diabetes, eye disorder and high blood pressure.
Cavities and/or missing dental pieces

Most participants mentioned that they were using dentures, or prosthetic devices; and that they have lost their teeth years ago. An analysis made by the Ministry of health, showed that in Chile, the prevalence of cavities increases through age. In fact, for the age group of 65-74 years, the prevalence is 99.4%. In fact, complete or partial edentulism (tooth loss) it has been linked to inequalities: an individual at the lowest educational level, has an average of 8 fewer teeth than those with a college degree (MINSAL 2010).

In addition, edentulism and the use of full dentures in older adults can affect their health and quality of life in several ways. For example, a study conducted in Chile, demonstrated that there was a statistical difference between people with teeth versus people using full dentures in their masticatory performance (von Kretschmann et al. 2015). Also, because of the difficulty to eat certain foods, there is a change in the dietary pattern, increasing the risk of malnutrition and mortality of older adults (Allen 2005; Gellar and Alter 2012; Tsai and Chang 2011).

Bone problems

The second most prevalent were bone problems. Bone fractures are a problem especially for women, who are more likely to have osteoporosis, and consequently, are at higher risk for hip fractures (Curtis et al. 2017). Another risk factor for osteoporosis and bone fractures is deficiency of vitamin D. In Chile, has been found that in older adults, between 36.5 and 70% of them has some defiance of this vitamin (González et al. 2007; Rodríguez, Valdivia and Trincado 2007). Another study found that in Santiago, in a sample of 283 female older adults operated for hip fracture, 98% of them presented lower vitamin D levels than recommended.
Because older adults often present a complex medical history, a correct diagnosis can be a challenge for medical staff, increasing the possibilities of missed diagnose (Zaynab 2012). Rodríguez et al. (2003) found that in two of the main Clinical hospitals in Santiago, Hospital Clínico Pontificia Universidad Católica and Hospital de la Urgencia de la Asistencia Pública, missed diagnosis and failure to treat osteoporosis was found in 90% of aged patients admitted for hip fracture.

Hip fractures also are a challenge for public health. Within the next years, doctors expect that along with the increase of the elderly population, female patients will hip fracture will rise, affecting the availability of beds in Hospitals (Gajardo 2000; Chelala 2013).

High cholesterol levels

The third ailment more frequent in both groups was higher cholesterol levels. As previously mentioned, many of the participants, and adultos mayores in general, have complete or partial edentulism, hence, must change their dietary patterns, which can affect their health.

A study conducted in Arica, Chile, found that older adults between 60 and 70 years had higher cholesterol levels than the group of 50-59 years (Díaz, Espinoza-Navarro and Pinto 2015). Finally, having high levels of cholesterol increase the risk for hypertension and heart disease (Román et al. 2002). However, these risks can be modified by dietary or drug therapy (Manolio 1992).

Eye disorders

The last predominant ailment between the two groups was the presence of eye disorders. This includes problems like glaucoma, cataracts, and low vision. Vision-reducing eye diseases is common among the aged, in fact, one person every three has
some ailment. Frequent causes of loss vision are age-related macular degeneration, cataracts, and glaucoma (Quillen 1999).

Glaucoma is a chronic condition leading to irreversible blindness. Salgado and Castro (2008) suggest that in Chile there is no clarity about the magnitude of the problem of *adultos mayores* with glaucoma, which can affect severely their quality of life.

**Social Support**

To assess social support, two surveys taken from the National Survey of Quality of Life in Older Adults (NSQLOA) were applied. This survey is conducted by the Universidad Católica in conjunction with SENAMA and the Caja de Compensación Los Andes, every three years.

**First Survey**

The first survey included five questions aimed to get information about the potential social support for each participant. Most questions aimed to emotional support, that is, the offering of empathy, concern, affection encouragement or caring (Langford et al. 1997). In addition, other questions aimed to instrumental support, which is tangible support that others may provide, such as help with housekeeping, transportation or money.

The answers could be yes, no or do not know/no opinion. The questionnaire had a high level of internal consistency, as determined by a Cronbach’s alpha of 0.557. Table 5-6 shows the percentage of participants who answer yes to these questions, in both groups.
Table 5-6. Perceived social support, frequency and percentage, ELEAM residents and club members (CM)

<table>
<thead>
<tr>
<th>Question</th>
<th>Frequency ELEAM</th>
<th>Percentage ELEAM</th>
<th>Frequency CM</th>
<th>Percentage CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>In case of sickness, do you have someone to turn up?</td>
<td>21</td>
<td>84%</td>
<td>23</td>
<td>92%</td>
</tr>
<tr>
<td>Do you have someone around when you are in need?</td>
<td>13</td>
<td>52%</td>
<td>23</td>
<td>92%</td>
</tr>
<tr>
<td>If you feel lonely or sad, do you have someone to turn up?</td>
<td>14</td>
<td>56%</td>
<td>13</td>
<td>52%</td>
</tr>
<tr>
<td>Do you have someone whom you can share your joys and sorrows?</td>
<td>11</td>
<td>44%</td>
<td>12</td>
<td>48%</td>
</tr>
<tr>
<td>If you needed money, do you have someone who will borrow money?</td>
<td>5</td>
<td>20%</td>
<td>20</td>
<td>80%</td>
</tr>
</tbody>
</table>

For the first question, 84% of ELEAM residents identified that they have someone to help in case of sickness. When answering that question, most of them mentioned the ELEAM staff as possible social support. On the other hand, 92% of club residents, said that they can count on someone, those possible persons were spouses and their daughters and sons. Results from club members are closer to the results from the Second National Survey of Quality of Life in Older Adults (NSQOA) conducted in 2010: the national score was 91.3%. These differences can be attributed to the fact that *adultos mayores* who answer the national survey do not live in collective residences, thus, the national average does not include their experiences.

Question 2 addressed the possibility of having someone around to provide assistance. 52% of ELEAM residents answered yes; however, it was expected that
because they live on a long-term care center with staff available 24/7, their positive response rate would be higher. To supplement their answers, some of them mentioned that because they live in a collective residence, staff members oversee several people, therefore, they do not feel like they can pay exclusive attention to them. Instead, 92% of club members believe they have someone around to help, and it is mainly because most of them live with their adult children, so they are in contact with them almost all day, even though a lot of them are in their workplace during the day, but still, they manage to keep contact with their parents through cellphones. These scores differ in comparison with the national scores from NSQOA. The national survey has 82.2% for question 2; instead ELEAM residents got 52% and club members got 92%.

The third question assesses for emotional support. 56% of the ELEAM residents mentioned that they could find someone to talk about their feelings; instead 52% of club members said so. The NSQOA result for question 3 was 82.2%.

Most ELEAM residents mentioned particular staff members such as the social worker, and some nurses. In addition, those who answer no to question 3, said things like “it’s not necessary to share my feelings with anyone, I don’t want to be a burden” and “Why I would share? Nobody cares about me, that is why I’m here”.

The lack of social support it has been considered as a risk for institutionalization in Chilean older adults. Sepúlveda et al. (2010), conducted a descriptive study about long-term care center residents in three Chilean southern cities: Temuco, Padre Las Casas and Nueva Imperial. They found that most of them did not have any contact with their adult children.
On the other hand, club members benefit from participation in Clubes de adulto mayor or any other association. Research conducted in Chile (Herrera, Elgueta and Fernández 2014) found that older adults who participate in any kind of public activities have a higher perception of well-being. As a matter of fact, club members, named besides their families, fellow club members as a reliable source for social support.

Question 4, aimed to also get information about emotional support, showed that for ELEAM residents, only 44% of them could count with someone to share their joys and sorrows. On the other hand, 48% of club members said the same. These scores are significantly lower than the national average from the NSQOA. There is a -32.3% and -28.3% correspondingly.

**Second survey**

Table 5-7 shows the results from the second survey on perceived reciprocity applied to ELEAM residents and club members:

<table>
<thead>
<tr>
<th>Answer</th>
<th>Frequency ER</th>
<th>Percentage ER</th>
<th>Frequency CM</th>
<th>Percentage CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>I give more than what I receive</td>
<td>1</td>
<td>4%</td>
<td>4</td>
<td>16%</td>
</tr>
<tr>
<td>I receive more than what I give</td>
<td>10</td>
<td>40%</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td>I give and receive equally</td>
<td>14</td>
<td>56%</td>
<td>16</td>
<td>64%</td>
</tr>
</tbody>
</table>

The first answer, “give more than what they receive” in social support was the least frequent, with 4% of ELEAM residents, and 16% of club members. In the NSQOA, 24.4% of the participants choose that option.
For answer two, “I receive more than what I give”, most ELEAM residents choose this option compared with club members. Actually, 40% of ELEAM residents choose that answer, and 20% of club members. National scores for NSQOA were close to those reported from club members: the national percentage was 17.9%.

ELEAM residents added that they felt that way because they received too much from staff members: they receive food, care, and companionship. It is important to remember that residents pay 80% of their income as tuition. The director of the ELEAM mentioned that this measure, responds to a symbolic function more than economical, because residents know that they are paying for a service, they are not living in there for free.

Finally, for answer three “I give and receive equally”, national score was 57.7%. In this sample, 56% of ELEAM residents, and 64% of club members choose the same answer. ELEAM residents explained that they felt that way because they do give support to their fellow residents, and they felt that they received the same from their counterpart. On the other hand, club members mentioned that they do feel like they give support to their friends, and especially, to their adult children. Most of the women take care of their grandchildren, helping to their adult children to avoid an economic burden, and providing a familiar care.

For this reason, intergenerational relationships are important in well-being, in fact, as Lamb (2014) suggests, it is necessary to address dependency between generations in positive terms. Only in this way, all the parties involved on social support can feel that they are giving and receiving.
Life Satisfaction

Life Satisfaction refers to a construct that represent cognitive and global
evaluation of the “quality of one’s life as a whole” (Pavot and Diener 1993). For
measuring life satisfaction, I used the “Satisfaction With Life Survey” made by Diener et
al. (1985).

The Spanish version previously applied in Chilean population translated by
Reyes-Torres, available in Diener’s official website (Diener 2009). The “Life with
satisfaction scale” (SWLS) is a short 5-item instrument, that had a high level of internal
consistency, as determined by a Cronbach’s alpha of 0.693. Table 5-8 shows the
scores from ELEAM residents and club members.

Table 5-8. SWLS, mean scores ELEAM residents (ER) and club members (CM)

<table>
<thead>
<tr>
<th>Item</th>
<th>Mean Score ER</th>
<th>Standard Deviation ER</th>
<th>Mean Score CM</th>
<th>Standard Deviation CM</th>
</tr>
</thead>
<tbody>
<tr>
<td>SWLS</td>
<td>22.72</td>
<td>6.4</td>
<td>24.22</td>
<td>4.9</td>
</tr>
</tbody>
</table>

Both mean scores are in the category 20-24 points, average score. According to
Diener, individuals in this category are mostly satisfied with their lives, still, there are a
few areas that they would like to improve.

