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Introduction

A GOOD OLD AGE

IT WAS SUMMER of 2016 when Iris arrived at Oakville, a skilled nursing facility nested amid brownstones on a tree-lined street in New York City. I tagged along while a social worker completed her routine initial evaluation. Iris had broken her femur when she fell on the steps outside her apartment as she was coming back carrying grocery bags. After surgery she had spent three days at the hospital, from where she was transferred to Oakville's post-acute care unit to continue her recovery.

Iris was a seventy-eight-year-old Black woman: a retired social worker, a passionate traveler, and the owner of a condo in Brooklyn, where she lived by herself. She had a quick mind and a no-nonsense manner. Throughout her intake she asked repeatedly: 'How long am I gonna be here?'* The social worker replied mechanically it would be two to four weeks, the standard length of physical therapy for patients with a fracture like hers.

Two days later I spotted Iris trying to ride her wheelchair on the thick carpet of the post-acute care unit's hallway. I approached her and asked if she needed help. When she smiled and said yes, I half-joked that technically I was not allowed to push her wheelchair, as I didn't have proper training. She cracked another smile: 'Then we'll both get in trouble.' I pushed her carefully into the dining room and up to a table where another older woman was waiting for her lunch to be served.

* Throughout the book I use single quotes to reproduce speech captured in my observations and reconstructed from my field notes; double quotes and block quotations indicate speech that was recorded and transcribed verbatim.

Soon after starting her physical therapy sessions, Iris was making her way around the post-acute care floor using a walker, and after a couple of weeks she was able to walk very slowly leaning on a cane. At that point she started telling Oakville's social workers that she wanted to leave on July 29, three days before her scheduled discharge date. I asked her why she was so keen on returning home sooner. She said:

> I'm ready to go home. I'm ready to be at home. It's not that I dislike anybody here or anything like that, but I've been away from home; there's business I need to take care of. I'm in charge of my own business and finances. I am *very* independent. I am seventy-eight years old, I'm retired, I'm independent, I'm in charge of my own finances, I have my own income, and I'm not on Medicaid.

Not grasping the significance of these affirmations, I asked: "So you're not nervous about going home by yourself with the cane? Like when you look ahead, do you feel totally comfortable?"

Iris shot me a piercing look, visibly annoyed: "Are you kiddin'?"

Iris's irritation constitutes the starting point of this book. In that moment I did not understand why I had upset her. As far as I could tell, Iris did need a lot of assistance, enough to make anyone nervous about returning home without support, as she seemed to suggest she would be doing. Like all the patients who came to Oakville for post-acute care, Iris relied heavily on objects and people as she dealt with the aftermath of her fracture and surgery. Hadn't she seemed eager for me to push her wheelchair into the dining room when it was still too hard for her to maneuver? I tried to apologize for my comment, but Iris cut me off and elaborated: "I wanna be out of here July 29, and that's my dogmatic perception of my abilities, and what I can do. In nine days, I can accomplish a lot."

A few days after that bumpy exchange, I sat down with Iris as she was doing a crossword puzzle in the dining room. She was pleased: Her doctor had removed the staples from her incision and she was going home in three days. She had already arranged transportation and two friends were coming to Oakville to help her pack. She picked up her cell phone and called one of them to ask her to bring some stuff on Friday and to buy food so that the refrigerator would not be empty upon her arrival home. She hung up and told me her friend would roast a chicken for her. We sat quietly for a while watching CNN on the television that was usually on in the dayroom. 'I can't wait to get home,' she said, 'with all

my junk and my computer. I probably have thousands of emails, and I need to contact people and let them know why I haven't been in touch.'

Once Iris left, it was difficult to get ahold of her. 'I'm traveling all summer,' she said over the phone. We met at her neighborhood senior center one year after she had been discharged. A couple dozen elders, mostly Black women, sat at plastic tables talking and laughing over loud music playing from a radio. Iris arrived wearing bright pink lipstick and a golden trench coat; she was still limping but no longer using a cane. She told me that after leaving Oakville, she had had a few weeks of home care services, which were a "total waste of money" because she did not really need any help. When we talked on the phone the following year, she was about to catch a plane to Las Vegas, 'and from there I'm going to LA to get on a cruise to the Mexican Riviera. I'll be gone for two weeks. Then I'm going to Florida.' When she came back to New York City, she updated me with a dizzying string of events: 'I've been to lunch at the senior center four days this week. I was at a breakfast on Sunday in Queens, and then I was up in Westchester for a dinner with friends. So, I've been busy. I'm still chunking around the city.'

Aging experts and Americans at large would consider Iris a model old person. Her firm assertion of being "very independent," her dogged resolution to live by herself, her travels and the bustling social life she commits to as she turns eighty years old: These are the qualities that have come to be expected of older individuals in the twenty-first century. Doctors routinely advise older adults to stay physically and mentally active, and to do as many tasks as possible with no help. Zach, a physical therapist at Oakville, once told me: "Even if you're dying, it's totally different if you are able to go to the bathroom on your own and do things for yourself, than depending on someone to give you a glass of water." Old people take such advice seriously. Abundant research shows that independence is a priority for older adults and that they endow it with different meanings, such as doing things alone, making one's own decisions, having financial resources and purpose in life.[1]

Although we may take them for granted now, these ideas are pretty extraordinary. Only a few decades ago older adults were treated as a population if not helpless then at the very least requiring a great deal of assistance. Nursing homes were a likely alternative for elders in need of long-term care. The notion that old people can and should be independent, and the ecology of services, policies, and medical institutions created to enable that purpose, are new, and part of this book is concerned with tracing the social origins of this phenomenon.

