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The American Family as a Context for Healthy Ageing

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INTRODUCTION

As Achenbaum eloquently describes in Chapter 3, the American family looks quite different than it did half a century ago. In fact, fewer people live in *families* as traditionally defined and more live in non-family households. In 1998, 15 per cent of all people lived in non-family households (US Bureau of the Census, 1998), compared with 6 per cent in non-family households in 1950 (US Bureau of the Census, 1955). Meanwhile, life within family households changed as well. In 1994, 78 per cent of family households were headed by a married couple, compared with 88 per cent in 1950 (US Bureau of the Census, 1995). Family change extends beyond the household; for example, family generations are now smaller, although it is likely that more generations are alive at once (Bengtson, Rosenthal, and Burton, 1990).

Many public commentators and some scholars of the family interpret these trends to mean that the family is in decline and under siege from legal, economic, and social change (Popenoe, 1993). And the evidence is compelling, as far as it goes. Nevertheless, most adults are married (although it is a second marriage for many), most have children, and most rate their marriage as very happy and place a high value on family life. Moreover, the American family retains responsibility for reproduction, socialization, and transmission of property across generations. It is the main unit of consumption and often also produces considerable amounts of goods and services. The family provides care and support for its members, especially children and the disabled elderly. Most people's social networks centre on their families. This evidence suggests that the family remains a key social institution in the United States, even in its altered state.

However, the transformation of the American family does mean that people are living their lives in family constellations that may differ from those common in the past. Since the hallmark of family change is increased diversity, Americans are also likely to have families that differ from the families of at least some of their contemporaries. The key issue, then, is not the salience of

the family as an institution, but the implications of these new and diverse family forms for family functioning and individual well-being.

The transformation of the American family has overlapped with a second significant social change: population ageing. The Census Bureau estimates that nearly 13 per cent of the US population will be over 65 in the year 2000, compared with 8 per cent in 1950 (US Bureau of the Census, 1996). Demographers expect this trend to continue for the foreseeable future, in part due to the ageing of the large baby-boom cohorts. Over the next fifty years the United States will thus become a mature nation in which one citizen in five is 65 or older. As part of the same process, the older population itself will age, with huge increases in the number of people who are 85 and older (US Bureau of the Census, 1996).

The confluence of family change and population ageing has led to increased interest in family roles and relationships in later life (Cohler and Altergott, 1995; Treas and Lawton, 1999). The bulk of this work has focused on the provision of care for frail elders. For example, researchers have identified the family members most likely to provide care and have considered the implications of such care for caregivers' lives (e.g. Dwyer and Coward, 1991; Moen, Robinson, and Fields, 1994). Family caregiving is clearly a critical issue for an ageing society experiencing family change—especially since the division of responsibility for elder care among family, market, and state is already ambiguous in the US (Soldo and Freedman, 1994).

With some notable exceptions, less attention has been devoted to family experiences among non-disabled older persons—which form the majority of experiences (exceptions include Bengtson and Harootyan, 1994; Cooney and Uhlenberg, 1992; Eggebeen and Hogan, 1990; Logan and Spitze, 1996). Disabled elders and their families need and consume a disproportionate share of resources, which to some extent justifies the attention they have received. On the other hand, a narrow focus on family caregiving reifies an image of a dependent older generation (Logan and Spitze, 1996). Even more important, such a view misses a great deal of the relationship between older persons and their families. For example, exchanges between adult children and their parents are generally more evenly balanced than the literature on caregiving suggests. In fact, parents are much more likely to help their adult children than the reverse until quite late in the parent's life (Bengtson et al., 1990; Logan and Spitze, 1996).

In this chapter we therefore take a different perspective. Rather than considering the impact of ageing on the family, as in the caregiving literature, the reverse is examined: the impact of the family on ageing (Blieszner and Bedford, 1995). We consider the implications of contemporary American family structure for the ageing process itself. In our view, family roles and relationships form a context in which the later lifecourse unfolds. Thus the characteristics of the modern American family may have important consequences for the well-being of future cohorts of mature persons long before they experience any need for care.