However, mean scores are not enough to compare both groups. In fact, despite
the mean score is similar in both groups, and belongs to the same category, the
distribution of scores is completely different. ELEAM residents presented a higher
standard deviation that club members. Figure 5-1 summarizes the information for both
groups:
For ELEAM residents, 3 out of 25 presented very high scores, 9 had high score, and 7 had average score. This responds to the fact that most of them have a better health status than the rest of the residents. However, there is also one case with a score of 9, which is a 74-year old woman, who also presented lower scores in self-rated health and social support.

Club members showed a completely different score distribution compared to ELEAM residents. Although 11 out of 25 club members had average scores, there are not respondents in the categories extremely dissatisfied and dissatisfied.

Well-being studies have found that life satisfaction has a U shape during the life course. That is, that during early years, levels of life satisfaction are high, and then, around middle age decreases, to increase again in old age (Mroczek and Spiro, 2005; Blanchflower and Oswald 2008; Diener, Inglehart and Tay 2012; Easterlin et al. 2012;
Frijters and Beatton 2012). However, among the oldest-old, that is, people aged 75 and over, it has been found that life satisfaction again declines rapidly. This has been attributed to low levels of perceived health (Gwozdz and Sousa-Poza 2010).

“**I Still Feel Good**”

Regarding demographic data, both groups showed differences, especially in marital status. For instance, among ELEAM residents, most of the male participants were never married, and in women, most of them were widows. Also, among men, 50% of them were childless, and 46% of women. Instead, their counterpart, club members, among males, 9 out of the 10 participants were married, and 1 was widower. Among female club members 7 were married and 6 were widows. 0% of male participants were childless, and 26% of female club members them were childless.

This confirmed a previous Chilean study (Herrera, Elgueta and Fernández 2014) that showed that if one member of the household participates in these clubs, increases the probability of another household member to participate in these.

In addition, these results confirm previous findings in Social Gerontology, that suggest that marriage and having children are protective factors against institutionalization in old age (Freedman 1996; Zhang and Hayward 2001).

Regarding self-rated health, both groups had the same score, 5.1 out of 7.0 points. However, when rating their health in comparison with their peers, there was a 0.4-point difference between both groups. Although this difference is not significant, this difference can be attributed to the fact that this sample of ELEAM residents feels “better” in terms of their health in relation to others, because most of the people that live in the same center, have health problems, therefore, their referents differ from those for club members. In fact, club members showed a small difference, that can be attributed
to the fact that their referents are active older adults, since most of them participate constantly in activities.

Regarding the questions for social support, there were not significant differences between ELEAM residents and club members. The only significant differences were found in two questions regarding instrumental support. In the question “Do you have someone around when you are in need?”, 52% of ELEAM residents answer yes, whereas 92% of club members said so. The second question, “If you needed money, do you have someone who will borrow money”? only 20% of ELEAM residents’ answer yes, instead, 80% of club members agreed.

Regarding life satisfaction, although the average scores were similar for both groups, 4 ELEAM residents out of 25 were dissatisfied and extremely dissatisfied with their lives. Instead, among club members, 11 out of 25 had average score, and nobody was dissatisfied or dissatisfied with their life.

Although this study involved a small sample of 50 participants in total, Mann Whitney U test statistics were used to find correlations between the five aspects of well-being: self-rated health, physical health, social support and life satisfaction. The results showed no correlation among this items; however, social support ($U= 136$, $p= .0$, 2-tailed) appears as the most significant item between the five aforementioned.

In general terms, the results from this first phase of data collection suggest that in this sample of two groups of older adults with similar physical status, age, socioeconomic status, but different living arrangement, social support it is the factor that influence perceived well-being in old age. These differences were evident in the comments that participants made while answering the surveys, suggesting that
quantitative data, in this study was not enough to explain the findings. In addition, data suggests that childless, never married individuals, with lower social support, are most likely to being institutionalized in old age, in fact, as mentioned before in Chapter 4, those are the requirements to be admitted in the ELEAM.

These results show only one portion of well-being in older adults. These results focus on the current state of these older adults, providing a snapshot of their present, but lacking context. These results do not provide information about the past of the participants and how it affected their present.

As mentioned in the literature review in Chapter 2, this research is part of a new approach in studies about older adults, whose principal objective is to contextualize the lives of older adults (Danely and Lynch 2013; Sokolovsky 2009a), focusing on a dynamic approach that explores how people grow old in different cultural and historic contexts. Using the life course perspective, that means, that we consider the life cycle as a whole, therefore, older adults have a past that it is important to consider, because it will provide important clues about what happened before, during childhood and adulthood that can explain certain tendencies that we saw in the data collected through surveys.

Chapter 6 addresses life story interviews conducted with half of the participants from both groups, to give context and meaning for the quantitative data collected during the first phase of this research.
May 2016

I returned to Chile, after spending the spring semester in Gainesville, processing the survey data, and getting ready for the second and final phase of fieldwork. I was ready to return to the ELEAM.

During the time I was in Gainesville, I exchanged emails with the director of the ELEAM, Mrs. B, to know how life around the center was going. Unfortunately, during this time one resident died, and one of the participants of my study was in delicate health. She told me how some residents still remembered me, and asked for me occasionally. I sent Mrs. B an email before going to the center, despite she told me several times that I did not need to let her know, I was welcomed at the ELEAM, the staff already knew me, and I knew the code to unlock the security gate that marks the limits of the “outside world” with the ELEAM.

I was on my way to the center, it was a Monday, and because it was May, it was starting to get cold in Curicó, so I thought of “the weather” as a topic to engage small talk. Then I realized that I would not need that: I already knew the people, it was not necessary to talk about the weather. After all, when you see someone after a long time, there is a lot to catch up on, especially considering that I was away for about four months.

I was walking by the reception desk, and there was Miss J., the same receptionist, we talked a little bit, and then I was again looking at the security gate…
could not remember the code! I know it was four digits…I did not have to ask for help, Miss J, from her desk told me the code. It was simple, but four months do make a difference apparently. The door unlocked, and I am entered the center, feeling it is like my workplace. There they are: the same staff members, pulling wheelchairs, and some residents walking around to and from various activities. I was walking outside Mrs. C’s office (she is technical director) and she called to me. “You are back!”, emphasizing the word are, as she was not sure that I was going to return. She just wanted to let me know that I can visit the center whenever I want, that I do not need an authorization, after all, I was another volunteer last time that I was in the ELEAM.

After our conversation in her office, I went directly to the commons room, to the corner where usually Susanita and Pascual hang out. And there they were: talking to each other, sharing some snacks. They looked exactly the same as four months ago: Pascual wearing his hat, drinking mate in his wheelchair, Susanita is seated next to him, trying to eat with hands damaged by arthritis.

“¡Miren quién se apareció, la señorita!” (look who just showed up), Pascual shouts in his deep voice. He never learned my name…I know that he did not forget it. Then, Susanita follows: “Oh ¡mi niña! Volvió” (Oh, my little girl it is back). Susanita also never called me by my name, she always called me niña or niñita, as most grandparents calls their granddaughters.

I do not have a seat, but I know perfectly where I can get it, I do not have to bother the staff with my “newbie” questions as the first time that I was in the ELEAM. I return to the corner in which Susanita and Pascual are eating. They look happy, and to be honest, I am happy to see them. They start asking a lot of questions about my trip,
my stay in the United States, and my family. So, I start answering their questions, one by one. Actually, I have many stories about my life in Gainesville, and my life in Curicó, I even told them that I presented their data in a poster session in a student competition. Susanita and Pascual are so curious about how people in other countries, so far from Chile, and they are interested about knowing about their lives.

After five minutes or so, I say that is enough about me, I want to know about them: Something happened during my absence? Are there any gossips? And then all the happiness from the beginning just goes away when Susanita, in a slightly sad voice answers “Nada nuevo por acá mi niña, la vida sigue igual acá” (Nothing new my little girl, life it is the same around here). Pascual nods with his head in silence, in sign of approval.

Sometimes I forgot that although they have trips and visits they are in an institution, of course life it is different from the “outside”. They have a routine that they follow every day: the same staff members, the same conversations, the same food, bedtime, and then, repeat for seven days a week.

June 2016

I am finishing the life stories with the ELEAM residents, so I have to contact the presidents from the clubes de adulto mayor to talk with them. First, I contacted señora Carmen, from the “Campo Lindo” club. She told me that there are three days that I can visit the club; however, I can visit her whenever I want, she is really looking forward to see me.

We decided that I would visit them on Friday, because that is the day when most of the participants assist, because a physical professor goes and perform a class with them, as part of a program from the Municipality.
I arrive about 40 minutes before the class, but there are already some members in the cabin. They are all curious, just like the participants from the ELEAM, they also want to know how was my trip, and since then I was in Chile. I started answering questions, and then, when it is their turn to answer I noticed a big difference between them and the ELEAM residents: they do have stories to share: during the summer (January and February) some of them received visits from their adult children and grandchildren, and others went to the beach with their families. After returning to their routines, they still keep their vegetable gardens, some of them even suggest that after the meeting I should go with them to see how my vegetable garden has been taken care of.

When I visited the other club, “Estrellitas del Vaticano”, it was the same: many questions regarding my life in Gainesville, and they did also have stories about their vacation, their families, especially the grandchildren. They did have a lot of going on in their lives, they still must take care of themselves.

**Foreword**

The last vignette was an excerpt of the fieldwork notes that I took during the second phase of the study. In Chapter 5, I addressed surveys and questionnaires, the aspects that the literature considered as key in well-being in older adults. Because this research considered two different groups of older adults of 25 participants each, both groups were paired in terms of age, years of education, activities of daily living (ADL) and income; therefore, the main difference among Group 1, ELEAM residents, and Group 2, club members was the living arrangements.

The statistical analyses showed that both groups had similar epidemiological profiles, presenting the same health problem as previous research has found among
older adults in Chile and other populations. However, in terms of social support, club members felt that they had a safety net, instead, ELEAM residents were not so sure about it. These results also confirm the parameters for admission to the ELEAM: they had to show that they were lacking social support to be institutionalized. Finally, in terms of life satisfaction, although mean scores from both groups were in the same category of “average”, the variability within each group was different. Among ELEAM members, there was a higher variability, even there was a person dissatisfied with her life. Instead, among club members, most scores were in the average category. With these data, it was concluded that the sum of each one of these factors it did affected the perception of well-being among ELEAM residents. Therefore, in this sample of 50 older adults, the living arrangement marks a difference in perceptions of well-being. However, the qualitative data only provided a “snapshot” of perceptions of well-being, and do not provide context or deeper explanations for differences between these two groups.

