BOHR International Journal of
Social Science and Humanities Research
2022, Vol. 1, No. 1, pp. 66–77
DOI: 10.54646/bijsshr.2022.11
www.bohrpub.com

Retired: What happens when they aren't at the bridge table?

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Received: 05 June 2022; **Accepted:** 16 June 2022; **Published:** 28 June 2022

This ethnographic study is based on in-depth interviews of retired males and females. Their perspectives on their financial condition, choice of housing, lifestyle, and health are explored. The individual interviews of 40 retirees equally split between women and men elicit responses that provide fundamental insights into the consumption and motivation of this growing consumer market. Responses indicate satisfaction with financial plans and with housing choices. The strong motivation for the family is evident. Challenges from health issues such as arthritis are frequently mentioned. The opinions of these retirees on issues such as physician-assisted suicide are included.

Keywords: retirement, retired, marketing, motivation, seniors, ethnographic

Introduction

Over 20% of the United States population and 17% of the world population will be over retirement age (1, 2). The life expectancy of this group is growing (3). Many in this demographic possess a large pool of disposable income (4). This segment represents an understudied target market.

Literature in the marketing disciplines has extensively addressed planning for retirement (5). However, what happens with the spending habits of those that successfully plan for retirement is an understudied area in marketing. A conservative estimate suggests this group spends a trillion dollars annually in the United States.

For retirees, adjusting to life after retirement involves finances, health, and lifestyle choices. Adapting to their finances, health, social life, and philosophy has seen retirees use various methods to cope with these choices (6). For example, some can enjoy their freedom from work by doing all they had planned to do after retirement. However, others cannot become involved in once planned activities because of poor health or reduced income.

Understanding the similar or dissimilar adjustments in lifestyles can help marketers. Using a qualitative approach with questions covering certain facets of retirement provides insight into retirees' choices. Often, retirees do not know where they want to live or what to do after retirement; many do not know their options. This study employs a convenience sample to generalize to the population of retirees in the United States (7). Engaging these retirees in in-depth discussion aims to discover what rewards and difficulties they have encountered since retirement. "Participatory research is a collective inquiry which builds group ownership of information as people move away from being objects to acting as subjects of their own research process" (8).

Literature review

The literature around retirement is extensive. So, this section is not an exhaustive review. Instead, the goal is to position this research within that rich context and use existing findings to guide the qualitative interview. The review also provides a framework for using qualitative studies in marketing.

The qualitative approach is the "best" approach for understanding how retirees "think and feel" (9). While many approaches to qualitative research exist, this project uses extensive one-on-one interviews to achieve depth and gain insight into sensitive projects. This approach has a long

history in marketing and has been successful with vulnerable groups (10, 11).

Again, the approach is depth interviews (9), guided by topics developed from the literature. These topics form the foundation of a semistructured interview. More sensitive questions are presented toward the end of the interview after establishing rapport between the investigator and subject. Additionally, as the literature suggests, follow-up questions for clarification purposes would be employed as necessary.

The literature suggests a salient but not sensitive question for retirees is about living arrangements and relocation. While this is primarily a financial question, it has also become a lifestyle question since, after September 11, 2001 more senior citizens opted to stay close to their families (12). This choice is a change from earlier periods where retirees sold their homes to purchase a different one at the desired retirement location (13, 14). This question eased the respondents into other financial and lifestyle questions.

Another relevant topic is health and medical care choices. Access to infrastructure plays a part in successful aging. Technologies for successful aging have provided quality life outcomes (15). Advances in medicine and access to medical care have allowed retirees to live longer and enjoy these benefits (16). Their planning for financial security and housing arrangements dominates the beginning of retirement. Navigating these finances and housing choices drives lifestyle choices (17).

Getting settled before or immediately after retirement is a healthy plan. "Thinking positively about getting older extends one's life by seven and one-half years." This is from an article on lifestyle choices (18). While the order of questions is planned, the flexibility to alter the order of questions to flow with the conversation is essential. Many topics are intertwined. Structured questions about choices made around finances, living arrangements, and lifestyle motivations form the interview's first three sections. The interview concludes with a discussion on health.

Two studies, in particular, guided the development of the questions that likely lead to some insight into the topic of "aging well." The first study used the individual life histories of 824 individuals. These subjects were selected as teenagers more than 50 years ago and studied for their entire lives. They answered a questionnaire every 2 years and had physical examinations every 5 years. The study describes the developmental processes that make old age vital—being ill without feeling sick, regaining the capacity for creativity and play, acquiring wisdom, and cultivating spirituality—and offers suggestions for successful and happy aging (19).