The chapter begins by reviewing recent changes in the processes by which families form, persist, and dissolve, and their implications for family and household structure. A conceptual framework for understanding the family as a context for ageing is then sketched, followed by a brief review of what is known about family context and later life well-being. The focus is on the ways in which families influence the health of individuals in the second half of life. Health is arguably the most critical component of 'successful' ageing (Rowe and Kahn, 1997). Moreover, understanding why some older persons remain healthy and others do not is a major research challenge. We contend that family may play an important role in shaping health trajectories in the second half of life. Finally, the implications of contemporary family structure for healthy ageing within future cohorts are assessed, who will mature with family histories that differ markedly from those of previous generations.

FAMILY STRUCTURE IN THE CONTEMPORARY UNITED STATES

In the United States, as in most developed countries, families are social networks formed by ties of blood or marriage. As Achenbaum describes in Chapter 3, changes in the structure of US families can be traced to changes in the processes by which families are produced, maintained, and dissolved: union formation and dissolution, living arrangements, and childbearing. Each of these processes underwent considerable change in the latter half of the Twentieth Century. In each case, the change led to greater heterogeneity in family structure. Currently, American family structure is more diverse than at any point in US history. Let us examine some of the broad national US trends identified in both Chapters 1 and 3 in more detail, in particular highlighting ethnic and racial differences.

Union Formation and Dissolution

As Harper describes in Chapter 1, like the rest of the developed world, American men and women are delaying marriage into their mid-to-late twenties, often entering a cohabitation first. Divorce rates are high and stable, but rates of remarriage have fallen, so that a larger proportion of adults are unmarried now than in the past. In 1970, unmarried people made up 28 per cent of the adult population. In 1996, 40 per cent of all adults were unmarried. Seventy-one per cent of women born in the early 1950s had married by age 25, compared with 54 per cent of those born in the late 1960s (Raley, 2000). In fact, the shift away from marriage has been so dramatic for blacks that now a *majority* of black men and women are not married, compared to about a third of white men and women (Waite, 1995).

Declines in marriage are closely linked to increases in cohabitation, although it is difficult to untangle the nature of the association. Cohabitation has become an increasingly common step in the courtship process: only 7 per cent of the women born in the late 1940s cohabited before age 25 compared with 55 per cent among those born in the late 1960s (Raley, 2000). Most couples begin their intimate life together by cohabiting rather than by marrying, so that the form of the union has changed more than its existence. However, even when we consider both marriage and cohabitation, young adults are less likely to have formed a union now than in the past. Among young women born in the early 1950s, about a quarter had not formed a union by age 25, compared with a third of those born in the late 1960s (Raley, 2000).

A substantial proportion of all marriages end in divorce or separation due to marital discord. The divorce rate, which reflects the number of divorces in a year relative to the number of married people, rose continuously for more than a century, then levelled off at a fairly high level in about 1980 (Goldstein, 1999). The best estimates suggest that around half of all American marriages will be disrupted (Cherlin, 1992). The marriages most likely to end include those with no children, with children from a previous union or older children (Waite and Lillard, 1991), marriages begun at a young age, and marriages between partners with relatively low levels of education (Martin and Bumpass, 1989).

Although high divorce rates make marriages seem unstable, other types of unions are much more likely to dissolve. Cohabitational unions show quite high chances of disruption, with a quarter ending in separation within three to four years compared with only 5 per cent of marriages, according to one study (Wu and Balakrishnan, 1995). Many cohabitations become marriages, but these show lower stability than marriages not preceded by cohabitation (Lillard et al., 1995).