The idea that people should stay independent as they age is not just recent: It's also perplexing. Consider another Oakville patient, Camille, who in the span of two years was admitted four times to post-acute care. An eighty-five-year-old Puerto Rican woman, Camille had lived by herself in the same apartment for forty years, until she broke her knee and tibia and had to be hospitalized. She spent four months recovering at Oakville; during that period her sister Monica, who lived in Puerto Rico, moved to Camille's home in Brooklyn and came to Oakville every single day to visit her sister.

Just one week after Camille was discharged, she ended back at the hospital due to a gallbladder infection and subsequently came back to post-acute care for a few more weeks. This time she was discharged with home care services: a Medicaid-funded home attendant who came a few hours every day to help her walk, get dressed, and use the toilet. Monica stayed on as well, sleeping on a mattress in the living room of Camille's one-bedroom apartment. A few months later Camille had hip surgery and spent several more weeks at Oakville. She was discharged with an increase in home care hours per day. Her fourth stint came about a year later, when she fell while trying to go to the bathroom by herself.

Measured against Iris's achievements, Camille might be considered somewhat of a failure. She is on Medicaid (an insurance program for low-income people), cannot seem to fully regain her physical independence, relies on home attendants and family. But examining these stories side by side reveals important commonalities. Between her assertions of independence, Iris offers glimpses of just how *dependent* she is. She relies on people to help her get around the post-acute care unit while she's still recovering, counts on friends to bring her food and clothes, and leans on her neighborhood senior center for social ties and free lunch. Conversely, Camille keeps affirming her independence in the midst of her obvious dependencies. The first time Camille came to post-acute care, and as her recovery stretched over several months, her sister Monica suggested she stay at Oakville as a long-term resident. 'This is like a hotel, better than a hotel. You could have your own room,' Monica enticed. Camille would have none of it: She wanted to go back to her own apartment. When I met her during her second stay at Oakville, she was in a lot of pain and struggling to walk. But she was convinced of her future independence: "I will do everything myself again, so I don't get bored." During her third stay, when Camille was approved for more home care hours because she needed increased supervision, she confided: 'But when I get better, I want to be alone. I like being independent.'

Echoing what sociologist Robert Bellah and his collaborators call the moral vocabulary of individualism, "the first language in which Americans tend to think about their lives" and which values self-reliance above all else,[2] Camille and Iris place a great deal of their sense of purpose and self-worth on the ability to present themselves as independent. And yet for both, to different degrees, this ability hinges on all sorts of supports. This paradox is not unique to old age: All human beings need others in order to flourish, independence is always "enmeshed" in social ties.[3] But this enmeshment becomes particularly conspicuous, even existential, in old age. However active and healthy older adults try to be, the reality of aging is that, eventually, it demands a great deal of care and support. We become, quite visibly, the opposite of independent.

This book zooms in on this contradiction. It critically examines the American preoccupation with independence and the consequences, both at the individual and the societal levels, of pursuing this ideal "even if you're dying." My core argument is that independence is the main value that underpins notions of "good" old age in the United States: all the way from elder-care policy and funding, to the everyday interventions of health care workers, and to how old people see themselves. It is the unquestioned yardstick that serves to determine not only an older person's social worth, but also their entitlement to care and social services. At the same time, what counts as "independence" is not fixed. Like other cultural values, such as "diversity" or "justice," independence is a capacious category that can hold multiple, sometimes contradictory, standards for evaluating people and behaviors. And, like other ideals, it is extremely elusive: constantly reshaped and pushed away by the social and economic realities of aging in America. This book shows the enormous amount of work that old people, their families, and health care workers put into making independence materialize—and what it looks like when these projects fall through.

At the center of my analysis are the interactions and decision-making processes I observed in the post-acute care unit in New York City where I met Iris and Camille. Post-acute care is an intermediary setting that provides rehabilitation services to two million old people every year.[4] They are places in which elders explicitly grapple with new forms of impairment and the needs for assistance these forms of impairment create. For example, a hip replacement surgery could mean needing a cane for months, perhaps indefinitely. It could mean hiring a home attendant or asking your daughter for help with grocery shopping. These decisions force older adults to reckon, sometimes for the first time, with the limits of their independence, and to negotiate these limits with their families, health care workers, and themselves. To see how these

negotiations played out and evolved over time, I also followed old people out of post-acute care into their homes and other sites of care provision across New York City—where I found that although independence is embraced as a universal higher good, the extent to which individuals are able to comply with this project has a great deal to do with their social and material conditions.

Examining the pursuit of independence in old age is important because of the sheer magnitude of the phenomenon of aging in America. The United States population is older than ever before and is projected to continue to age rapidly. This will have massive consequences for many aspects of social life: from the composition of the labor force and the soaring need for elder care, to how our cities are designed and how our families are organized. It is, therefore, no small matter to understand what it means to grow old in America today, and growing old in America today involves relentless struggles to maintain independence. This book explores the conundrums and dramas, the meanings and connections that people experience as they chase independence in old age. In doing so, it seeks to shed light on the remarkable power that this value holds over our imaginations and institutions.