Another study was conducted on 4034 Germans aged 40−85. The authors revealed three dimensions of aging experiences as being particularly relevant: (a) negative physical decline, (b) continuous growth, and (c) social loss. "All three dimensions of the aging experience were also related to both positive and negative affect and, with the exception of physical decline, to life satisfaction" (16). According to Kamler, aging is a process of change. Older adults are both learners and teachers. Therefore, they should be given opportunities for mentoring and should recycle what they have learned back into their communities (20).

A salient question is how long this retirement lifestyle lasts. A survey shows that the once elusive goal of living 100 years is becoming more attainable daily. However, most Americans (63% of the 2032 seniors surveyed) say they do not want to live to attain that goal (21). Retirees "still seem to believe the stereotype of poverty and frailty in old age" (22). They would rather not live to be 100, fearing poor health and loss of financial resources. An article makes the point that most of the retirees surveyed said that one of the worst things about the 21st century was that "most people will live to be 100 years old" (23).

Within the retirement lifestyle, happiness is typically a goal. According to research supported by the National Institute of Mental Health (NIMH), depression is not a normal part of aging. Statistics show that only one in six elderly people with clinical depression gets diagnosed and treated for the illness. The bottom line is that depression is not a normal part of aging, and seniors must take the symptoms seriously.

Changes in sleep patterns since retirement have been suggested as an indicator of depression. However, literature also suggests that changes are natural. For example, a study used the 2°week diaries of 40 people (17 males and 23 females) between 50 and 70. The results of four consecutive nights of laboratory recordings indicated that retirees spend more time sleeping on weekday nights than their employed peers and that the employed participants had later bedtimes on weekend nights than retirees. Twenty-nine measures of electroencephalogram (EEG) sleep structure were analyzed, and no significant main effects were found with regard to employment status (24).

Another related topic is exercise and its link to improved satisfaction. According to an AARP-commissioned survey on exercise for seniors, 63% of Americans aged 50−79 believe that exercising is the best thing they can do for their health. However, 89% of those polled believed that people their age should exercise thrice per week for 20−30 min each time, and 71% believed that moderate activity is essential. That is what the doctor ordered, but that is not what seniors are doing (25).

The literature suggests that while some specific medical issues are relevant, retirees consider them more personal. The topics range from discussing arthritic conditions to the most sensitive issue, medically assisted suicide. For example, it is estimated that 80% of people over the age of 60 have arthritis. The article Growing Old (26) stated that many older people consider pain a natural aging process. These older consumers feel that admitting to pain might reveal the presence of severe disease. They also might not report pain because they do not want to bother their caregiver or physician (26).

Diabetes is suggested as another medical issue disproportionately affecting retirees. "Can Weight Loss Decrease Heart Disease in Type 2 Diabetes?" is a study examining people between 45 and 75 years of age, classified as overweight or obese. More than 50% of adults in America are considered overweight, and type 2 diabetes has reached epidemic proportions in the United States, primarily due to obesity. However, "short-term weight loss has been shown to have beneficial effects on diabetes and cardiovascular disease" (27).

Not all conditions are strictly physical ailments. For example, memory loss is a concern for retirees. Marketers have also found that forgetfulness impacts choice (28). According to a 2001 study, a new line of research known as prospective memory is divided into event- and time-based memory. An example of event-based memory is remembering to close the windows when it rains. A person's age makes no difference in event-based memory. An example of time-based memory is remembering to visit someone at 10:00 a.m. and remembering to come back in half-an-hour. Age did make a difference here. It was also found that the task's complexity made a difference (29).

The prevalence of Alzheimer's disease does not go unnoticed by retirees. Lists with warning signs of memory loss and signs of Alzheimer's are common.

1. Saying the same thing or asking the same question repeatedly.
2. Getting lost easily.
3. Losing interest in favorite activities.
4. Having difficulty in naming everyday items.
5. Losing things more often than normal.
6. Showing personality changes, such as withdrawal, confusion, and suspicion.

Because many of these symptoms can also be signs of nutritional deficiencies or depression, it is essential to have a doctor examine a person showing the above symptoms. Therefore, it is crucial to have an examination by a primary care physician (PCP) (30).

Another sensitive topic is the prevalence of acquired immune deficiency syndrome (AIDS) and its escalation among seniors (31). "People living longer and healthier lives, rising divorce rates, the absence of work or family-related stress, even Viagra, may be responsible for the new promiscuity of older people who seem to have missed two decades of public health messages often targeted at the younger, more-at-risk groups" (32). Education is all-important, and the trend in Britain is to create a new sex advertising campaign aimed at older people.