Living Arrangements

Paralleling these trends in union formation and dissolution are increases in the proportion of persons who live alone. Unmarried persons are far more likely to maintain independent households than in the past (Santi, 1990). As discussed above, some of these persons choose to cohabit with a partner. However, others are choosing to form a one-person household. In 1990, 12 per cent of persons lived alone, compared with 7 per cent in 1970 (US Bureau of the Census, 1995). The shift toward living alone is particularly noticeable among unmarried young adults and the elderly, who in the past typically lived with relatives (Goldscheider and Goldscheider, 1993; Schoeni, 1998). There are substantial racial and ethnic differences in this regard. Unmarried African-Americans, Hispanics, and Asians are more likely to co-reside with relatives than are whites (Goldscheider and Goldscheider, 1993; Himes, Hogan, and Eggebeen, 1996).

Childbearing

Despite dramatic changes in other family processes over the past three decades, US fertility levels have been relatively stable. The total fertility rate, which expresses fertility rates in terms of the lifetime number of births they

imply for a woman, rose from a low point in the mid 1970s and has remained around two births per woman in the 1990s (Ventura et al., 1999). However, this apparent uniformity conceals several characteristics of contemporary US fertility that have important consequences for family structure. First, fertility levels vary markedly by race and ethnicity. In 1997, the total fertility rate for non-Hispanic Whites was 1.8. The comparable figures for Blacks and Hispanics were 2.2 and 3.0, respectively (Ventura et al., 1999). Second, the ages at which women have their first birth vary substantially. Morgan (1996) describes 'early' childbearing, in the teens, 'on time' childbearing, in the twenties, and 'delayed' childbearing, in the thirties. Moreover, the share of births to women of each age is shifting. This is because over the past two decades birth rates for women in their twenties have been relatively stable, while birth rates for women in their thirties have increased steadily and births to teenagers first increased then decreased (Ventura et al., 1999). These patterns are in turn linked to the characteristics and life circumstances of women. Another variation in family structure is introduced by the substantial fraction of women who remain childless. These patterns also differ by race: Blacks and Hispanics show younger ages at first birth than do Whites and others (Morgan, 1996). Finally, as elsewhere in the developed world, unmarried childbearing has reached historically unprecedented levels (Bachrach, 1998). In 1996, 32 per cent of all births and 44 per cent of all first births in the US occurred to women who were not married (Ventura, Martin, Curtin, and Mathews, 1998). However, over a quarter of unmarried mothers are cohabiting with the child's father at the time of the birth so their children are living in 'intact' if unmarried families (Bumpass, Raley, and Sweet, 1995). The proportion of births to unmarried women depends on the share of all women who are unmarried, the fertility of married women, and the fertility of unmarried women. Marital fertility is relatively low in the US, which accounts in part for the high fraction of births to unmarried women.

Unmarried childbearing also varies substantially among racial and ethnic groups in the US. The percentage of births to unmarried women is highest for Black women (69 per cent), and lowest for Chinese Americans (7 per cent), with Whites intermediate between these two extremes at 26 per cent. Rates of unmarried childbearing also vary a good deal within Hispanic origin groups, with rates for Puerto Rican women, approaching rates for Blacks (59 per cent), whereas rates for Cuban-origin women (24 per cent) approximate those of non-Hispanic Whites (Ventura et al., 1999).

Family Diversity

The married, two-parent family has been the most common family form in the US for some centuries. And it still is. However, increases in divorce, the likelihood of remarriage, the rise of cohabitation, and high levels of non-marital childbearing mean that single-parent families and unmarried-couple families

are now common alternative family forms. At the same time, the greater likelihood that an unmarried person will live in his or her own household has increased the fraction of persons living alone—without family. Differentials in family processes by race and ethnicity lead to corresponding racial and ethnic differentials in family structure. For example, single-parent families are much more common among Blacks than among other groups. In 1997, a single woman headed 33 per cent of Black households, compared with 20 per cent of Hispanic households and 10 per cent of White households (US Bureau of the Census, 1998).