Living Longer, Aging in Place, Dying Broke

Things were not looking great for older Americans at the beginning of the twentieth century. The nuclear family had replaced the intergenerational household, reversing earlier arrangements where 70 percent of old people lived with an adult child. The rise in physically demanding factory work, as well as labor unions and mandatory retirement policies, excluded many elders from the work force.[5] There were no universal pensions. By 1930, one-third of the older population was in poverty. With the Depression this proportion rose to a whopping 66 percent.[6]

Old age went from nonexistent category (in the sense that no special designation or particular importance was given to this stage of life) to highly visible social problem.[7] Starting with Social Security in 1935, by some accounts the greatest poverty-reduction program in the history of the country, a host of state interventions targeted older adults as a population in need of assistance. The Senate began to grapple with this issue more systematically in 1959 with the creation of a Subcommittee on Problems of the Aged and Aging, which declared, in its first report, "It is no longer possible, as it once may have been expedient, to ignore or shrug off these problems and the urgent need to solve them." In 1961, the subcommittee was upgraded to a permanent Special

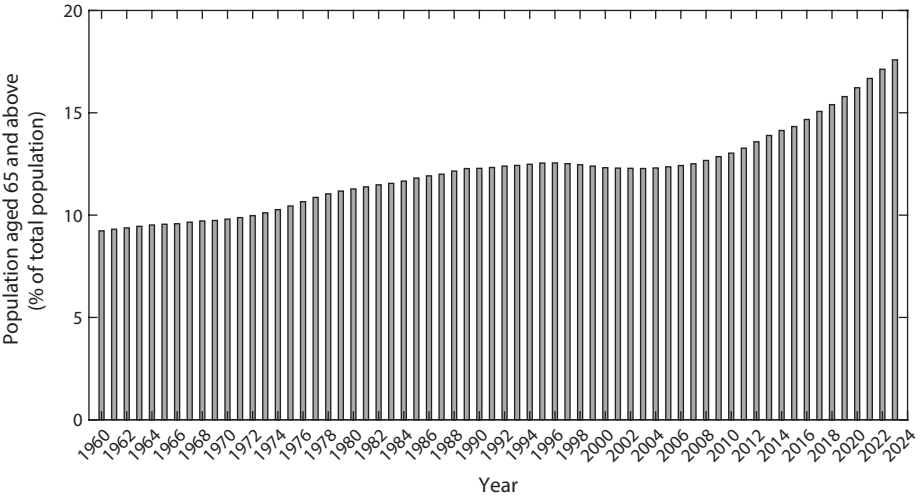

FIGURE 1.1. Population aged sixty-five and older as a share of total US population, 1960–2023. *Source:* World Population Prospects, United Nations Population Division (https://data.worldbank.org/indicator/SP.POP.65UP.TO.ZS).

Committee on Aging, and the first decennial White House Conference on Aging took place. For four days, more than 2,500 delegates representing some three hundred organizations debated policy statements and recommendations for "the problems, potentials, and challenges of an aging population."[8]

Transformative pieces of legislation were passed soon afterward, in 1965. The Older Americans Act established the US Administration on Aging and state agencies to address the needs of older people. Medicare and Medicaid were government-funded insurance programs that contributed enormously to fund health care for older adults. As a result of these policies, as well as of important advances in public health and medicine, average income levels, housing quality, and health indicators for old people improved dramatically.[9] Even if large differences persist in the distribution of these goods among the population, Americans today are living an average of three decades longer than they were at the beginning of the twentieth century. The number of people aged sixty-five and over more than tripled between 1950 and 2010, from 13 million to 40.8 million, and is expected to increase to 86 million by 2050.[10] Old people now constitute 18 percent of the total population in the US, up from 9 percent in 1960 (see figure 1.1); the Census Bureau projects that by 2034 older adults will surpass children in population size. Over the course of

the twentieth century, older Americans have gone from an endangered group to a booming population.

How and where old people live has also changed dramatically. In the 1980s, demographers warned that the aging of the population would produce a surge in the number of persons living in nursing homes across the country. What has happened instead over the past thirty years is a significant *decrease* in the proportion of long-term residents of nursing homes relative to the total population sixty-five years old and above.[11] Elders overwhelmingly choose to stay in their homes and avoid institutionalization for as long as possible. This phenomenon is known as "aging in place," and it has become a buzzword among gerontologists, policymakers, and other stakeholders, not just in the United States but internationally. Aging in place is touted as a solution to the problem of long-term care, with the benefits of being at home increasingly promoted in public discourse, academia, and by old people themselves.[12]

Many of those who age in place do so alone—another significant change in the landscape of aging. In the 1950s only 10 percent of old Americans lived alone; today one-third of them do so. This figure rises to 40 percent for those eight-five and older, and to over half of all older adults in places like New York City.[13] But aging in place, even alone, does not mean doing so without assistance. On the contrary, it is estimated that 70 percent of all older adults will need long-term care at some point in their lives. In the US this support system is highly fragmented, made of the unpaid labor of more than forty million adults (mostly women) who care for an older family member or friend plus a myriad of "home- and community-based" services (HCBS) that serve old people in their own homes or in other residential settings, and which account for some of the fastest-growing occupations in the US. This demand is largely driven by the age group that demographers call the "oldest-old:" people eighty-five years and older, who constitute the fastest-growing population category in the United States.[14] These individuals are more likely to have disabilities or chronic illnesses that require comprehensive health care and social services.

Who pays for all this? A recent survey found that almost half of older adults believe Medicare will pick up the steep bill for long-term care costs, whether it is care provided in a nursing home (which can amount to $100,000 per year) or home- and community-based (around $60,000 per year).[15] That is incorrect. Medicare only pays for *short-term care* such as hospitalizations and rehabilitation (including twenty-one days of post-acute care per year). Instead, Medicaid is the main source of coverage for long-term care services. But Medicaid is a means-tested program—that is, only people below a very low threshold of

income and assets (which varies by state) are eligible to receive these benefits. This forces millions of people ineligible for Medicaid but who nonetheless require home- and community-based services to use private insurance, pay great sums out of pocket, or "spend down" their savings until they can apply for Medicaid.