"Researchers say most seniors expose themselves to the virus through unprotected sex because they feel they and their partners are not high-risk carriers" (33). A federally sponsored group called the National Association of HIV Over Fifty (NAHOF) aims to contain and possibly lower infections by educating seniors. The virus is acquired through the usual routes: high-risk unprotected sexual activity, homosexual or heterosexual; intravenous (IV) drug use; and transfusion with infected blood, usually after surgery. "In postmenopausal women, atrophy of vaginal tissue renders it more easily damaged during intercourse. The resulting lesions may more easily transmit HIV (33).

The final topic dealt with the question of PAS. There is extensive literature on PAS and euthanasia (34). In this study, the retirees are presented with a clear distinction between PAS and euthanasia. Discussion with retirees in this study is limited to PAS.

Is PAS the same as euthanasia? PAS is the physician providing the means for death, most often with a prescription. The patient, not the physician, will ultimately administer the lethal medication. "Euthanasia generally means that the physician would act directly by administering the lethal injection to end the patient's life" (35).

Some arguments in favor of PAS are the following:

1. Respect for autonomy: Competent persons should have the right to choose death.
2. Justice: Competent, terminally ill patients are allowed to hasten death by treatment refusal. For some, treatment refusal will not suffice to hasten death; suicide is the only option. Justice says, "treat all cases alike."
3. Compassion: Suffering means more than pain; there are also physical or psychological burdens. It is not always possible to relieve suffering. Therefore, PAS may be a compassionate answer to unbearable suffering.
4. Individual liberty versus state interest: A complete prohibition on assisted death excessively limits personal liberty.

Some arguments against PAS are the following:

1. Sanctity of life.:There are religious and secular traditions against taking human life.
2. Passive versus active distinction: This argument says a vital distinction between passively "letting die" and actively "killing." The first is justifiable, while the second is not.
3. Potential for abuse: Here, the argument is that certain groups of people lacking access to care and support may be pushed into assisted death. Furthermore, assisted death may become a cost-containment strategy. Burdened family members and health care providers may encourage the option of assisted death.
4. Professional integrity: Opponents point to the historical, ethical tradition of medicine, which is

strongly opposed to taking life. The overall concern is that linking PAS to the practice of medicine could harm the public's image of the profession.

5. The fallibility of the profession: The concern is that physicians make mistakes. There may be uncertainty in diagnoses and prognoses. Therefore, the state must protect lives from these inevitable mistakes.

Supporting these counter-arguments is the study, "Gender and Physician-Assisted Suicide: An Analysis of the Kevorkian Cases, 1990–1997," which examined 75 suicides that Dr. Kevorkian admitted to assisting during 1990–1997. Most of these had a disabling, chronic, non-terminal stage illness. In 5 female cases, the medical examiner found no evidence of disease. About half of the women were between the ages of 41 and 60. Conversely, men were almost as likely to be middle-aged or older adults. Their conditions were less likely to be chronic or in a non-terminal state than the women's. The main reasons for the hastened deaths mentioned by the people and their significant others were that they had disabilities, were in pain, and feared being a burden (34).

All topics were discussed in private. The conversations also include discussions of mortality and final arrangement planning. This basis in the literature led to the 56 multipart structured questions asked of the retirees.

Research design and instrumentation

Respondents came from two senior centers in Florida that are geographically distant enough to avoid overlap. Twenty retirees were from each senior center. Approximately 750 retirees are registered as members at each center.

Respondents ranged from 64 to 90 years of age. With the approval of each senior center governing board, a sign-up sheet was posted for volunteers to participate. The sign-up sheet explained the purpose of the study and acknowledged that each person was volunteering and could stop the interview. However, there were no incentives provided for participation. Furthermore, there was concern about gender disparities prior to the interviews, as more than four times as many retirees are widows as widowers (36). However, one center yielded an equal number of males and females, with 10 each. The other center had 11 females and 9 males.

Volunteers were contacted to arrange a private interview that began with completing informed consent. Each person was allowed to be interviewed at their home or the center. Participants were again informed that participation had no direct benefit but that completing the project would benefit retired seniors everywhere. Each person was assured confidentiality and that no identifying information would be part of the final paper. This approach is a convenience sample with some randomization from the volunteer nature of the sign-up (37).

The structured questions are in **Appendix A**. Interviews were recorded and transcribed. Only one researcher conducted the interviews, a female aged 80. Analysis of the responses came after the completion of all interviews. However, during the interviews, specific patterns started to appear. Conversations coalesced around certain topics, and the order of questions deviated accordingly.

Findings

As noted earlier, the interview began with an explanation of the purpose of the study. The interview continued with the completion of the informed consent. Several demographic questions were utilized at the beginning of the interview to build early rapport. These early questions were relatively simple and designed not to be intrusive.