Although these shifts in family structure are striking, they should not be over-dramatized. As described by Dimmock and colleagues for the UK in Chapter 5, even at the height of the married-couple family, many people lived in other family types, most often due to the death of one member of the couple before all the children were grown (Watkins et al., 1987). When death ended many marriages relatively early in life, remarriages and stepfamilies were common, as were single-parent families caused by widowhood. The unique aspects of today's patterns are the increases in unmarried-couple families, never-married mother families, and persons living outside families.

Thus far, we have emphasized changes in the co-residential family. However, contemporary family processes have at least three important implications for family structure beyond the bounds of the household. First, parental divorce typically removes one parent from the household, as does the break-up of a cohabiting relationship with children. In the United States as elsewhere, this parent is most often the father (Hogan and Lichter, 1995). Second, variability in age at first birth in successive generations leads to substantial heterogeneity in the age patterning of generations within families (Bengtson, Rosenthal, and Burton, 1990). Similarly, differences in fertility levels—including being childless—change the relative sizes of generations. Third, divorce, cohabitation, and non-marital childbearing produce new family roles—partners, stepchildren, ex-spouses, former in-laws, step-grandchildren, and so on (Riley and Riley, 1993).

The Family as a Context for Healthy Ageing

Both scholars and the public have passionately debated the strengths and weaknesses of contemporary American family structure. If nothing else, the intensity of this debate should testify to the enduring significance of the family in American society. Until recently, most research and dialogue concentrated on the family of the first half of life. The focus on family experiences at relatively young ages reflected the primary interests of family scholars—family formation and the family as a social incubator for the next generation. As a result, vast literatures examine topics such as contemporary union formation and the implications of divorce for children.

Recently, family researchers began adopting a life course approach to the family (Treas and Lawton, 1999). This perspective acknowledges that although

the principal *events* that form one's families of origin and procreation occur in the first half of life, family *roles* endure for a lifetime. The family of origin brings lifelong membership. Moreover, lengthening life expectancy and fewer years spent within marriage increase the salience of adult intergenerational relationships and interactions with adult siblings (Treas and Lawton, 1999). Similarly, for most persons, parenthood brings a lifelong role that mirrors the role of the adult child (Logan and Spitze, 1996). For some persons, marriage may still bring a lifelong relationship. Yet even divorced persons may experience significant long-term relationships with former spouses and in-laws, especially if the presence of children brings continuing contact.

Family experiences in the second half of life are thus receiving an increasing amount of research attention (Treas and Lawton, 1999). As noted above, this research extends beyond the narrow focus of caregiving for disabled elderly to consider a broad spectrum of family relationships. For example, recent work has examined the structure and content of relationships between parents and adult children (Cooney and Uhlenberg, 1992; Logan and Spitze, 1996), between adult siblings (Bedford, 1995), and between grandparents and grandchildren (Robertson, 1995). This literature suggests that family members are key members of individuals' 'convoys' of social relations across the lifecourse (Antonucci and Akiyama, 1995). Family members, especially parents and adult children, are involved in reciprocal exchanges of both instrumental and emotional support.

Health in Family Context

A lifecourse perspective on the family suggests that families will be critical to individual well-being at all ages. Thus adult family relationships are of interest not just in and of themselves, but for what they imply for the welfare of family members. Building on broader frameworks of the life course and human development (Setterson, 1999), we here conceptualize the family as a context for healthy ageing. In our view, the family forms a social world that systematically influences individual identity, perceptions, and action. These in turn shape the more proximate determinants of health, such as health behaviours, perceived loneliness, and stress or allostatic load.

The family context is built on sets of social roles—child, sibling, spouse, parent. Entry, incumbency, and exit from these roles structure the lives of individual family members. Each role carries normative expectations and obligations for behaviour and helps to define individual identity. These norms shift with age of the role incumbent; for example the expectations and obligations for a parent of a teenager differ from those the same parent will experience when the child is in his or her thirties. Similarly, normative prescriptions vary in strength; greater consensus surrounds parent–child obligations than obligations between siblings (Rossi and Rossi, 1990).