Meanwhile, Medicare does provide health insurance for all individuals over sixty-five years old—but it does not pay for everything. Not only is long-term care excluded, but its benefits have become almost entirely managed by private insurance companies through what are commonly called "Medicare Advantage" plans, which often come with coverage restrictions, prior authorization requests, and out-of-pocket costs.[16]

So, even if old people in the US are, on average, healthier and wealthier than ever before, they and their families are also facing what the media calls a "senior care crisis" or a "silver tsunami." Increasing numbers of older adults live in their own homes, which is highly encouraged by policymakers. But to do so requires an array of supports that are both extremely costly and not always available. All in all, millions of elders are increasingly at risk of "dying broke," unable to afford the escalating costs of long-term care.[17]

From Decline to Possibility

Tightly woven into the processes above are profound transformations related to the *cultural* expectations that surround old age. Take John F. Kennedy's presidential campaign. Kennedy ran on a platform that tapped into the problems of old age as a growing source of concern for Americans—concerns he framed in terms of an alarming lack of decent housing, jobs, health insurance, and other resources (see figure 1.2). The pamphlets advertising his Kennedy Bill of Rights featured old individuals leaning on the presidential candidate, reflecting the idea—dominant for the first half of the twentieth century—that older adults were "physically and financially dependent, incapable of making productive contributions to society, and in desperate need of public support."[18]

Fast-forward to 2019, when several US cities, such as Boston, San Francisco, and New York, launched major campaigns to combat age-based stereotypes and discrimination. Displayed prominently on subway cars and other urban spaces, they featured inspiring profiles of people who have stayed energetic and vibrant into old age: a 103-year-old woman who uses a smartphone and "spends time with her boyfriend" or a 73-year-old hip hop dancer whose signature movement is doing splits (fig. 1.3).

FIGURE 1.2. Senior Citizens for Kennedy campaign, 1960. Pamphlet produced by the Democratic National Committee and the Senior Citizens for Kennedy and Johnson. *Image credit:* John F. Kennedy Presidential Library.

These images indicate a remarkable transformation in academic and popular representations of aging: from dependency and decline to activity, health, and possibility. It is worth highlighting the role that the medical community has had in changing these public perceptions. While medieval writers had approached aging as a mystery, a stage of life imbued with meanings

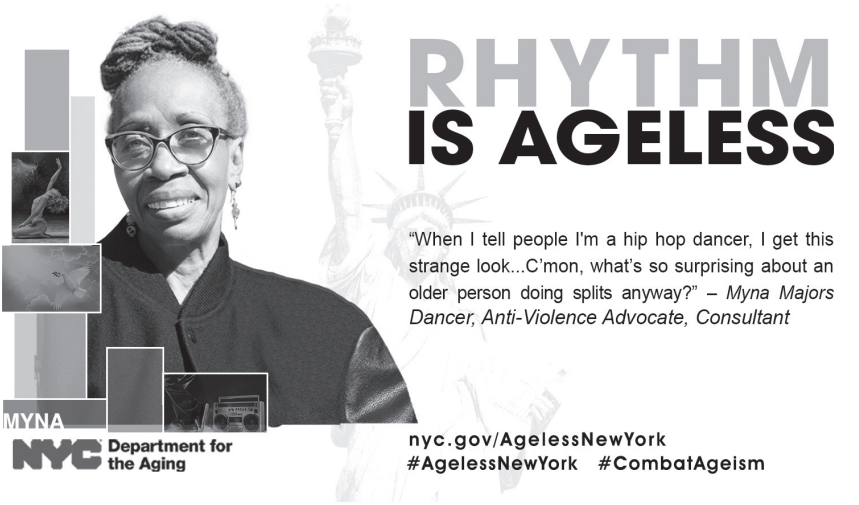

FIGURE 1.3. Ageless New York campaign, 2019. *Image credit:* New York City Department for the Aging.

related to God, nature, and spiritual transcendence, modern medicine redefined aging as a process of decline—a decline that could be studied and managed through expert intervention.[19]

Gerontology and geriatrics emerged in the early twentieth century as disciplines exclusively dedicated to the scientific study of old age; by the mid-1940s they had formed societies in the US and began publishing their own journals. And even though gerontology has a long history of disagreements about how to conceptualize aging, beginning in the 1950s, its mainstream theories tended to project middle-aged standards of instrumentality, activity, and usefulness onto later life.[20] Gerontologists came up with all sorts of catchphrases to suggest that it was entirely possible to maintain these standards in old age: "affirmative aging," "productive aging," "healthy aging," "creative aging," "resourceful aging," and the one that has stuck the most: "successful aging."[21] Introduced in the late 1980s by John Rowe and Robert Kahn, successful aging was defined by the belief in human beings' ability to avoid disease and disability if they made the right choices in late life.[22]