This chapter focuses on the second phase of the research, conducted between May and August 2016. This second phase has two objectives. The first objective is to complement the previous data obtained during the first phase through life stories conducted to half of the participants. The decision of consider 25 participants relies on the idea of studying a few cases, in great detail, to get information about how the life course differs for each participant in individual terms. Using the life course theoretical orientation, I will show that events happened in early life, will influence later life. For instance, family of origin had an impact on later events such as education, timing of retirement, and pension earnings.
The second objective is to compare the narrative data obtained from both groups in terms of commonalities and differences within groups, across groups, and also between genders.

Data suggested that in terms of well-being in later life, both groups were focused on the concept of “estar tranquilo” (being peaceful) in old age, which had different meanings for each group: ELEAM members focused on keeping good relationships with their fellow residents, and enjoying time on their own. Club members focused on having good relationships with their families and keeping autonomy, which they accomplished through recreational activities.

Methods

Sample Selection

In phase I, scores for life satisfaction were calculated for each one of the participants using the Satisfaction with life scale (Diener et al. 1985), in its Spanish version translated by Reyes-Torres. The results were classified in six categories: from extremely dissatisfied to highly satisfied. These scores were used to select ELEAM members and club members with scores from every possible category, and from both sexes, to count with a diverse sample as possible. In total, twelve ELEAM members, and thirteen club members were selected to participate in this second phase of the study.

During May 2016, the selected participants from each group were contacted, and asked if they wished to participate in the second phase of the study. Twenty-three of the selected participants accepted but one club member was not considered because she died a few days before being contacted. Her data was eliminated from the study out of respect, and her case was changed for a new club member with similar characteristics.
who did not participated during the first phase of research. Therefore, her socioeconomic data along with the life story interview was conducted during this first phase.

Even though the informed consent read during the first phase considered authorization to conduct life story interviews, the script was read again to participants to remind them about their rights as participants. Participants were given other copy of the script that they received during phase I, including contact information of the researcher and the IRB office of the University of Florida.

In total, twelve ELEAM residents were selected to participate in the second phase, the table 6-1 shows demographic data of the participants selected for the second phase of the study, from ELEAM residents.

Table 6-1. Demographic data collected during first phase, selected participants among ELEAM residents

<table>
<thead>
<tr>
<th>Id number</th>
<th>Gender</th>
<th>Age</th>
<th>Education</th>
<th>ADL</th>
<th>Self-rated health</th>
<th>Self-rated health (peers)</th>
<th>SWLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Man</td>
<td>72</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>2</td>
<td>Man</td>
<td>79</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>3</td>
<td>Woman</td>
<td>82</td>
<td>12</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>4</td>
<td>Woman</td>
<td>82</td>
<td>12</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>5</td>
<td>Man</td>
<td>65</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>6</td>
<td>Man</td>
<td>72</td>
<td>9</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>7</td>
<td>Woman</td>
<td>77</td>
<td>12</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>27</td>
</tr>
<tr>
<td>8</td>
<td>Woman</td>
<td>69</td>
<td>0</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>9</td>
<td>Woman</td>
<td>76</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>10</td>
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<td>6</td>
<td>7</td>
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<td>16</td>
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<tr>
<td>11</td>
<td>Man</td>
<td>84</td>
<td>6</td>
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<td>22</td>
</tr>
<tr>
<td>12</td>
<td>Man</td>
<td>66</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>30</td>
</tr>
<tr>
<td>13</td>
<td>Man</td>
<td>70</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>9</td>
</tr>
</tbody>
</table>
There were an equal number of men and women in the final sample of 12 ELEAM residents. Table 6-2 shows the characteristics of club members selected to participate in the second phase of the study:

Table 6-2. Demographic data collected during first phase, selected participants among club members

<table>
<thead>
<tr>
<th>Id number</th>
<th>Gender</th>
<th>Age</th>
<th>Education</th>
<th>ADL</th>
<th>Self-rated health</th>
<th>Self-rated health (peers)</th>
<th>SWLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>Woman</td>
<td>74</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>5</td>
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</tr>
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<td>28</td>
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<td>78</td>
<td>3</td>
<td>0</td>
<td>5</td>
<td>4</td>
<td>23</td>
</tr>
<tr>
<td>29</td>
<td>Woman</td>
<td>82</td>
<td>4</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>30</td>
<td>Man</td>
<td>87</td>
<td>7</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>32</td>
<td>Woman</td>
<td>62</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>21</td>
</tr>
<tr>
<td>33</td>
<td>Man</td>
<td>65</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
<td>36</td>
<td>Man</td>
<td>70</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>32</td>
</tr>
<tr>
<td>37</td>
<td>Woman</td>
<td>68</td>
<td>8</td>
<td>2</td>
<td>7</td>
<td>7</td>
<td>34</td>
</tr>
<tr>
<td>41</td>
<td>Man</td>
<td>68</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>24</td>
</tr>
<tr>
<td>42</td>
<td>Woman</td>
<td>84</td>
<td>3</td>
<td>1</td>
<td>5</td>
<td>6</td>
<td>19</td>
</tr>
<tr>
<td>43</td>
<td>Woman</td>
<td>66</td>
<td>9</td>
<td>2</td>
<td>5</td>
<td>6</td>
<td>27</td>
</tr>
<tr>
<td>51</td>
<td>Woman</td>
<td>70</td>
<td>0</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>16</td>
</tr>
</tbody>
</table>

Between the 12 participants from club members, most of them were women, and 4 were men. In previous Chapters, it was explained that in *clubes de adulto mayor*, most of its participants are women, and that is the reason it seems that men are underrepresented in this sample group.

**Data Collection**

Interviews were conducted in Spanish, within a single session lasting approximately an hour. During the interviews, to help participants in their narratives, I used a table that included all the life stages: infancy/adolescence, adulthood, and old
age. For each life stage participants were asked about their mandatory activities, what they did in their free time, and relationships with family and friends.

Participants were asked which of the following terms did they prefer to being called by others: anciano/a, adulto mayor, abuelo/a and tercera edad. Since this was an open-ended question, participants could also suggest another term if they wanted. ELEAM residents got in addition the question “how did you get here?”, to generate the reasons why they were institutionalized.

For ELEAM residents, 11 interviews were conducted in the small chapel located in the center, and one was conducted in the resident´s room, because he was bedridden. For club members, the interviews were conducted in their homes. In two cases, married couples were interviewed together. Still, they were asked a few questions in solitary, to avoid omission of data because the other partner was in the same room.

Data Analysis

Interviews were transcribed using the software Dragon Naturally Speaking v12.5: I listened the interviews and was reading the interviews simultaneously to the software, in Spanish. This process took about 90 minutes per interview. Once the transcription was ready, interviews were checked for errors. After, the transcription was printed and stapled together with the questionnaires from phase I, and any additional notes from the interviews. Only selected excerpts were translated into English.

For the narrative analysis, an issue-focused analysis (see Kornblit 2007) was conducted. This kind of analysis, as the name suggests, it is focused on a particular issue. This is also known in the Spanish literature as “Análisis temático”, which requires the reading of the transcripts of the interviews to make them familiar to the analyst, and
then identify thematic clusters to later organize data according to the relationships that can be established between these concepts.

In this case, the analysis will be focused to gather all the elements named (or suggested by their stories) by the participants that contributes to a better life. This analysis was conducted through four steps: coding, sorting, local integration and inclusive integration following Weiss (1994). The first step, coding, consists in linking the responses from the interviews with concepts and categories that arise in the interview material. Then, categories were sorted into folders, to get “a set of folders containing excerpts from cases, each folder holding a category of material” (Weiss 1994, 157). After that, the local integration stage was made. In this phase, the interview material was integrated with the observations made by the researcher, to embrace the creation of theories that explain the results. Finally, in inclusive integration, the results obtained from local integration were used to develop a framework, to create general conclusions.

The next section addresses the narratives for each of the life stages: childhood/adolescence and adulthood, and the effects of these stages during old age. In addition, commonalities and differences present in cross-group level, and between genders.

**Results and Discussion**

As previously mentioned, narratives were analyzed in terms of each life stage: childhood/adolescence, adulthood and old age. Within each life stage, there were topics that emerged and were compared. However, because this is a study focused on older adults, the analysis of old age was deeper in relation to the previous stages, and included particular information for ELEAM residents, with questions focused on gathering narratives about the reasons why they are institutionalized, and the positive
and negatives aspects of living in the ELEAM. On the other hand, there were also questions directed to club members, to get their stories about why they were attending the club, and the positive, and negatives aspects of it.

**Childhood/Adolescence**

Childhood and adolescence were considered as the period between birth and age 17. Because legally speaking, in Chile, 18 years is considered as “age of majority”. Most of the participants were born around mid-1930’s and 1950’s. In addition, 22 out of 24 participants were born and raised in rural and semi-rural areas. When asked about their mandatory activities, 12 out of 14 female respondents mentioned that because they were girls, they were the caregiver by default when their mother and/or father was away working:

“I had to wash clothes and do the dishes. In the meanwhile, my mom went out to work the fields. I remember that she always was looking for jobs…so I was taking care of my brother while my mom worked, I was the housewife when she was gone” (ID 11, 69-year old female ELEAM resident)

Female participants explained that although some of them had brothers, still, they were responsible for doing the house chores, while their brothers were playing around:

My dad also worked a lot, sometimes he spent week outside, working…sometimes when he returned, he was always fighting with my mother because he wanted the house to be clean and ready for him. And because my poor mother was all day washing, she didn’t have time to do everything…me and my sister were exhausted, after all, we were little girls. And guess what, my brothers were just playing outside! (…) one obviously doesn’t question those things at the moment, because one was a girl, but…bad luck, is what you got” (ID 9, 77-year old female ELEAM resident)

These excerpts show that during childhood and adolescence women did not question their responsibilities, because that was the way they were taught. Later, during
adulthood and old age, when they evaluate their lives, they realized that there was gender inequality in their homes.

Male participants identified their childhood as a time to play. In addition, they mentioned that during childhood they had more stamina to play, and they do feel a difference now that they are older. Most of them prefer to spend their days watching television instead of doing any physical activities:

“I didn’t like school, it was boring. You spent all day reading...when one is a child one want to play, to jump around...because there is a desire to live, there is so much energy to do things...unlike now, that I want to spent all day sitting here, in the dining room, or in my bed” (ID 6, 65-year-old male ELEAM resident)

“When I was a little boy I really enjoyed playing outside with my friends, we were living in the campo (rural area) so we had a lot of places to hide and play...But now...it isn’t the same, I’m tired” (ID 30, 87-year-old male club member)

It is observed that both, ELEAM residents and club members were exposed to traditional gender roles during their childhood: girls must help their mother with the house chores and boys can play in the meanwhile, or help their dad with work.