However, family context is not a simple reflection of family structure. The structural framework of family roles is elaborated by the qualities of family relationships. Family relationships emerge from the day-to-day patterning of social interactions between and among family members. They are based on actual behaviour of family members—which may be measured against internalized norms. These behaviours, and the ways they are interpreted, are rooted in powerful emotions, especially love and guilt (Bengtson and Murray (1993) quoted in Logan and Spitze, 1996). Family relationships may be positive or negative—or perhaps a combination of both (Bengtson, Rosenthal, and Burton, 1996).

Thus the family is characterized by normatively guided roles manifested in relationships based in part on emotionally motivated exchanges. Three features further distinguish the family context from other types of social relationships. First, families have long histories. Family roles and relationships begin in early life. Unlike friendships, family relationships are ascribed and difficult to dissolve, even if they are a source of continued distress (Antonucci and Akiyama, 1995). An event that took place years before may thus mar or cement a relationship (Antonucci and Akiyama, 1995). However, this is not to imply that family relationships are static. Instead, they evolve over time, continuously renegotiated and reconfigured. Second, the lives of individual family members are interdependent (Treas and Lawton, 1999). Events in one person's life may reverberate in the life of other family members. For instance, a child's divorce may lead a parent to give extra help and support to the child, which may include offering co-residence or taking custody of a grandchild. Geographic mobility may alter the relationship between siblings. Third, the family is a critical link between individuals and other social institutions and structures (Bronfenbrenner, 1986). For example, in the United States one's economic well-being is closely tied to one's family structure. Both access to resources and consumption are channelled through the household. Family members benefit from the resources of other family members. Families provide economies of scale in consumption of goods and services, allowing their members to live better than they could alone (Burch and Matthews, 1987). Similarly, the effects of gender stratification, the workplace, and racial and ethnic stratification are also channelled through the family.

We suggest that family context affects individual health via individuals' experiences of family *demands* and *resources*. The tasks and interactions embodied in family roles make physical, cognitive, and emotional *demands* on role incumbents. However, these same roles offer rewards and supports which individuals can use as *resources* to meet these expectations as well as their own needs. In addition, others in the family may constitute a resource, by sharing task demands, by providing positive interactions, or by simply fulfilling the expectations of their own roles. Demands and resources are conceptual tools for specifying the mechanisms by which families influence the health and well-being of their members.

Overall, the greater imbalance in expectations and obligations in a dyadic relationship, the greater the potential for imbalance in experienced demands

and resources. Thus the spousal relationship is typically characterized by a greater degree of reciprocity than the relationship between parent and child or between grandparent and grandchild. All else equal however, a dyadic relationship in which one member needs extra instrumental or emotional support will increase demands and reduce the resources available to the other person. A disabled spouse in need of care provides a very different configuration of demands and resources than a healthy spouse. Young co-resident grandchildren bring very different demands and resources than older grandchildren living with their own parents.

The balance of family demands and resources is a link in the causal chain between family structure and relations and individual health. This balance is ultimately subjective—the individual's internal evaluation of his or her situation. We expect that the balance of family demands and resources will in turn shape individuals' health behaviours and their perceptions of stress and loneliness. For example, a demanding family role such as caring for a grandchild may lead to stress. To the extent that bonds with others in the family are absent or unsatisfying, individuals may feel lonely. In turn, health behaviours, loneliness, and stress act on the more proximate biological determinants of health, such as endocrine function and immune response (Cacioppo et al., forthcoming).