The axiom that, if they want to, old people can be healthy, sexually active, engaged, and self-reliant has found enduring purchase. Consider the November 2024 issue of the bulletin printed and circulated by AARP, a leading organization for older adults. In bold, all-caps letters evocative of superhero

fonts, the cover announces: "SUPER AGERS. How Scientists Are Finding New Ways to Detect, and Treat, the Diseases of Aging—Before They Even Begin!" The inside story is an account of the most recent scientific breakthroughs to prevent Alzheimer's, regenerate vital organs, and fix broken hips "simply and easily" using stem cells. There is also a table entitled "A Perfect Day of Not Aging" with an hour-by-hour list of recommendations. Go for a walk between 7:00 and 9:00 a.m.: The vitamin D your body produces with sunlight may slow the aging process. Meditate around noon to activate the prefrontal cortex, which is important for cognition; then have a mixed salad with salmon—omega-3 can reduce inflammation, "a culprit of biological aging." Get some cardio in by 3:00 p.m.: Afternoon exercise may reduce the risk of premature death.[23]

Representations of old age as a time of excitement and possibility are ubiquitous in popular culture as well. Media stories regularly depict old people who have accomplished some amazing feat, presenting nonagenarians who run marathons "as a reasonable expectation rather than miracles of biological luck."[24] The branding of older adults as active consumers is a well-known strategy of a multibillion-dollar market that targets baby boomers with real estate, tourism, fashion, pharmaceutical, and wellness products.[25] What made *The Golden Girls* one of the most successful TV shows of the 1980s is that it portrayed four older women focused on their careers, their bodies, and sex.[26] These tropes resurfaced recently in *The Golden Bachelor*, a 2023 spinoff of the popular dating reality show that featured women aged sixty to seventy-five competing for the love of seventy-two-year-old widower Gerry Turner. The first episode of the show, which broke streaming records for the ABC network, introduced viewers to contestants like Leslie, a sixty-four-year-old fitness instructor who stepped out of a limo using a walker only to fling it away dramatically and show off a sheer mini dress. "Do I look like I need help?" she teased the bachelor, who gasped: "Wow!"

Everyday language, too, has shifted. Terms such as "the aged," "the elderly," and "senior citizens," widely used throughout the twentieth century, were recently deemed offensive and stigmatizing by the American Geriatrics Society and the American Medical Association.[27] The preferred nomenclature is "older adults" or "older people," which the US Census Bureau officially uses to denominate the population sixty-five years old and above, and which I mostly adhere to in this book. The dominance of this term, historian James Chappel argues, is no accident. Its vagueness (older than whom?) is fitting for an era in which older people are intent to prove that they are not a distinct social group with distinct needs, but really just like other citizens.[28]

It's not that "super agers" accurately represent the reality of most Americans. Poverty and disability remain huge issues for older adults. Research consistently shows that social factors (gender, race, socioeconomic status) determine longevity, access to money, quality of physical and mental health, housing, environmental conditions, and social networks.[29] As Deborah Carr writes, the promise of "golden years" rings hollow for many Americans. Rather than reflect actual experience, the tropes of "successful aging" amount to a *cultural set of expectations* that, however close to or removed from reality, furnish our collective imagination of what good old age should look and feel like.

The irony is that while these representations emerge as a response to negative views of old age, they betray a deep discomfort with (and judgment toward) conditions associated with aging such as frailty and dependency. Rather than accept these conditions as a normal part of life, the cultural repackaging of old age hinges on claiming proximity to youthfulness.[30] Narratives of aging as possibility and narratives of aging as inevitable decline thus represent two sides of the same coin: the devaluation of old age and the kinds of dependencies it eventually brings if we live long enough. At the end of the day, Leslie must throw away her walker to impress the bachelor.

Three (Partial) Ways of Thinking About Independence in Old Age

In a way, chasing independence in old age is not surprising at all. Independence is the quintessential value in the United States: a widely shared principle that structures political institutions, labor markets, parenting practices, welfare programs, and more. It is one of those big ideas, like love or justice, that travels and goes "viral" in different social worlds.[31]

This power comes largely from its polysemy. Independence articulates an entire set of values, so that when we invoke it, "we invoke other elements in its wake."[32] Take its kindred concept, autonomy. Autonomy basically affirms the individual right to self-determination, the capacity "to determine the course of one's own existence through acts of choice."[33] This positive notion of freedom (freedom to) is what distinguishes autonomy from independence, which denotes negative freedom: the freedom to be left alone.[34] In everyday language, though, this distinction is collapsed. In the United States people use "autonomy" to mean "independence," and they use "independence" to mean

a host of qualities associated with self-determination, such as dignity, individuality, responsibility, and self-knowledge.[35]

Or consider the concept of self-reliance, which links independence to the capacity to provide for one's own needs. Popularized in the writings of Ralph Waldo Emerson ("The great man is he who in the midst of the crowd keeps with perfect sweetness the independence of solitude") and Thomas Jefferson (who exalted the virtues of self-sufficient yeoman farmers as the state's moral guardians), self-reliance indicates that we only deserve what we personally work for. It is the moral bedrock of the American work ethic and of the image of the self-made man: one who is independent in an economic sense.[36]

Modern ideas of independence are even more saturated with meaning, as they include a strong psychological component: To be independent is to have will power, the appetite to overcome obstacles. We are all expected to *want* to be independent. Failure to display this desire is considered pathological, something that must be corrected—as indicated by the range of projects designed to teach individuals to pursue self-reliance, such as reentry and rehabilitation programs.[37]

Given this complexity, how have scholars theorized independence in old age? Roughly through three approaches. The first belongs to gerontology, which emphasizes the importance of maintaining independence in old age while also reducing its meaning to medical definitions of bodily ability. Starting in the 1960s gerontologists developed various measures and enabling factors of functional independence, understood as the physical capacity to do things without assistance from others. Here, independence is considered to be an individual attribute, one that is quantifiable and improvable.[38] This paradigm dominates the health field, and various scales of functional capacity are widely used to assess eligibility for support services and to design and measure the effectiveness of medical interventions across institutions that provide care.