None of the male ELEAM residents completed their formal education, either because of lack of resources or being forced to work. Moreover, some of them did not like attending school, and skipped classes. Once they were caught, their parents let them know that there were only two options, working or studying:

“I was a rascal, I skipped classes, I spent all my time playing. And because the school was far away, my dad once told me ’do you like playing? The you stop going to school, and you better get working’ so I didn’t study anymore (...) Imagine, me, a little kid with 5 or 6 years...and sitting there in the classroom for so many hours...so boring! That’s why I skipped classes, to play all day long” (ID 1, 72-year-old male ELEAM resident)
This situation was also shared among male participants from clubs. For instance, 100% of male club members did not finish their formal education, to start working and earn money:

“I only studied three years, because I wanted to work. I started working in a vineyard. Because they paid me for working, I started to like this idea of having my own money...my parents didn’t give me more education, because we were poor...and the truth is, I didn’t really like school, because it was far away...and I was afraid of being alone” (ID 41, 68-year-old male club member).

“I studied seven years...why? Because I wanted to do something with my life, so I entered to the army” (ID 30, 87-year-old male club member).

As mentioned above, socioeconomic status was a key factor in years of education. This was also shared among female participants from both groups, who also dropping out school:

“When my dad died, I was 9 years old, so I only studied 6 years, because my mom didn’t have the resources to send me to school. Because we needed money, I was a baby sitter at that age...I was like 11 or 12 years old and I was taking care of this toddler, he was like 3 or 4 years old. His mom was by his side, but I was taking care of him, especially when the mom wasn’t around” (ID 37, 68-year-old female club member)

The main difference among male and female participants regarding years of education, is that the latter, many times were told that they could not keep studying because they were women, and it was not necessary to them to have education:

“I studied, but only for three years...schools were far away, so I have to walk from Buena Unión to Los Romeros, and that was a lot...besides, there wasn’t any transportation (...) Me and my sisters couldn’t walk alone, because we were women, and that was dangerous...and back then, it was almost a sin for women to have education. I know, that’s stupid, but that’s the way the things used to be” (ID 42, 84-year-old female club member)

When asked about what they liked to do in their free time, 10 out of the 14 female respondents from both groups mentioned that they enjoyed having time alone:
“Because I was working all day, what I enjoyed the most was listen to the radio at night, that was, like, “me” time, I could be alone, and just being there, doing nothing...that was when I was like...12 or 13 years old. Before that I liked to run...but then I started working, so I couldn’t play anymore because I was too tired” (ID 29, 82-year-old female club member)

Analyzing the narratives about what contributed to their well-being during their early life, it becomes evident that for men from both groups, during childhood, having fun, and then, being able to work and have money was key in their happiness. On the other hand, for women from both groups, they enjoyed having time for “their own”, since most of them were forced to work from early age.

In this section of childhood and adolescence it been shown the impact of the family of origin. The exposure to gender roles and the socioeconomic status of the family was key in shaping the early years of all participants. Exposure to gender roles from an early age influence attitudes about women and men’s roles in later life (Morgan and Waite 1987). In fact, the “impressionable youth” hypotheses argue that youth absorb the ideology of the period when they grew up, and this remains relatively stable over their life course (Alwin and Krosnick 1991). However, it is not very clear to what extent attitudes about gender roles helps to motivate family and career decisions. According to Lendon and Silverstein (2012), evidence shows support for both perspectives, there is a reciprocal relationship between gender ideology and life pathways of women.

Because these group of men and women came of age during a time in which the traditional gender roles for women were to be a housewife and mother, and for men were being the breadwinner, they kept performing traditional gender roles during their life course, as it will be shown in following adulthood section. Most of female
participants from both groups got married at early age, got children, became a housewife, and took care of their husbands even though their relationships as a couple were not good. On the other hand, male participants were breadwinners and among those who had children, they did not participate much in child rearing.

**Adulthood**

Adulthood was considered as the period between ages 18 to 59. These parameters were chosen considering that in Chile, 18 years is considered as “age of majority” and 60 years is legally considered as old age. During adulthood, most respondents were working, however, there were some differences in terms of marital status, especially between ELEAM residents and club members. The topics that emerged for this life stage were: work/leisure, marriage/parenthood, division of labor within families and cultural context.

**Work/leisure**

When asked about what they liked to do in their free time, women from both groups, mentioned that because they were used to be at home, they enjoyed being there:

“I really enjoyed doing house chores. Just being at home…I didn’t like to get out…I was really happy when I was at home, I enjoyed taking care of plants, moving their pots…I remember that I got a *pirita* plant, and every day I cleaned its leaves, I like it to be shiny, that was my main entertainment. My only option was staying at home…so I had to love it" (ID 4, 82-year old ELEAM resident).

This resident mentioned that she was forced by her godparents to be at home; therefore, as a coping strategy, she tried to enjoy her situation as much as she could. Six out of eight female members from *clubes de adulto mayor* suggested that they enjoyed using their sewing machine:
“I always sew, all my life I did that...when I was young, like 20 years or so, I was called to work in a home, and I really enjoyed using my sewing machine, I did sheets, tablecloths and placemats (...) I was single, and I didn’t have any children, what else could I be doing?” (ID 37, 68-year-old club member)

It is important to note again, the importance of gender roles especially among women. Most of them were doing what was expected for women, choosing for leisure “traditional” hobbies like sew and staying at home. Despite that there are about 20 years of difference among the female respondents, and that Chile was experiencing several changes during 1960 and 1970, moving towards a modernization of the country, these participants did not notice any changes in their gender roles in relation to their mothers. This can be attributed to the fact that most of the “development indicators” such as greater access to education and better socioeconomic status, did not reach the popular and vulnerable sectors. In fact, as Parrini (1999) suggests, because the dictatorship increased inequities, identity based on traditional gender roles was reinforced in sectors with low educational levels: it was better for a woman to stay at home being a mother, and for men to look for jobs, although most of them were only temporal. Still, it is possible to found alternative discourses, like this one:

“I liked to work, because that meant that I was earning my money and that I decided how I wanted to spend it. After I got married I kept working, because I worked before, I get used to have my own money...and that it’s complicated from some men, but luckily, with my husband we talk about everything, so he doesn’t have a problem with it” (ID 32, 62-year-old female club member)

In this excerpt, the participant realizes that not having a formal work was the norm for women, and that she is an exception. Also, she mentions that a woman working is a potential problem for some men. Among the activities that female ELEAM residents did during their adulthood were: housewife, waitress, farmer, newspaper
vendor and maid. Among female club members were: farmers, housewife, newspaper vendor, maid, secretary and food vendor.

Men’s experience were completely different. Some male ELEAM residents preferred to work to being able to pay for their bad habits:

“What I liked the most was working…yes, working. It didn’t matter what, but I wanted to work, so I could pay for food and shelter…and, hey, let’s be honest, I wanted to relax, drinking beer…so if I wanted to drink, I had to work, right? Besides, if one didn’t work…how could I have fun? There are alcoholic men out there, but I just enjoyed a few beers occasionally, but I never was an alcoholic, no sir” (ID 1, 72-year-old male ELEAM resident)

This male resident points out that working was, “the only option” for men. Also, he mentioned that there were alcoholic men, however, he was not one of them. Alcoholism was a frequent problem mentioned by both, men and women from both groups. However, when women mentioned it, it was because their husbands were alcoholic.

All male respondents from both groups enjoyed working, because they felt that they were doing what was expected from them. ELEAM members worked as foreman, construction workers, farmers, and security guards. Instead, male club members were: electricians, farmers, food vendors, newspaper vendors and military. Whatever their work was, they enjoyed it:

“I was really happy at work. I started working as a chief in the military…and I studied, I worked really hard…I don’t want to brag, but I did such a good work, that when they called the best man to be the bodyguard of my general Augusto Pinochet, they chose me! It was an honor to protect him” (ID 30, 87-year-old male club member)

Marriage/parenthood

Although the sample for first phase of ELEAM male residents, included many men that were childless, for the second phase, three out of six had children, and many
of them were never married. Most of them recognized that they were not good partners, because they liked to drink and party:

“I got a partner, but we didn’t have children…we didn’t because just it didn’t happen. We broke up because I did wrong, I have to be honest…I liked to going to parties with my friends, and we did a lot of noise. At first, she didn’t say anything, but then things got worse…she couldn’t take it anymore, and she left” (ID 12, 76-year-old male ELEAM resident)

“When I was 18 I got married, but it didn’t last…it was a short marriage, like 3 years, because I really loved to play soccer, so my friends always went to my home to invite me, because I was really good (…) because of that I lost my woman…back then I thought that soccer was equal to happiness, supposedly…and I say supposedly, because I realized that I will never be as happy as I was when we were together…think about it, I was so stupid! I had happiness just in front of me, but silly me, that I wanted to play soccer” (ID 13, 68-year old male ELEAM resident)

In the last quote, the resident realized that he was wrong when he chose soccer instead of her partner. There were similar narratives among male ELEAM residents. In fact, some of them said that because of their bad choices they ended up living in an institution. However, the reason behind why they are living in the center will be discussed in the section about old age.

Among female residents, three of them had children, while three were childless. The latter mentioned the main factor because they did not have children was because they could not find an appropriate partner:

“I always love children. I would like to have one of my own. But I just didn’t meet the correct man…I was engaged, we even got a house, but I learned that he was cheating on me, so I just left him. I don’t like to think about it, it’s part of the past, and if it didn’t happen, there must be a reason” (ID 4, 85-year-old female ELEAM resident)

“I didn’t have children, I guess I would have been a good mother, but I never found a good man for me, who could take care of us as a family” (ID 7, 72-year-old female ELEAM resident)
Unlike female ELEAM residents, most of female club members did have children, in fact, some of them mentioned that they wished to have had fewer children. Because the access to reproductive and sexual education was limited when they were in their reproductive years (around the sixties), they did not know how reproduction worked:

“We were so naive. When we were like 8 or 9 years we thought that if we kissed with a boy, we will get pregnant. We didn’t know anything, parents didn’t talk about it and in school you didn’t learn those things (...) when I got my first child, then I learned how things worked. I got married, and then, a month later, I was pregnant...if back then I would know about the pill, I would take it, and I wouldn’t have had children” (ID 43, 66-year-old female club member)

“I got six children...six! And to be honest, I didn’t want to have so many...when I got my last children, I asked to the doctor if I could have something, a treatment, because I didn’t want more children...I was like 30, or 35 years old. So, the doctor put me a treatment [an intrauterine device] and I didn’t have any children...who knows how many children I would have had” (ID 28, 78-year old female club member)

In Chile, just in 1965, the National Health Service (SNS) began the implementation of sanitary measures aiming family planning programs. A life story study (Castañeda and Salamé 2015) conducted with 64 female older adults showed that from the beginning of the program, many women were not aware of the program, because many doctors did not mention it to their patients. In addition, there was a whole “cultural taboo” about using contraceptives, due to misinformation. In fact, according to another study, reproductive programs in public health centers are still not used as sufficiently as they should be (Magaña et al. 2011).