In this manner, variation in ageing persons' families may partly explain individual differences in the onset, timing, and severity of health problems (Waite and Hughes, 1999). Chronic conditions are responsible for the bulk of health problems in later life. These conditions develop over long periods and display great variability in age at onset. For both reasons, family structure and relations in late mid-life to early old age may be quite important to health trajectories in the second half of life. Family obligations and expectations clearly transcend the boundaries of the household. However, the immediacy, intimacy, and intensity of household-based family roles will lead to particularly powerful effects on individual well-being. Various family households make very different demands on the adults in them and offer very different levels and types of resources. For example, being married brings the demands of the spousal role, but a member of a married couple may rely on a spouse as a resource. The particular closeness of marital relationships suggests that these reciprocal bonds may be especially well developed. In contrast, although those living alone have no demands placed on them by others within the household, they have no one living with them who may act as a resource. The person living alone must fulfil all of the requirements of independent living and lacks instrumental and emotional support from co-resident others.

Multigenerational households present a more complex case. Co-residence with children, grandchildren, or others may be a response to economic hardship or may reflect cultural traditions that emphasize kin solidarity and intergenerational ties (Himes et al., 1996). Although co-residence between older parents and their children is often assumed to provide for the care of the parent, research suggests that intergenerational households are usually based on the needs of the younger generation (Aquilino, 1990; Ward et al., 1992). Thus, although such households are often expected to be uniquely supportive, they may actually present special stresses and challenges to senior members.

Evidence Linking Family Context and Health

The chapter has outlined a framework for understanding the processes by which family context influences the health of family members. We next turn to a brief review of the evidence regarding the relationship between family context and health. The bulk of this literature concerns the relationship between overall social relations and health and marital status and health. Relatively little research has examined the relationship between other family structures and health. This gap is an important area for future research.

Social support (the emotionally sustaining content of relationships) and social integration (the existence of certain key relationships) are both positively linked with emotional well-being in dozens of studies (George, 1996; Thoits, 1995). Social support reflects the positive quality of relationships, which may also have negative or demanding aspects, called relationship strain. Relationship strain has independent negative effects on well-being. Thoits (1995) argues that although mental health researchers often presume that their findings on social support can be generalized to physical health very little research on this link has been done. This literature has been more concerned with the influence of overall social relations on health, rather than the influence of the family on health (but see Antonucci and Akiyama, 1995). However, family members are prominent members of individuals networks of social support.

A great deal of evidence also attests to the importance of marital status to health and well-being. Being married has consistently positive effects on physical health that do not appear to reflect only selection into marriage (Lilliard and Waite, 1995; Goldman et al., 1995; Umberson, 1992; Ross et al., 1990). For example, married cancer patients are less likely than unmarried patients to die over the five years following diagnosis, even taking into account stage at diagnosis and treatment. Ross et al. (1990) conclude that unmarried women face risks of dying that are 50 per cent higher and unmarried men face risks that are 250 per cent higher than those faced by their married counterparts. Married men and married women rate their health more positively than unmarried men and women. Married men and women are also less likely than singles to suffer from long-term chronic illnesses or disabilities (Waite and Hughes, 1999).

Umberson et al. (1996) conclude the evidence on the emotional benefits of marriage is inconclusive, at least when the married are compared with the never-married, although the divorced and widowed seem substantially worse off than the married. However, a recent paper by Marks and Lambert (1998) finds large and significant advantages for the married across a range of measures of psychological well-being for both men and women, compared with

those who either become or remain unmarried. Only those who marry for the first time during the period of observation do better than the stably-married. And Horwitz, White, and Howell-White (1996) find that after controlling for premarital rates of disorder, marriage enhances mental health for both young men and young women.

Whether and how other family households affect health is less clear. Most analyses group non-marital household structures together in comparisons to marriage. Marital households are rarely distinguished by presence of others such as dependent or adult children or others. However, Rogers, Hummer, and Nam (2000) argue that *family composition* captures the complex relationship between family arrangements and mortality much better than marital status alone. They argue that large and important differences exist between married couples living with dependent or adult children, with other relatives, or alone. They find substantial effects of family composition on mortality, which they speculate are due to differences across household types in economic resources, social support, and stress.