A second path pushes back against narrow functional definitions of health and ability, and instead centers what older people themselves define as independence.[39] Scholars find that the concept's meanings among elders are highly context dependent and can change with circumstances: For example, delegating tasks to caregivers can be interpreted as independence if it allows an increasingly impaired person to age in place. This subjectivist approach is thus a socially inclusive one, where rather than an ability to do things without help, independence can incorporate cooperation with family, friends, and institutions in order for older people's needs to be met.[40] This can account for

the apparent paradox that people can *feel* independent despite their increasing dependence on others.[41]

A third approach is less preoccupied with measuring independence or dissecting the meanings of this discourse, and more preoccupied with its detrimental consequences. When independence is elevated and equated with doing away with support, older people can become prisoners of dire circumstances: autonomy turned from lofty goal to "moral straitjacket."[42] Anthropologist Margaret Mead bitterly observed in a 1971 article published in *The New York Times* that "old people in this country have been influenced by the American ideal of independence and autonomy. . . . So we live alone, perhaps on the verge of starvation, in time without friends, but we are independent." This view calls out the ways in which independence is often understood as the right to be left alone—which easily turns into neglect, or the "right to rot."[43]

To an extent, all these ways of thinking about independence in old age were present in my field site. The functional assessment of people's ability to do things unassisted, the different meanings elders and their caregivers attach to claims of independence, and the dire image of independence as an ideological prison, are part of the story that I tell here. It is not so much that these theories are incorrect; rather, they are insufficient. They treat independence as a quality that you either have or you don't; an idea that is either true or false, good or bad. Instead, my research revealed a more complex, messy picture.

To appreciate this complexity, let's return to Camille, the eighty-five-year-old woman introduced earlier. After she had a double hip replacement surgery, Oakville staff were working on getting her to stand again. One morning in the rehabilitation room, occupational therapist Liz coaxed: 'Let me see how much you can do for yourself. Lean forward as much as you can, on the count of three push yourself up. Take your time, I need you to come forward.'

Camille tried to push herself up from her wheelchair but froze midway and started complaining about pain. 'Okay, sit back down,' said Liz. 'I want you to scoop forward a little more on the chair. And try. Now lean your body forward and push yourself up, push, push, push, but you're pushing back—I need you to come forward.'

Camille groaned: 'I can't.'

Liz rubbed her back and said softly, 'I'm sorry you're in so much pain. Okay, rest for a minute,' and she stepped away to work with another patient.

I continued to sit on my stool next to Camille, with whom I'd been chatting throughout her rehab session. After a while, I got distracted talking with another patient and before I knew it Camille was standing up, her hands

holding tightly onto the armrests of the wheelchair behind her. I looked at her and smiled.

She smiled back: 'Yes, I can do it myself.'

Right then Liz hurried back and Camille beamed, 'Did you see me?' Liz smiled, too, but cautioned: 'That was very good, but don't do it without me! I am trying to get you to a complete stand. And I need you to be safe.'

Although Liz had been encouraging Camille to 'do for herself,' Camille got lectured when, following her own instincts, she did stand on her own. Scenes like this were frequent and they stuck with me. They began to reveal that independence was hardly an attribute that described people's realities. Rather, it seemed to be a yardstick that older adults were measured against and strived for, but its contents and limits were never clear. What counted as "independence," and who got to determine that? To get at this question, to really understand how independence shapes ideas about and experiences of aging in the United States, requires taking a closer look at what cultural values are and what they do as people invoke them in their everyday lives.

Prismatic Effects

I did not begin this research looking for independence. I started to conduct participant observation in a post-acute care unit because I was interested in how paid and unpaid caregivers (markets and families) interacted to provide elder care. Pretty soon, though, the vocabulary of independence engulfed me. Everyone talked about it. It appeared as a value with gravitational force, one that pulled people toward a particular kind of life—even if, by most measures, that life was not really achievable. Independence seemed to be "morally magnetic," a phrase sociologist Nina Eliasoph uses to describe the discourse of empowerment: "Simply and almost irresistibly good, for reasons that we assume don't need much further explanation."[44]

At the same time, at Oakville people used this value to refer to and to explain all sorts of things. A lot of times, it meant that older patients would go home rather than stay in a long-term care unit in the facility. Other times, it meant that patients were expected to do things on their own such as walk or climb steps. Still other times, "independence" denoted older individuals' capacity to make rational decisions, including if and when *not* to do things on their own. And at any given moment, as the interaction between Camille and Liz indicates, these connotations could come up against patients' own ideas of what they could do.

This brings us to a longstanding tension in cultural sociology, about how to conceptualize values. Sociologist Steven Hitlin suggests that we think of values as "bright lights": positive ideals that motivate a person to keep going, "useful representations of a distant destination that we never quite reach but continually view as worth striving toward."[45] This approach to morality remains somewhat linked to Talcott Parsons, whose model of social action assumed a connection between values as shared imperatives and how people behave. The Parsonian view has been criticized by scholars, most famously Ann Swidler, who argued that the link between values and action was weak at best and that people who share similar values can behave very differently. Instead of thinking about culture as a motivational force, she and others claim, we should think about it as a set of tools that provide us with different strategies for everyday problem solving. In this view, "values" appear ex post facto, when people justify or make sense of their actions.[46]