Also, being a single mother was a problem back in the sixties. As one participant mentioned, there were a lot of prejudice surrounding motherhood:

“I felt so bad when I knew that I was going to be a single mother, because people always said awful things, like that I will never find another man because I already had a child...and yes, this is true, there are some men that think like that...but there are also who don’t care about, and they
know that your children is the most important person for you, so they buy the full package (laughs). I always told my husband: you must love this entire package, my daughter and me” (ID 32, 62-year-old female club member)

Along with this participant, there were also two single mothers, however, they did not remarry another couple after becoming mothers. Like this participant suggested, they also found that both, men and women had a lot of bias against women with children being married. Even, one mentioned that she was afraid to be beaten by a potential new couple, because he could find that she was not a virgin.

Still, female participants that were mothers, considered their children as key to being happy:

“When I was younger, like...I don’t know, I was like 20 something, I really enjoyed being with my daughters when they were little...they were so sweet, and you get the opportunity to teach them, to love them...I think that’s one the best feelings about being a woman: being able to have children, feel them, raise them...suffer for them...because as a mother, the only thing that really matter is their happiness” (ID 32, 62-year-old female club member)

Most of them turned to their children as their main source of happiness, even more than their partners. As it will be shown in the next section, even during old age, mothers and fathers are still worried about their children, although all of them are adults and have their own families.

In addition, work was mentioned among the male participants from both groups as a source of happiness during their adult years. That aspect was already described in the work/leisure section.

**Division of labor within families**

In addition to the factors that influence division of labor within families aforementioned in the childhood/adolescence section, social context plays an important
role, because the unique historical and social time period change which distribution of roles is considered as accepted (Perry-Jenkins, Newkirk and Ghunney 2013). Yet, there is evidence that for women, school enrollment, full-time employment and independent living increase the possibilities of egalitarian roles for women and men in families. On the contrary, early marriage and marital parenthood are associated with unequal roles within families (Cunningam et al. 2005).

Among female club members, 13 out of 14 become mothers, and they assumed most of the responsibilities of child rearing:

“Sometimes I was up until 1 am, washing their clothes, so they could go to school. I stayed at home, taking care of them…and the truth is, that it was worth it, because nothing compares to be right there when they [children] need you” (ID 42, 84-year-old female club member)

In the meanwhile, men were working, in order to fulfill their role as breadwinners:

“My wife took care of our children, because I spent all day working. Back then, if you wanted to earn good money you have to work away from home, and I worked in Punta Arenas (a city located almost 3,000 km south of Curicó). So, I came to Curicó every three months. So, my wife was alone with our children, I’m really thankful for that” (ID 37, 70-year-old male club member)

Although they could not participate in direct parenting, most of club members were working to provide better options for their children. A completely different situation was lived from the male ELEAM residents, among all the men who did have children, they never worried about their children, because they did not cohabitate with them, and also, because they did not have any kind of relationship with them or their mother.

Cultural context

Unlike childhood and adulthood, some members mentioned the importance of the cultural context in which they were living their adulthood. For instance, some of them mentioned the military dictatorship during 1973 and 1990, as an important factor
that affected their lives, especially because the country did not felt as a safe place to live:

“Look, I wasn’t affected directly by the dictatorship, but I can say that it did affect me psychologically, because the military killed so many people…and innocent people! Pregnant women and children…tell me, what they were going to do? Organize a rebellion? Please! They [the military] were crazy! Obviously, I don’t share that kind of thinking. And although I wasn’t in any political party, I was sad. It’s impossible to ignore everything that was happening in our country. I did hurt to be a Chilean back then” (ID 12, 76-year-old male ELEAM resident).

Some participants also avoided talking about the military dictatorship, because they mentioned that talking about politics divides people, or that can start a fight. That is one aftermath of the military dictatorship that is still present after almost 30 years of the return to the democracy. People are still afraid of speaking about politics, especially *adultos mayores*, because they are still open supporters of Pinochet and his regime. Although among the participants there were two men who were members of the army during the dictatorship, and one of them was, as mentioned before, Pinochet’s bodyguard, neither of them mentioned the dictatorship, and when they were directly asked about the topic, they asked to not talk about it. Therefore, the topic was changed.

**Old Age**

Old age was considered from age 60 and above. There was not considered an option for the oldest-old as some research suggest, because significant differences were not found among people aged 75 and over.

In Chapter 2, I mentioned that this research considered the life course perspective, especially in terms of considering old age as a “sum” of the previous life stages. Following this idea, during this life stage, it was evident how events occurred
during childhood, adolescence and adulthood have an impact in the current conditions of the participants from both groups.

The following section focuses on six topics that emerged in the narratives of old age in both groups. First, I address how ELEAM residents and club members prefer to be addressed in old age. Then, I explain the main findings from the narratives. The main topic was leisure; as mentioned in Chapter 2, the current age-segregated model (Riley and Riley 2000), present in the Chilean society, dictates that leisure is related with old age, during their adulthood, they worked, so now during old age, it is their time to enjoy of their “free time”.

The second topic was pensions. Income has been found a factor that influence well-being (Urzúa et al. 2011; Lloyd-Sherlock et al. 2012), and respondents from both groups mentioned their pensions as a “problem” during old age.

The following three topics focus on particular aspects concerning ELEAM residents: first, they were asked about the reasons why they were living in the institution; then, they were asked to name the positive and negatives aspects of living in the center.

Finally, the sixth topic, addresses a particular aspect for club members, and it explores the reasons why they are participating in clubs. As previously mentioned in other Chapters, most participants of these clubes de adulto mayor are women.

“I prefer adulto mayor, because we are fine, we do everything”

Participants from both groups were asked which term did they preferred to be addressed during old age. The options were: adulto mayor (older adult), anciano/a (elderly), tercera edad (third age) and abuelito/a (grandparent/grandmother).
The most popular option was *adulto mayor*, chose by six ELEAM residents and nine club members. They mentioned that they preferred that term because it was “politically correct” and they felt respected:

“I prefer *adulto mayor*, because we are fine, we do everything, we stay active...instead *tercera edad* it is like it is the final stage, that you are dying...and we are so alive! In this club, we do a lot of activities, we have trips, some members even go with their wheelchairs, others use a cane, but they participate” (ID 51, 70-year-old female club member)

Most of the participants mentioned the negative stereotypes associated with old age, especially with the term *anciano* or *anciana* (elderly): being useless, not active, dependent, outdated. For this reason, no one chose this term:

“The other day I heard how a neighbor’s grandchildren was talking about a neighbor, he said ‘oh, this place is full of *ancianos*, so old’ and I heard him...who does he thinks he is? We are old, but we are fine, we do things” (ID 33, 65-year-old male club member)

“I remember that in the other center that I lived some staff members called us *ancianos*, and nobody like it, because it was like disrespectful, we are not useless” (ID 2, 79-year-old ELEAM male resident)

Among the narratives of club members, their discourse was centered towards “being active”, that was what differentiated themselves from the elderly, which for them meant being dependent. Instead, ELEAM residents focused on how *anciano* was a synonym of something disrespectful, because they were not useless.

In addition, *tercera edad* (third age) was also associated with negative stereotypes among participants from both groups. They felt that third age was a concept that meant that they were close to death, and many of the participants mentioned that they felt so active that they did not felt like they were going to die soon. Although this could have been a “natural” transition to talk about death, members from both groups avoided the topic, therefore, it was not addressed.
Abuelito or abuelita (grandparent) was accepted by three ELEAM residents as an appropriate term, especially if it came from staff members, because it was considered as a form of affection, especially if it came from younger volunteers or staff members. However, club members were aware that grandparent was only accepted if was told by their grandchildren, because otherwise it did not make any sense:

“I don’t like that people on the street call me abuelita. I think it’s not correct if I am not their abuelita. I mean, it is not like I am going to fight because someone call me like that, but it will be good that people will stop calling older people abuelitos” (ID 28, 78-year-old female club member)

In addition, among three ELEAM residents had no preference in terms:

“Honestly, I don’t care how people call me, the only thing that matters it is that they treat me respectfully” (ID 12, 76-year-old male resident)

Two of the twelve club members mentioned that they did not worry about how they were treated. However, 22 out of 24 respondents from both groups mentioned the importance of respect, some of them did care more about the way in which they were addressed instead of the terms. However, most of the participants of this study mentioned that they preferred the term adulto mayor (older adult).

Leisure

Because all the participants were retired, the section about work is not considered for this section. Instead, only leisure will be considered. This section only includes the results from female club members, because there is a separate section for ELEAM residents, in which they were asked about what they enjoyed the most about the ELEAM.

When participants were asked about what they enjoyed to do in old age, female and male ELEAM residents mentioned having contact with their children:
“One of the things that I enjoy the most is to visit my children. They are living in other city, but I have planned to visit them, before my wife get her surgery. When visit them I always find something to do in their houses, like fixing the electric power system, or doing a fence, whatever. I like to help my children with their stuff, whatever is it, because I can’t just be here at home doing nothing...Because I worked as a welder for so many years, I like to do small fixes around...not only for my children, but also for friends” (ID 37, 70-year-old male club member).

Nine out of ten club members mentioned that they enjoyed doing things around their houses, or helping their children. Men especially mentioned that because they spent all their life working, now that they did not have to work anymore, sometimes they found themselves looking for any activity to do, to feel active.

Twelve out of fourteen female club members mentioned that they enjoyed being at home, because they felt that they spent most of their adulthood taking care of children, therefore, they wanted to enjoy their new life stage. However, like men, they were also worried about their children and grandchildren, and visited them as much as they could.

It is important to remember that the second group, club members, were comprised of older adults from two clubes de adulto mayor, and one of them, Campo Lindo, was in a semi-rural area. For this reason, all female members of that club, mentioned gardening as one of their favorite activities:

I think what I enjoy the most is gardening...I have a little vegetable garden here, and I have lettuce, cabbage, onions, cilantro, tomatoes...so, every time that I can, I do something in there, it’s so nice, is almost therapeutic. The bad side is that I have to bend down, and sometimes I get dizzy...it’s just old age” (ID 26, 74-year old female club member).

Also, five out of fourteen female club members mentioned religion as a main source for peace, and a way to dealt with life’s difficulties:

“For me, happiness is being at home, my home. And what other source of happiness you can have if you could talk with the one who is there

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indicating a picture of Jesus]. Yes, I do talk with him, and he helps me…I’m a very catholic person, I do believe in god and the virgin (...) Every day, when I woke up, at 5 am, I pray, I pray the rosary, full, and when I finish, I fall sleep again, and then I get up. The full rosary take me like 30 minutes, and I enjoy that, I felt like I give away all my sorrows when I talk with God…there are people who are annoyed by what I do, but I feel good, calm (ID 28, 78-year-old female club member)

Ardelt and Koenig (2007, 2009) showed that religion can improve subjective well-being among older adults: they found that among Americans, intrinsic religiosity –the one that provides a master plan for living, beyond individual benefits- had a positive effect on purpose in life, which is related to greater subjective well-being and lower death anxiety. Instead, extrinsic religiosity –the one that it is used for personal benefits- it is related to higher death anxiety. In Chile, Barros (1991) found that for adultos mayores, religion is considered as a key element of life. Despite the fact that the number of religious people in Chile is decreasing, still, among older adults these levels do not decline (PUC and Adimark 2016). This is likely because many of them were raised in highly-religious households, and even, some of them studied in Catholic schools, during a period in which being religious was part of the norm.