In our own work, we have found that the relationship between household structure and health does not follow a simple married–not married distinction (Waite and Hughes, 1999; Hughes and Waite, 1999). In one study, older adults living in married-couple households (with or without own children) show higher levels of functioning across physical, emotional, and cognitive dimensions compared with adults in married-couple households that also include other persons. Adults in any type of married-couple household tend to show higher levels of functioning across dimensions than single adults living alone, single adults living with their own children, or single adults living with others. In fact, household types tend to array themselves by average levels of functioning across physical, emotional, and cognitive measures so that older adults in married-couple households (with or without own children) show the highest levels of functioning, followed by married-couple households with others, then by single adults alone, then by single adults with their own children, with single adults living with others consistently showing the lowest levels of functioning (Waite and Hughes, 1999). We find that these patterns for the most part persist when we examine change in health, rather than health at a point in time (Hughes and Waite, 1999).

CONTEMPORARY FAMILY STRUCTURE AND THE FUTURE OF HEALTHY AGEING

Mature Americans are embedded in family contexts that differ substantially from those of the past. However, the experience of current elderly does not capture the full implications of contemporary family patterns for healthy ageing. The family behaviours described above evolved over several decades. In general terms, successive cohorts of older persons will thus have spent successively more of their life courses experiencing these patterns. For example,

persons who are currently aged 65 and over were born into families of origin and formed families of procreation before the main shifts in family behaviour. Their children and grandchildren did participate in these shifts, which in part shapes the older generation's experience of ageing. In contrast, the baby-boom cohorts will reach age 65 having experienced families of procreation that follow contemporary patterns. Members of Generation X will presumably have both grown up in new-style families and formed new-style families.

Let us conclude by considering the consequences of contemporary family structure for the ageing of future generations. In particular, we have in mind the baby-boom cohorts. These cohorts were in the vanguard of family change and are now beginning to reach their fiftieth birthdays. Their numerical strength will accelerate the long-term ageing of the US population, raising critical questions regarding their well-being in maturity and the subsequent consequences for society. Based on their experience thus far, it is likely that members of the baby-boom cohorts will reach maturity with a more diverse set of family structures relative to members of preceding generations. They will be less likely to be currently married, more likely to be living alone, and perhaps more likely to be living in a complex household. Their family histories will certainly be more variable. The incidence of cohabitation, multiple marriages, non-marital childbearing and childlessness will all be greater in these cohorts. Baby boomers will have spent less of their life in married-couple households and more living alone, in single-parent or in complex households.

At first glance, it seems that these differences in family structure would place these cohorts at a health disadvantage relative to earlier cohorts, all else equal. The distribution of family types is shifting toward types that previous research has shown to be linked to poorer health outcomes. The shift in marital status is particularly important in this regard. Recall that it is not just an individual's family status when he or she enters later life that is critical—it is equally his or her family history. Thus by this line of reasoning, baby boomers' relatively diverse families should correspond to both greater diversity in health outcomes and an overall lower level of health. However, while this rather pessimistic scenario may be accurate at a high level of generality, it offers limited insight into the heterogeneous processes that will underlie this gross pattern. Understanding these processes is likely to be critical for both research and policy in the coming years. Furthermore, the actual implications of the contemporary family for health will depend heavily on how family roles and relationships continue to evolve. Thus a more useful way of assessing the future is to pose questions about some unresolved issues relating to family context and health in the second half of life.

What Expectations and Obligations Will Family Roles Entail?

Social roles are the foundation of the family. However, these roles are changing quickly. This change takes two forms: the redefinition of traditional roles and the creation of new roles. For example, the role of mother has been redefined by increases in women's work outside the home and increases in non-marital

childbearing. The role of father is bifurcating—the 'good' dads who are fully involved with their children and are equal partners in maintaining the household and the 'bad' dads who are absent and essentially divorced from their children (Furstenberg, 1988). New family roles include never-married mother, step-parent, ex-spouse, partner, and stepchild. The roles are currently ill-defined; families negotiate their expectations and obligations as they arise.