As a result, several of the questions are categorical and demographic, such as "How old were you when you retired?" Responses to several of these types of questions are in **Table 1**. In addition, categorical questions are asked throughout the interview. Where deemed appropriate, the answers to these additional categorical questions are in **Table 1** and have been noted in **Appendix A**.

Living arrangements and financial plans begin with "what were your plans when you retired?" Responses demonstrate quite a bit of intentionality in preretirement planning and retirement choices. Traveling, playing golf, playing more duplicate bridge, playing tennis, volunteering where needed, and spending quality time with family and grandchildren were all options. Others were less definitive, and some had no plans at all. Similarly, there were various answers to "Where would you live when you retire?" The biggest takeaway came from the follow-up to these responses. Plans to locate in a particular locale did not work out because of family conditions or financial setbacks. Even though their plans had to be changed, almost everyone was satisfied that the move had been for the best in the long run.

Sixteen males lived with their wives, one with his daughter, son-in-law, and granddaughter, and three lived alone. One said, "I would rather be happy alone than miserable with someone else." Of the females, 14 lived alone, 6 lived with their husbands, and 1 widow lived with her mother.

The most significant impetus behind the "best-laid plans" not working out was changed health or finances. The conversations around financial aspects seemed to go as expected. Unlike housing, "Do you have an investment plan?" resulted in reasonably standard answers. Fifteen of the females had financial plans with or without professional help, while sixteen of the males reported plans. The balance of the participants said they did not have a formal plan. The most common word used to describe the financial aspects was "comfortable." Life insurance only accounted for approximately half of the respondents' plans. All had medical insurance, while only half had dental insurance. The

TABLE 1 | Summary of responses to categorization of demographic questions.

Question number from Appendix A	Questions	Center 1		Center 2	
		Female	Male	Female	Male
		N = 10	*N* = 10	*N* = 11	*N* = 9
1	How old were you when you retired?	Range	Range	Range	Range
		26–67	55–78	46–76	54–77
2	How old are you now?	Range	Range	Range	Range
		64–85	68–83	65–89	70–80
7	Do you live alone or with other family members?	Alone 5	Alone 1	Alone 9	Alone 2
		Others 5	Others 9	Others 2	Others 7
8	How has your health been since you retired?	Good 7	Good 5	Good 8	Good 7
		Fair 0	Fair 1	Fair 1	Fair 0
		Poor 3	Poor 4	Poor 2	Poor 2
11	Do you have a pet or pets?	Yes 2	Yes 3	Yes 4	Yes 3
		No 8	No 7	No 7	No 6
14	Do you have life insurance?	Yes 3	Yes 7	Yes 6	Yes 8
		No 7	No 3	No 5	No 1
27	Do you recycle?	Yes 10	Yes 10	Yes 11	Yes 7
		No 0	No 0	No 0	No 2
29	Do you do volunteer work?	Yes 3	Yes 4	Yes 8	Yes 4
		No 7	No 6	No 3	No 5
39	Have you ever been the victim of a scam?	Yes 2	Yes 2	Yes 2	Yes 2
		No 8	No 8	No 8	No 7
40	Do you participate in various lotteries? Florida Lottery, Reader's Digest, Publisher's Clearing House?	Yes 4	Yes 6	Yes 3	Yes 3
		No 6	No 4	No 7	No 6
50	Do you wear a seat belt when you are in your car?	Yes 9	Yes 9	Yes 10	Yes 8
		No 1	No 1	No 1	No 1

respondents were asked about their wills as part of their financial planning. All but 1 had a will, and 34 had living wills.

Despite considerable planning, these retirees acknowledge that income was lower after retirement. This lower income had some impact. One male responded, "I can't travel and see my children as much." Four others also commented on a reduction in travel, while one mentioned that he had stopped investing. Two mentioned either not buying a new car or giving up their car. The balance said they could not think of any changes, with four saying they were living a better lifestyle today.

The final question dealt with arrangements after death. Almost all the retirees from both centers had prepaid funeral plans or instructions for their survivors. However, four of the nine males at one center said they had no plans. The other five desired cremation. All 11 females from that center wanted cremation, but 1 wanted a memorial service, also.

Cremation was the plan of choice for 7 of the 10 males at the other center. One other had no plans; a second wanted a vault, and a third wanted a below-ground burial. However, 5 of the 10 females wanted cremation. It made no difference to one of the other 5 females, while a second one wanted to be buried in a mausoleum in New Orleans. A third wanted whatever the children wanted. A fourth had bought a burial plot and a headstone, and the fifth wanted no service but burial below ground with family at the graveside.