Pensions

This section addresses the economic concerns from participants between the two groups: ELEAM residents and club members. It is called pensions because the only economic income for 100% of the sample was their basic pension, that in November 2016 was USD$156 (IPS 2016).

Most of the participants feel like their income is not enough to satisfy their needs. This is especially true among female club members:

“How someone is going to live with less of what they [the politics] said is the minimum wage? The economic situation for older adults is very complicated here in Chile…one did everything during her life, raised
children…I even took care of other people’s children, because I was a maid…and I feel like I don’t get enough money for what I did” (ID 43, 66-year-old-female club member).

“One as a housewife that never worked, only have the consolation of having taking care of the children, because later you receive a misery, that some call 'pension'. We are getting older, we are getting sicker, and every day we need more money to medications…we know use the public health system, because it’s free, but still, you have to pay for most medication, you can’t get all for free” (ID 42, 84-year-old female club member)

As previously mentioned in Chapter 3, the pensions in Chile are lower than the minimum wage, and because the current system is a defined contributions scheme, that it is based on individual capital accounts, which are managed by private companies (AFP). Because of this, people who did not make monthly contributions during their working years are at a disadvantage because they have less money in their accounts. This is a problem especially for women, because many of them did not have a formal work due to being a housewife and taking care of their children, or had maternal leave, or had to abandon their work for taking care of children and/or their family.

Among this sample, men also felt that they monthly income was not enough to cover their expenses:

“I retired when I was 50 years…the pension is not good, at all. I was watching the news last night, and I saw people that receive less money than me…and now people are saying that pensions are decreasing…and I think…the anchorman last night said which was the minimum wage…and I receive way less than that…so…do the math” (ID 41, 68-year-old male member)

“The problem is, that I was used to gain CLP$ 400,000 monthly, and despite I was responsible, and I put money into the AFP every month, I’m losing money right now…because my pension is less than half of what I did earn when I was working. And although I knew that I was going to retire…but I never thought that I would have such a squalid pension” (ID 37, 68-year-old male)
These two examples show how the new system of defined contribution did not directly benefit the actual retirees. Both men and women from this sample felt that the current pension system is not good enough, because although they made their contributions to an AFP, they are not getting enough money.

These narratives show how events occurred in early life influenced their well-being in old age. For instance, as mentioned in the childhood/adolescence section, family of origin does impact the lives of its members: most of the participants were born to poor families, and could not access to education. This, in turn, affected their work options in adulthood/middle age; which later will affect the pension that they currently receive.

Cumulative disadvantage/advantage theory helps to understand the stratification among older adults. This theory suggests that inequality is not a static outcome, instead, inequalities are produced across the life course, and, are maintained during old age (O’Rand 1996). On the other hand, Ferraro and Shippee (2009) coined the “Cumulative inequality theory”, as an effort to join the cumulative disadvantage/advantage theory with the life course perspective. In the case of these narratives, it can be addressed through this theory. For instance, the first axiom of the cumulative inequality theory suggests, “social systems generate inequality, which is manifested over the life course through demographic and developmental processes” (Ferraro and Shippee 2009, 334). In the case of the participants from both groups, as mentioned above, they were born in poor families, which limited their options during the life course. In addition, current social policies such as the defined contribution pension system in Chile, contributes to increase inequalities, especially gender inequalities:
because of traditional gender roles, most women in the sample, dedicated their adult
years to motherhood and overseeing the house chores.

Although members from both groups feel that their pension is not adequate to
cover their expenses, ELEAM residents described feeling “not as bad”, because they
were living in a long-term center. They pay 80% of their pension as a fee to the center,
and the remaining 20% they can spend as they wish:

“If I didn’t live here, I’m pretty sure I’ll be homeless…I know I have a basic
pension, and that is not enough. Before I lived in a center, I lived a couple
of months on my own. And in that time, like years ago, that wasn’t enough,
that’s why I asked for help” (ID 1, 72-years-old male ELEAM resident).

“I know that with my current pension I wouldn’t be able to pay for food,
sHELTER and medicines…that’s the best about living here, that you know for
sure that every day you will get that here. I’m so thankful for that” (ID 4,
82-year-old female ELEAM resident).

In this sense, ELEAM residents are in better condition than their counterparts,
because although some of them are living in an institution because they do not have
social support, and were vulnerable, they do have, in a way, “guaranteed” shelter,
medications, and food. Instead, the club members, because most of them only depend
economically on their pensions, they are worried about how to finance their expenses.
However, most of them, as showed in Chapter 5, have better social support than
ELEAM residents, because they do have contact with their children and other family
members. Therefore, in another way, they do have a “support network” if needed.

How did you get here?

This question was asked only to ELEAM residents, to get their narratives about
the reasons why they are living in an institution instead of somewhere else. It is
important to recall that in Chapter 4, were mentioned the main characteristics that an
adulTo mayor must fulfill to be accepted in this institution. Besides being at least 60
years old, there were some requirements regarding vulnerability, such as having a low socioeconomic status, lack of social support and having some dependency level. For this reason, residents have in common these factors.

Regarding their explanation of why they are institutionalized there were some differences found between female and male residents. The latter, suggested that there was an event that triggered their inability to maintain their autonomy:

“I got an accident, and because my leg wasn’t good I couldn’t work. So, I talked with a social worker, and she helped me to get my pension. She helped me because I didn’t have any protection, I was alone, I didn’t know if I could eat...so that’s why she sent me to a center” (ID 1, 72-year-old male ELEAM resident)

“I’ve been living in centers like this for the last 14 years. Since I lost my leg in an accident. A train hit me, I didn’t saw it” (ID 2, 79-year old male ELEAM resident)

“I was loading sacks of potatoes into a truck, and a big stick got through my head, my skull…I lost a little of encephalitic mass, and I ended up like this, paraplegic. On May 21st, will be 15 years since I got the accident, I was 61 years old, back then” (ID 12, 76-years-old male resident)

These excerpts confirm the main requirements for being accepted in the ELEAM. First, they lost their dependency, therefore, their health was compromised. In addition, they mentioned that they did not have a safety net among family and friends to help them to cope with this new situation. In fact, the three male residents mentioned in the excerpts, were single when they suffered their accidents. Most of male residents recalled that they lacked social support, their only option was to seek help in public institutions through a social worker. In some cases, they asked for help, and in other cases, they were derived from the hospital.
Among female residents, the main factor influencing institutionalization was also the lack of autonomy. However, their narratives are slightly different: they mentioned that gradually, they lost their ability to being independent:

“I remember exactly how I was losing my ability to do things around the house. First, it was my back…Oh God! It hurt so much…then, my legs, I couldn’t cook, because I was in pain. And finally, my hands: the arthritis was awful! And because my children couldn’t take care of me, they went to the municipality to seek help” (ID 17, 84-year-old female resident)

“When I was young, I did everything: I could take care of myself…but then, one becomes old and it’s not capable of doing the same things on their own…I didn’t want to come here…but my neighbors told me that was for the best’ (ID 11, 69-year-old female resident)

However, they do mention that someone else helped them to seek for help. Because their health was compromised, they were not able to take care of themselves, therefore, relatives or neighbors advised them to seek help. Yet, there are some cases in which the residents chose to live in the ELEAM, in search for a better living:

“My children started to fight with each other…you know, when you don’t produce money…there are always fights (crying). So, one day I told my daughter: you know what? I would prefer to live somewhere else, I want to spend my last years in a better place. Well mama-she said. And I came here. I like to live here” (ID 23, 70-year-old female resident)

“I live here because I’m a case of domestic violence. I don’t like to talk about it…but I think it’s fair to tell you something about it: I came here because I was looking for help. My family wasn’t good for me” (ID 9, 77-year-old female resident)

In both cases, although different, show how even though both residents did live with their families during old age, they were not a source of support. In fact, they decided to seek help, and improve their quality of life.

Male residents did not mention that they were institutionalized by choice, instead they said they were living in the ELEAM because something happened and their
narratives were more uniform. Instead, female residents described different reasons why they were living in the ELEAM.

In addition, in a case, a female resident felt that she did have a safety net with her family, however, because her health was getting worse, she did not have another option:

“I didn't want to come here. I was living on the third floor in a nephew's home, and I had to climb stairs every day. One day, Fernando [his nephew] told me ‘aunty, please don't take this the wrong way, but we’re afraid that you fall down the stairs, and we don't want that responsibility’. His wife told me the same, and she added that here I would have everything…at first I said no, but after that, I keep thinking…what I could do if I fell…I already got arthritis. So, I accepted, and that’s why I’m here…and I think that was for the best, because I’m good here” (ID 4, 82-year-old female resident)

In some cases, residents avoided living in a long-term care center as much as they could, however, because of their health problems they did not have another option. In conclusion, both, men and women mentioned the same factors for institutionalization: dependency, lack of social support and lower socioeconomic status. However, the main difference was found in the way they told their stories: men mentioned a particular event, such an accident, as responsible for their loss of autonomy; instead, women mentioned how they felt that gradually lost their ability to do things on their own. In both cases, because they did not have a safety net (in most cases) their only option to cope with this loss of autonomy, was living in the ELEAM. Still, there were some exceptions, especially among women, that they chose to live in the ELEAM because their living conditions were not the best.
**Positive aspects about ELEAM**

For this section, participants were asked to describe their favorite things about the ELEAM, or what did they enjoy the most. Among women, they mentioned that being able to be alone and quiet was the best:

“I enjoyed the peacefulness that sometimes you get here. Also, I like to hear music…now they put good music, because before they had another music. The kinesiologist asked me which kind of music I liked, and I told him that I liked classical music. But here everyone like Mexican music, or tropical music…that doesn’t fit me, but I accept it, because you must live in harmony with the rest…but from time to time I would like to hear more classical music, it would be very good” (ID 4, 82-year-old women)

Women especially mentioned the importance of living in peace, and avoiding fights and differences among the residents. In addition, one resident mentioned that she enjoyed not doing house chores, because she spent her life doing so:

“I like everything about here…everything is good, I have food, shelter…I have everything…It’s so awesome that they [staff] even wash your clothes! At the beginning, I washed my underwear, until someone told me that here they have washing machines, that I didn’t have to wash my clothes…it’s amazing, all my life I did my own laundry, with my hands. Now I just use my clothes and put them all together…but still, I like walk and take the clothes to the laundry” (ID 11, 69-year-old female ELEAM resident)

Since most of the female residents were housewives during their adulthood, they were used to doing all the chores. Therefore, despite of being in the ELEAM for some time (the resident quoted above has been living in the ELEAM for almost four years), they still try to help with something, despite not being necessary.