Because the expectations embedded in family roles are a central determinant of family demands and resources, the way these roles evolve should have important implications for individual health. For example, will shifts in the gendered division of household labour mean that co-resident adult children will demand less of mothers' time? As formerly unusual family roles become more common, will greater normative consensus emerge regarding what is owed to and expected from family members? If so, the stress that family members experience from 'ad hoc' family norms will be reduced.

On Balance, What Will Be the Qualities of Family Relationships?

Contemporary families bring opportunities for both increased family solidarity and increased family conflict (Bengtson et al., 1996). For example, the easy availability of divorce suggests that any marriages that persist into maturity will be especially strong. Stepfamilies and other new family forms introduce others who may provide fulfilling relationships of all types. As Riley and Riley (1993) argue, these new relationships are 'latent' and as such are likely to be activated based on compatibility and mutual gain. On the other hand, divorce and remarriage bring the potential for greater conflict—not only between spouses, but between parent and child and among siblings. The balance of these potential solidarities and conflicts as individuals age is critical to how individuals experience family relationships and in turn to their health.

A related issue is how other types of relationships will substitute for absent or difficult family relationships. For example, childlessness may leave people more time to develop friendships and other voluntary associations, which, unlike families, are unambiguously beneficial to health (Antonucci and Akiyama, 1995). Although the sibling relationship is unique in its degree of shared experience, only children can compensate by investing in friendships or in relationships with senior family members. The possibility of adaptation to family 'losses', especially since these adaptations may be beneficial for health, is an important corrective to the view that lack of family is inevitably harmful.

What are the Long-Term Implications of Contemporary Family Structure for Family Relations?

We argued earlier that family relationships both endure and evolve over time. Because the baby-boom cohorts are only now reaching later mid-life, we know relatively little about the long-term effects of contemporary family patterns. For example, how will the relationship of single mothers to their children develop as the children reach adulthood? How will parental divorce and remarriage affect relationships among siblings and stepsiblings in adulthood? The ways in which these and other long-term family relationships unfold will have implications for the well-being of mature baby boomers.

What Will Other Family Members Need?

Because the lives of family members are intertwined, mature baby boomers' family configurations will depend in part on the needs of their children and grandchildren. For example, co-residence with adult children is usually due to circumstances in the younger adults' life. To the extent that young persons in the future experience difficulties such as divorce or job loss, their parents may be called upon to provide co-residence or other support. Adult children in the home increase the demands placed on parents, especially mothers and especially single mothers (Logan and Spitze, 1996). As another example, difficulties in the lives of adult children are leading to dramatic increases in the prevalence of custodial grandparents. Here again, the senior generation is devoting time and resources to problems encountered in the younger generation. To the extent to which some baby-boomer parents will be involved in these demanding exchanges, their health may suffer.

How Will Other Aspects of Social Structure Intersect with Family Configurations?

We have already referred to several ways in which changes in gender roles intersect with family change. Because family patterns differ dramatically by race and ethnicity, heterogeneity in the family will be cross-cut by race and ethnicity. Similarly, economic well-being will be reciprocally related to family status. To the extent that persons with more demanding family situations are also disadvantaged by minority status or low socioeconomic status they will be at even greater risk of health problems in maturity (Waite and Hughes, 1999).

The chapter began by noting the confluence of two key social trends: changes in the structure of the American family and the ageing of the American population. Although the implications are unclear, it is quite clear that mature Americans will have increasingly heterogeneous family histories and statuses. Thus the family is likely to become ever more important in differentiating the ageing experience. For researchers, this offers many exciting opportunities to clarify the mechanisms by which American families shape healthy ageing. Policy makers will face the challenge of designing flexible strategies to meet the needs of various kinds of ageing families.