In this book I draw on both approaches.[47] On the one hand, independence certainly worked as a flexible tool that the people I observed drew on—especially post-acute care workers, for whom the many meanings of independence became a useful resource as they confronted the practical challenges of assessing different patients with different circumstances. On the other hand, I witnessed powerful, existential commitments to this ideal. Independence was loaded with meaning, providing older adults and their caregivers with a sense of who they should be or what they should strive for—a shared vision that oriented their actions.[48] It was a *principle of valuation* that older adults and those around them invariably reached for, not only to justify or explain their actions, but to decide what was best as they dealt with the conundrums of aging. It was an enduring, if elusive, parameter for determining the worth of people, behaviors, and objects.[49]

Far from smooth, this process proved hotly contested. Independence gave rise to a range of different ways of judging older people's capacities; it was subject to negotiations about standards for assessment; and it wasn't always clear who got to be the legitimate arbiter of these classifications. As sociologists of valuation have noted, the definition of worth is riddled with friction, requiring actors to continually create compromises to coordinate their actions.[50] As an abstract value that defines good old age, independence was a taken-for-granted object of consensus. But as a principle of valuation brought to bear on concrete situations, it sparked all kinds of different (and sometimes contradictory) criteria and categories.

To capture these dynamics, I find it useful to think with the metaphor of a *prism*. Prisms are multifaceted objects that appear to be transparent but are not. They can break up light into a spectrum of colors or refract and change the direction of the beam, making objects on the other side appear different depending on which panel we are looking through.

Independence, I argue, has prismatic effects on how we perceive the worth of old age. Like a prism, independence seems transparent and self-evident—but it actually has multiple surfaces that afford distinct, though related, optics.[51] There is the medical perspective, where older adults are considered to be better off to the extent that they can physically do things on their own. Legally, they are classified as autonomous, full persons if they are capable of making their own decisions. Financially, people value their ability to sustain themselves without assistance from government programs such as Medicaid. And morally, older adults are "good" to the extent that they take personal responsibility for leaving dependency.[52]

At Oakville, the place I studied, all these ways of seeing came together. Often they did so seamlessly, but at times the valuations of independence were disputed, as older adults' own categorizations conflicted with the medical or legal ones imposed by health care workers and, ultimately, by bureaucratic and economic forces. These "classification struggles" reveal that independence is not something people have or don't have: It's something that has to be *ascribed*, seen and acknowledged by others.[53] Attributions of independence matter greatly, and not just because of the moral significance of being recognized as an independent old person, although this was certainly important for the people I studied. Ultimately, classifications of independence also determine the distribution of resources—for instance, who gets physical therapy or who is entitled to a certain amount of home care services. The opposite is true as well. The extent to which individuals are able to be evaluated, and to evaluate themselves, as independent, has a lot to do with their material circumstances, including health insurance, housing, family support, and more.

As a cultural value, then, independence is an ideal toward which older people orient their actions and against which they and others measure their worth. This ideal is refracted into various forms of valuation inscribed in medical protocols, policy, and reimbursement guidelines—while being frequently reshaped or pushed out of reach by individual, economic, and social constraints. The chapters ahead chart what happens in those interstices: how attempts to ascribe and claim independence become contested, the ways in which the horizon of independence is constantly relocated, and the efforts and

resources that elders, health care workers, and families pour into trying to make independence, somehow, real.

The Setting, the People, the Book

Between 2016 and 2018, I conducted ethnographic research on transitions into and out of the post-acute care unit of Oakville, a skilled nursing facility in New York City. Oakville is one of approximately fifteen thousand skilled nursing facilities in the US that provide both long-term and post-acute care. It is a nonprofit, stand-alone facility, meaning it's not associated with any hospital or nursing home chain. Around three hundred long-term patients are housed across various units, including specialized floors for dementia and Alzheimer's patients. While I interacted with these residents in recreational and therapeutic settings across the facility, I carried out the bulk of my observations in the post-acute care unit. This unit has private and shared rooms to accommodate over forty short-term patients. Individuals are admitted following a hospitalization and stay anywhere from a few days to several months (usually two to four weeks), during which they undergo physical and occupational therapy and receive skilled nursing as needed. As I describe in the methodological appendix, Oakville's patient population is diverse in terms of race, gender, and socioeconomic status.

At Oakville, I attended dozens of weekly staff discharge planning meetings, as well as daily meetings between staff, patients, and family members to discuss their care plans. I shadowed social workers and physical therapists in their initial evaluations of incoming patients, and observed dozens of rehab sessions at the physical therapy unit, where older patients made great efforts to walk, ride wheelchairs, and exercise weakened muscles. Starting halfway through this fieldwork and over the course of a year, I followed ten elders after they had been discharged from post-acute care. I met with them and interviewed them multiple times in their homes, cafés, fast-food restaurants, senior centers, an art studio, an art gallery, a hospital, and Oakville's long-term unit. This allowed me to contrast people's narratives about, and expectations of, independence with their lived realities as they committed to aging in place in a place like New York City.

I complemented my ethnographic observations with thirty-two interviews with staff members at Oakville, patients, and patients' family caregivers. These interviews aimed at understanding people's rationales and worldviews about care, growing old, and what it means to live a good old age. The methodological appendix offers a more detailed account of the process of gathering data,

how I got access to my field site and interviewees, and the ethical and emotional challenges of studying old people and their caregivers in a system that fails them in almost every way.