Although 10 out of 12 of the interviewees selected to the second phase of the study were living for the first time in an ELEAM, some of them already lived in other centers. These two male residents were asked how this center was compared to the ones that they lived before:
“Let’s see…I have lived in…like 6 or 7 ELEAM, I think that the best ones are the ones in charge of Hogar de Cristo…except when this ELEAM was the hostería [the previous place were the ELEAM was located]. What happens is that we were all confined, after the earthquake, all of us were in the same place…some were screaming…the house wasn’t safe. This place, is the most beautiful thing that God has given me, imagine that we have everything here: food, shelter, bathrooms…so we clean ourselves, we have a clean face…we don’t lack anything, nothing! About food, image that 1000 million people every day, feel hungry, and simultaneously, we waste food…that food could easily serve like 2000 million people. And I know that because I read it on the newspaper” (ID 12, 76-year-old male ELEAM resident)

“This is the best, I don’t have any problems with the staff. But sometimes I think that there are some lazy people here…and I’m talking about the students, not the regular staff” (ID 2, 79-year-old male resident)

Both residents suggested that this ELEAM was best than the previous one in which they lived. The story narrated by the first resident, match with the story narrated by the director, about how chaotic was the situation in the hospedería after the earthquake. The second resident mentioned that the students who do their professional practice are sometimes “lazy”. Some residents also mentioned this concern.

**Negative aspects about ELEAM**

Along with the positive aspects about the ELEAM, residents were asked to talk about the thingd they did not like. As mentioned above, some residents suggested that students doing their professional practice were not as effective as the regular staff. In addition, some mentioned that despite the activities that the center conducts on a regular basis, they still feel bored:

“[it’s sad] that life here is like this, slow, every day the same…get up early, then eat always at the same time, then, after lunch, sit in here, and watch the television” (ID 7, 72-year-old female ELEAM resident)

In addition, another resident suggested that he did not like the way some staff members have sometimes treated him:
“I know that sometimes I can be a little annoying. The thing is that I joke around, and some ladies do not understand that...I remember that one day one was done with me, and told me ‘ok, go play with the other grandparents’ and I was like what? Play? But if we aren’t children! And now that I’m talking about it, I realize that I hate that, that’s what bothers me the most, that some people treat us like children, if like we didn’t know anything about life...they think because we are old and tired, we are like children...sometimes people come here and speak us sloopwly liiiike thiiiis [lengthening the words]. Well, let me tell you, we are deaf but no dumb!” (ID 1, 72-year-old male ELEAM resident).

**Participation in clubes de adulto mayor**

Club members were asked to tell why they were participating of the clubs. As mentioned in previous Chapters, in Chile, most women than men are part of these clubs. Some participants attribute this to the fact that men think that it is an activity for only women:

“The most “mainly-man” doesn’t like to participate here. In our club, there are like seven or eight men, and in total we are like 50, so it’s a very big difference. The thing is, even if a man is a widowed, he doesn’t like to participate in clubs...I know around here there are a lot of lonely men, and we have invited them to join us, but they do not want to come, they prefer to stay alone in their houses: ‘why I’m going to participate, if it’s full of women’ -they think. They’re so machistas” (ID 29, 82-year-old female club member)

Something similar added one of the male participants from the other club de adulto mayor:

We are like...6 or 7 men in the group...and in total we are like 26 members. I don’t get it, we have so much fun here...they don’t know what they are missing” (ID 41, 68-year-old male club member).

Gender roles since early age do interfere with perceptions about which people get to do certain activities during the life course. As mentioned in Chapter 3, most of the participants were born and raised in a time period in which leisure activities were separated by gender. In addition, women have a longer life expectancy, and they usually have better health than their male counterparts.
Estar Tranquilo/a (Being Tranquil) as a Synonym of Being Well in Old Age

Data showed that events during early life influenced perceptions of well-being in the two groups of older adults. For instance, most members from both groups were born in poor families, which affected their access to education, and later to safer jobs.

Also, gender roles learned during childhood and adolescence prevailed during adulthood; however, during old age, when doing an analysis of their life course, they noticed that there were some aspects that were wrong. Women questioned how unfair it was that they had to be in charge of house chores, especially during childhood, and among male ELEAM residents, after they lost their partners, they realized that their focus was wrong: that instead of prioritizing having friends, they should have spent more time with their partners and children.

When discussing about well-being in old age, participants from both groups mentioned that the most important thing was “estar tranquilo/a”. The literal English translation of this concept is “being tranquil”. However, this phrase had different meanings for each group. Among ELEAM residents, 10 out 12 participants mentioned the term “estar tranquilo/a” as an expression that meant keeping good relationships with fellow residents and being able to be alone:

“Now that I’m old, I think the only thing that matters it’s that I want to estar tranquila...you know, having good relationships with staff members, with the other residents...I don’t know how much time I have left, but I know that it’s important to being in good terms with the other abuelitos (...) But I also like being alone, to go to the backyard, and feel the sun in my face” (ID 4, 82-year-old female ELEAM resident)

“Estar tranquila, that is all that matters for me...I have not seen my family in a while, so now I have to focus on today...and what I have now? A beautiful center, I’m surrounded by other viejitos and we have to take care of each other, we are like a family” (ID 11, 69-year-old female ELEAM resident)
“I have been through a lot in this life, I had a girlfriend, I lost her, I got an accident and I lost everything! Right now, that I’m 72 years, and living here, all that matters is to being well, to enjoy each day, to talk with the others [residents], and watch TV, quiet...for me that’s a good life, that’s estar tranquilo...I’m here alone without disturbing anyone” (ID 1, 72-year-old male ELEAM resident)

“Yes, we are adultos mayores, we have been through a lot, I’m 68, but here are people that is older than me...and after all, at the end of the day, the only thing that matters is to estar tranquilo, avoid conflict, being well with everyone here” (ID 13, 68-year-old male ELEAM resident)

On the other hand, estar tranquilo/a had a different meaning for club members. Eleven out of twelve respondents mentioned estar tranquilo/a as a term that included having good relationships with their families, especially with their adult children and grandchildren. For club members, it was crucial to keep contact with them, and seeing each other regularly:

“I think the most important thing now that we are old is to see my family very often, especially with my grandchildren. They make us so happy when they visit us...I think that now, in my eighties, the most important thing in life is to avoid conflict, to being well...estar tranquila” (ID 42, 84-year-old female club member)

“Right now, I feel happy, I feel good, because my children come with my grandchildren almost every weekend, and I can enjoy their company...Maybe I’m not rich, but I feel tranquila, because I have my family” (ID 32, 62-year-old female club member)

“Being old is hard, because one can feel how his health is getting worse...but there are a lot of things to feel good, like the family: I visit my children almost every Sunday, I have lunch with them and I feel tranquil, because I’m happy” (ID 33, 65-year-old male club member)

“Every time that we are sharing with other people from the club I feel so good, just like when our grandchildren come to visit us. One of the most beautiful things in life is to have a family, to have friends, to have a good time...I don’t know how much I will live, but right now I feel good, I feel tranquilo” (ID 41, 68-year-old male club member)

In total, 21 out of 24 participants from both groups mentioned estar tranquilo/a (being tranquil) as a synonym of doing well in old age. For both groups, it meant to keep
good relationships with the people who surrounded them: for ELEAM residents were staff members and fellow residents, and for club members were their families and their friends.

However, in terms of worries, both groups have different things that they worry about. For instance, ELEAM members, do not worry about income because they pay 80% of their pensions as a fee to the center, and, in turn, the ELEAM offers them shelter, food and medical care. Most of male residents mentioned that before living in the ELEAM, their pensions were not enough to cover their expenses. However, ELEAM residents from both genders are worried about keeping good relationships with their fellow residents, because they live in a collective residence, and they do not have any kinship-related ties, and, sometimes they do not share some aspects, for instance, the preference for music. In this sense, there is a challenge for the ELEAM -and for any collective residence- of looking for consensus when people from very different backgrounds share daily. Some residents enjoy being alone, whereas others enjoy having conversations with others.

On the other hand, club members do have different worries: first, they feel that their income is not enough to cover their necessities, especially regarding medications and medical care. Although some of them lived with their children, apparently, they do not have as many conflicts as the ELEAM residents, who are, in a way, “forced” to live with other people. However, club members are worried about being autonomous, because they do have to take care of themselves, and they want to keep that status.

In terms of narratives, it is hard to close this section implying that one group had “better well-being” than the other. Because it seems that each group is, to some degree,
happy with their lives. As mentioned before, being well has different meanings for each group, and it seems that during old age, respondents from both groups look towards the positive aspects of their lives. In both groups, there were *adultos mayores* with difficult lives, however, they were able to consider the positive aspects, and learning something from their experiences, and focusing on keeping good relationships with the people that they interact with frequently.
CHAPTER 7
CONCLUSIONS

This study addressed the perception of well-being between two groups of older adults in Chile. Because the total of participants was 50, this study is not representative, of the entire aged population in Chile. The main purpose of this study is to generate insights about how a particular group of *adultos mayores* defines what it means to age well.

Chapter 3 discussed the “new Chile” that is still in gestation: along with the return of the democracy, sociocultural changes have emerged. This new country is extremely diverse, and more progressive. Immigrants from neighboring countries, as well as Haiti, Colombia and Dominic Republic are choosing Chile as their new home. Also, Chilean families are getting smaller, and alternatives to traditional living arrangements are emerging: there are fewer marriages, more convenience, and a new laws for civil unions, which provide “legality status” for same sex couples. Instead, the cohort that I worked with were “caught” by these changes when they were in middle age, or old age, therefore, they are participating as spectators of these changes, their adult children and grandchildren are the ones that are experimenting these changes.

In addition, the increase in life expectancy is increasing the number of older adults, especially women. The speculations of the implications of an aged country are everywhere: several countries around the world are living, or lived, in a similar situation. However, most of the research about these topics tend to be from the view of “apocalyptic demography”. It is true that there are consequences of this unprecedented demographic transition, however, information is a key to avoid the construction of myths. First, it is necessary to note that most *adultos mayores* are completely
independent, and that “caregiving”, in most of the cases is only needed for the oldest-old. Second, in Chile, statistics shows that the number of potential caregivers will decrease during the next years; however, it is important to consider that family is still a strong entity, and according to literature, social support is key to well-being. Although family and family relationships in Chile are in changing, it is not possible to estimate how this is going to change exactly during the following decades. Still, is important to consider the characteristics of the immigrants that chose Chile: most of them are younger couples that either have children, or plan to have children in a near future. Therefore, immigrants could be part of the “solution” for the increase in population aging, providing labor force.

Although as previously mentioned, Chile is changing, there are a few things that remain the same, such as the pension system. The current system was implemented during the military dictatorship, and despite having a reform in 2008, this system does not provide an adequate monthly income for adultos mayores. Women are especially disadvantaged because during the course of their work, they do not count, with regular contributions to their AFP account as men. Only a small percentage of the Chilean population does “behave” according to what the system expected. The system was created without considering that only a few people do actually had constant jobs during their life course, most of the Chilean population have sporadic jobs, especially considering that the country is known for its exporting products: fruits and vegetables; which means that are many seasonal jobs. During the last two years Chilean citizens from diverse age groups have manifested their disagreement with the current pension
Regarding services for adultos mayores, SENAMA has been key to the inclusion of the aged, with their programs and promotion of active aging. Still, as shown through an example how the media coverage a particular event of an old-lady chaining herself to an AFP office, older adult is a synonym of abuelito/a (grandparent). In summary, although Chile is moving towards the inclusion of older adults, there still much work to do.

In addition, it is necessary to count with more data about Chilean adultos mayores. There is a gap of information about how many older adults actually are institutionalized. The only statistics available is an estimation made 17 years ago, which is obviously outdated, especially considering how quickly the country is getting older. Currently there are scientists conducting aging studies in Chile, however, it is necessary to count with funding to conduct additional research, and generate academic interest.

Regarding institutionalization among older adults, it is important to recognize the importance of faith-based institutions (FBO) in Chile such as Hogar de Cristo and Fundación Las Rosas. This FBO, along with others are still filling the gaps between the State’s neoliberal politics and the actual market. However, most of the “commercial” options for older adults aim an upper income class. Maybe market solutions are not the best option for middle class; however, considering the current alliance between SENAMA and Hogar de Cristo, state-owned ELEAMS, but run by the FBO, that can become an adequate option for the middle class, who is not “poor enough” to access for
public services. For this reason, it is also to necessary to build new centers aimed to this social class.

Concerning the data obtained in this study, the first phase of this study was focused on aiming quantitative data through surveys and questionnaires. This provided a “standardized” data set that was useful to make cross-group comparisons through statistical analysis. In self-rated health, both groups got the same mean scores; however, self-perceived health in relation to peers showed a slightly difference. With ELEAM residents having 0.4 points more than club members. It is important to remember that both groups were paired in terms of physical status, therefore, there should not exist any major differences. These small differences found between groups reflect the fact that among ELEAM residents, the sample selected was composed by the residents who were in better health in relation to their counterpart. This means that they had another parameter to measure their health: they felt that they were in better shape than the rest of the residents, because they have, in fact, better health status than the other residents. Instead, club members surround themselves by other profile of older adults: active adultos mayores who participate in activities and organizations. Therefore, a small change in their health it becomes more evident among them.

The epidemiological profile showed similar scores, matching findings from previous research conducted in Chile. However, regarding social support both groups showed significant differences, with ELEAM residents scoring lower in four out of five questions. There were notorious differences in questions like “Do you have someone who is around when you are in need?”, in which 13 ELEAM residents out of 25 answer yes, and 23 club members answered yes. In “Do you have someone who will borrow
you money?” only 5 residents answer yes, whereas 20 club members said so. It was expected that ELEAM residents would score higher in the first question, because there are staff available 24/7; however, they do not feel like they can get help. On the other hand, because having a weak social support network is one of the requirements to apply for the ELEAM, residents feel like they can’t count with someone to borrow money. Finally, ELEAM residents feel like they receive more support in relation to what they give.

Life satisfaction also showed differences in cross-group comparisons. ELEAM members got a mean score of 22.72 points out of 35 and club members, 24.2 points. Although these scores place both groups in the average group in terms of satisfaction with life, the distribution of scores showed individual differences. Among ELEAM members there are participants extremely dissatisfied and dissatisfied with their lives. Instead, most club members have either average scores or high scores. Therefore, from the survey data, it was concluded that club members were slightly better than ELEAM residents in terms of instrumental social support and life satisfaction, showing that in this sample of adultos mayores, with similar age, socioeconomic status and physical health, but with different living arrangement, social support was the item that most influenced perceptions of well-being. However, these results lacking context, and provided only a “snapshot” of the current situation of participants.

Data from life stories, provided in greater detail how during events occurred during early life affected the perceptions of well-being in old age. It was found that during childhood and adolescence, there were more significant gender differences than cross-group differences. Current adultos mayores, when they were girls were helping
their mothers with house chores, and boys were either playing or studying. Only a few members from both groups completed their formal studies, because between the two groups they had to work because they came from vulnerable households. However, studying was not encouraged for women.

Then, during adulthood, men from both groups focused on work, again, following traditional gender roles. Instead, some women focused on motherhood, and the rest who did not have children stayed at home.

Later, in old age, participants from both groups mentioned that the only thing that they wanted in old age was “estar tranquilo/a” (being tranquil). This term had different meanings for each group. For female ELEAM residents, this meant being alone and/or listening to music, having good relationships with their fellow residents, and avoiding conflict. Male residents were also concerned about the latter, and participating in activities, such as gardening. Instead, “estar tranquilo/a” for club members meant being focused on their relationships with their families: both mothers and fathers were concerned about their adult children and grandchildren, and trying to help them as much as they can. This is especially important for male members, because they try to stay active. Doing things for their children and grandchildren is an opportunity to leave home. On the other hand, women preferred to stay at home, showing that social support was an important component of being well in old age.

Income was a concern especially among club members. Because their basic pensions are their only income, they felt that this monthly income was not enough to satisfy their needs, particularly medical needs, such as medications. ELEAM residents do not feel the same way, because medications, food and shelter are, in a way,
guaranteed. Although they pay 80% of their pensions as fee, their income is not a problem for meeting their basic needs. It is important to note that club members felt that they did count with potential social support if they need to borrow money; however, because they want to stay independent, they do not want to ask for help to their adult children.

ELEAM residents were also asked why they were institutionalized. Male residents described a particular event, usually accidents, that compromised their independence, and because they did not have any support, they applied for an ELEAM. Female residents mentioned a constant deterioration of their health, instead of a particular event, and like their male counterpart; in addition, they also mentioned the lack of support as another factor influencing their institutionalization. This is because both, physical dependence and lack of support are part of the requirements to apply to the ELEAM.

On the other hand, club members were asked why participated in clubes de adulto mayor. Most women participated because their friends invited them to participate. Instead, men do not participate as much as women, and they are part of these groups because their wives invited them. As participants mentioned, it is hard for a man to participate in this groups by self-will. In fact, in these groups about 75% to 80% of the participants are women.

From the narrative data it was concluded that unlike the quantitative data, it was hard to estimate which group was doing better than the other, because both groups seemed to being well in their own living conditions, and that each group have different challenges in old age. Still, both quantitative and qualitative data, suggest that social
support was a key element in perceived well-being for ELEAM residents and club members. The Mann Whitney test ($U= 136, p= .0, 2$-tailed) in the first phase, showed that social support was the item that highly impacted the perceptions of well-being among the two groups. On the other hand, narrative data also suggested that caring about relationships with others (fellow residents and staff members for ELEAM residents; family and friends for club members), was one of the components of estar tranquilo/a in later life.

The above confirms that the five aspects of well-being measured through surveys in Chapter 5, self-rated health, physical health, social support and life satisfaction seems to be measures of successful aging instead of well-being. As participants mentioned, although they did have some health problems, and their income was low in relation to adulthood, social relationships were by far, the most important factor for estar tranquilo/a. These conclusions suggest that for this particular group of adultos mayores, being well in old age is more related to finding a balance in old age, instead of what the literature of successful aging suggests: absence of disease, physical/cognitive capacity, and engagement with life. This is similar to the current debate on gerontology about harmonious aging: older adults are looking for balance instead of uniformity, and are concerned on cultivating good relationships with the people who surround them (Liang and Luo 2012; Lamb 2014).

Still, there were some challenges of the particular mixed-methods used in this research. For instance, during the data collection through self-assessments, some participants were asked if they have a particular health problem, and many of them did not mentioned although it was evident that they did have that particular problem.
However, this shows that perceptions about “being well” in old age are subjective. Also, the collection of narrative data was a challenge, especially in terms of keeping respondents on task. In this sense, the table with each one of the life stages was key to keep track of all stages were being covered during the interview. Also, as I mentioned in Chapter 1, the age gap was a challenge, because it took me more time in relation to previous research to gain rapport. ELEAM members especially were more cautious about sharing personal information, since people from other disciplines conduct research in the center, and they only go to ask questions instead of just spending time with them. For this reason, I was extremely careful in spending some time with each participant before doing the surveys, because I wanted to show to them that this research was different: although I was going to ask questions just like everyone else, I did spend additional time with them, even though that meant just sitting in a chair, watching TV in the commons room.

In summary, the life course perspective helped to provide a context for each one of the participant’s lives. The first phase provided a “snapshot” of the current situation of these older adults, and it was useful for conducting cross-group statistical analysis. Also, this data can be used to compare other Chilean populations of older adults, or populations from other countries. On the other hand, narrative data provided the explanation of why the residents presented their scores, and also exposed the differences among groups: in later life, because of their current status, ELEAM residents focus on their relationships with fellow residents to feel well; instead, club members focus on their relationships with their spouses and family, because they feel like they
constitute a “safety net”; however, they do have a different challenge of keeping autonomy.

As with many anthropological studies, the conclusions of this study are not black or white, instead, are more close to being gray areas. Although quantitative data suggested some mild differences among ELEAM residents and club members, the general conclusion can’t be straight forward: I can’t say that one group was doing better than the other, because most of ELEAM residents and club members were “doing well” in their own terms: they have adapted to their environment in order to get balance the gain and losses inherent to old age.

This research showed how different are older adults, even within a group with similar characteristics. That is why it is important to count with information about *adultos mayores* in an individual level, because knowing these variations; it is possible to understand which factors can contribute to well-being in old age, across populations.


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BIOGRAPHICAL SKETCH

Carola Salazar obtained her bachelor’s degree with a major in anthropology in January 2011, from the Universidad de Concepción, Chile. After graduating with highest honors, she taught a medical anthropology class in the same college.

In 2012 she was awarded with Becas Chile, a Chilean government scholarship to start her master’s studies in the Anthropology Department of the University of Florida. From 2013 to 2016, she was awarded with the Latin American fellowship from the Center for Latin American Studies at the University of Florida.

In spring 2014, she got her master’s degree with a major in anthropology with the paper: “Social Contract on Elderly Caregiving in Contemporary Chile: Perspectives of a Group of Social Scientists”.

In fall 2014, she started her doctorate’s studies in the same department. In summer 2016, she was awarded with the Graduate School doctoral research travel award and the Goggin award from the department of anthropology.

Finally, in spring 2017, she was awarded with the Elizabeth Eddy Fellowship, from the Department of Anthropology, to complete her dissertation.