Observing how particular people in a particular medical organization used the culture of independence led me to a larger story. Drawing on primary and secondary historical sources, I sought to trace the social origins of the valuations of independence I saw in fieldwork and interviews. With research assistants, I reviewed a selection of congressional hearings led by the Senate Committee on Aging between 1961 and 2011; all the articles published in the leading US gerontology journal that dealt with topics related to independence and long-term care between 1962 and 2023; and virtually all the issues of the magazine published by AARP, the main advocacy organization for older citizens, between 1959 and 2002. I also analyzed multiple surveys and reports published by research centers and government agencies, particularly the reports of decennial White House Conferences on Aging (1961 to 2015).

Through this combination of historical, ethnographic, and interview material, this book moves among different levels of analysis to provide an account of how the value of independence organizes aging and care in the United States. Chapter 2 examines how a particular imaginary of independence in old age became institutionalized in elder-care policy and funding structures. I follow the debates that unfolded during the second half of the twentieth century as gerontologists, policymakers, and elders themselves disputed where and how long-term care ought to be provided. These actors pushed forward different visions of how to deal with the dilemmas of long-term care, weighing the security afforded by nursing homes against the dependency these institutions embodied and their increasingly high economic costs. Their arguments ended up congealing around the notions of community care and aging in place, firmly linking the concept of independence with one's home and inscribing this connection in aging policy and funding structures. Yet these structures left large gaps in access to adequate housing and an extremely expensive home care economy, setting up the host of barriers we will see emerge throughout the following chapters as people strive to achieve independence in old age.

Chapter 3 turns to how the idea of aging at home as vital for preserving independence structures health care organizations. It introduces readers to the world of post-acute care and its goal of "restoring independence" for older adults who have gone through a hospitalization, in order to send them "back to the community." The chapter shows how the valuation of independence as the ability to stay away from nursing homes organizes care provision at

Oakville, and how health care workers understand their mission as enabling this distance for their patients by engaging them in the project of *rehabilitation*—which presupposes a functional definition of independence, or not needing physical assistance. In other words, the success of post-acute care rides on assumed connections between rehabilitation, functional independence, and being able to age at home. But many of the patients who came through the unit presented medical or personal problems that challenged these assumptions. Thus, while these projects are meant to operate in tandem—rehabilitation as a means to deinstitutionalization—in practice they were often decoupled: Functional independence became a goal in and of itself for those who could not leave, while plenty of people left the institution without having their functional independence "restored."

Chapters 4 and 5 dive deeper into the dilemmas that post-acute care staff encountered as they tried to carry out the twin goals of rehabilitation and deinstitutionalization, and the strategies they used to judge what counts as independence. Chapter 4 examines how Oakville staff "see" independence. To evaluate patients, set goals for them, and decide when they are ready to be discharged, health care workers need to turn an abstract ideal into specific benchmarks against which they can assess different cases. I show that they used three kinds of values, relying on the standardized assessment instrument nursing facilities use as well as the reinterpretation of these standards that happened in local interactions. These layered ways of seeing helped them adjudicate patients' physical, cognitive, and motivational status, thus providing a bridge between idealized independence and patients' actual circumstances. But they also created conflicts, particularly when staff's interpretations of independence came up against old people's ideas about themselves and their capacities.

Chapter 5 explores further ramifications of these overlapping modes of valuation by describing how they were entangled with economic modes of reasoning. Operating in a market-driven, efficiency-prioritizing health care system, Oakville staff were routinely confronted with the problem of discharging patients quickly while ensuring their safety. In this chapter, I show that as economic rationales intervened in medical decision-making, they reshaped the grammar of independence, producing not just shifts in meaning but shifting classifications. Workers made judgments about discharge that satisfied financial and moral imperatives by reclassifying patients that still needed care as "independent enough" to go home. In this process, they kept moving the bar of what counts as independence, effectively pushing the project of restoring independence out of the organization and into people's homes.

Following this trajectory, the last two empirical chapters take us out of Oakville and into the lives of older adults, to document how people invest significant work and resources into making visions of independence cohere. Chapter 6 challenges the assumption of independence as an innate predisposition that needs to be materially facilitated. Instead, I show the efforts that older adults pour into cultivating independent identities. I thus explore in detail the dimension of independence as a moral obligation and a personal responsibility whereby aging well becomes a product of people's choices and attitudes. Chapter 7 revisits the assumptions behind current aging policies described in chapter 2: mainly, that "home" and "community" care enable people to preserve their independence. Zooming in on the experiences of aging in place for the folks whose lives I followed after they were discharged from post-acute care sheds light on the shortcomings of these conventions. Variation in home care services, home infrastructure and design, access to community resources, and family care all impacted how individuals experienced the connections between their home, their community, and their ideas of independence. For some, lack of resources resulted in a disjuncture between their anticipations of aging in place and their lived realities: the promises of "independent living" falling through the wide gaps of the American safety net.

The book's conclusion is an attempt to imagine a different prism for looking at old age. I first do the exercise of taking the pursuit of independence seriously and discuss what it would take to facilitate this goal for a larger number of older adults. Then, I turn the question around and ask what it would look like to live in a world with *less* independence. I want to challenge the cultural devaluation of dependency and care, and think about what it would mean to normalize the changes in ability and cognition that come with old age.

To this end, a note on language. While, as mentioned, I largely adhere to the convention of using the term "older adults" and its variants, I also intentionally use "old" and "elders," following scholars who make a case for reclaiming these words rather than treating them as stigmatizing.[54] Similar to how disability activists have adopted the word "crip" or how LGBT activists have reclaimed the word "queer," owning the word "old" instead of shying away from it might be a small step toward a different politics of aging—one that decenters independence in our vision of an old age that is worth living.

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