Related to funeral arrangements were plans for treasured items. Most people have certain objects—art, jewels, antiques, crystal, or silver— that they have enjoyed over the years (38). Most had been giving away things for years and were almost finished. The son and daughter of one will select what they want. Several were undecided; three others thought it was a good idea but had not done anything yet. Of the last two, one said material things did not mean anything to him, and three said they did not have anything to give away. The others had no comment.

A recurring theme during all conversations was discussions about children and grandchildren. The number varied for males from nine to zero. Four was the most significant number the females had, one having none. The retirees' children played and continued to play an essential part in these people's lives. Over and over, grandchildren were mentioned. Retirees reported that the desire to be a part of their families' lives dominated their reason for living where they did.

After retirement, and usually after a physical move has been made from one location to another, the big question always arises of where to live and what kind of place to live

in. After moving to a new location, retirees sometimes want to rent for a time to decide exactly where they want to live permanently and in what sort of accommodation they want to spend their lives. Some people thrive on moving from one new place to another new place. They are interested in making new friends and living in different places. Perhaps because of their past jobs, others have been forced to make many moves. They want this one to be their last. All sorts of thinking and planning go into a retirement move. Of the 10 males at the one center, 7 lived in a home and owned it; 1 lived in a condominium and owned it; 1 lived in a villa and owned it; and 1 rented a condominium. Eight of the ten females lived in homes and owned them; one lived in a condominium and owned it, while one rented a townhouse. At the other center, eight males lived in a home and owned it, while one lived in a condominium, which he owned. The females had their own pattern of domicile living. Eight lived in a home and owned it; one lived in a condominium and owned it; one lived in a rented home; one lived in a rented condominium, and one lived in a rented apartment.

Two other essential lifestyle questions discussed were prior relationships. One question was about previous divorces, and the other was about the death of a spouse. One of the nine males at the one center had been divorced. Four of the eleven females had been divorced. Three of the ten females at the time had been divorced; seven had not. Four of the ten males at the other center had been divorced. Of the ten males, only one had lost his spouse. Three of the ten females had lost their husbands. Likewise, at the other center, a man had lost his wife. Nine of the eleven females had lost their husbands.

There are several options for the use of free time in retirement. Questions become less personal in this part of the interview. This conversation section began with a two-part question: "Do you own a computer? Do you use it?" Nine females across both centers reported having computers, and all used them. Thirteen males had computers, though two never used them.

Those that did have computers reported using theirs in many ways.

- Checking the stock market and medical research
- Setting up a database for wife's business
- Playing bridge, solitaire, and other games
- Searching the Internet, and accessing bank accounts
- Checking emails and receiving pictures from children
- Writing letters, papers, or the senior center newsletter
- Follow-up on genealogy, play solitaire, and write papers for writing class

Beyond computers, another way to occupy time is with pets. Some suggest that the owners do not have time to be lonely. One in every eight females at one center did not have a pet; one had two dogs; and one had a cat. Of the ten males questioned, seven had no pets, one had a dog, one had a cat, and one had a dog and cat. One group of seven females did not have a pet, while two had a dog, one had a cat, and one had a parakeet. Six males had no pets, while one had two cats, one a cat, and another a dog.

A large part of our entertainment for retirees is television (TV). All watched TV, but the amount varied a great deal. They watched "not much" or "one to 2°h a day" to "4 or 5°h a day." Others responded that they watched TV "occasionally" to "3—4°h a day." It would appear that watching TV took up a large part of their waking hours.

Their opinions about TV varied; one "considered it an abomination and a waste of valuable time." Another felt "it was wonderful and a great way to spend retirement time." There was variation in what was watched from sports, news, comedy, game shows, and movies. Others added PBS, Discovery and History channels, and soap operas. The Weather Channel and Golf Channel were also mentioned. Alternatively, there is live entertainment as well. About half reported attending professional events or the local community theater.

Many retirees' time is dedicated to religious, social, or civic organizations.

Most of the interviewees listed several organizations to which they belonged. Some of these are the following:

- Local senior center
- Five belonged to local country clubs
- Nine belonged to American Contract Bridge League (ACBL)
- Masonic Lodge, Elks, American Legion, Knights of Columbus
- Nine belonged to AARP

Religious affiliations were not frequently mentioned. It appeared that structured religion was no longer necessary. Seventeen men did not report themselves as more spiritual. A similar percentage of females answered "no" to the question about spirituality. One said she "was more spiritual but in a different way." One said, "She did not believe in God." However, six reported religious affiliations, with one saying, "Church is important."

Other questions were about hobbies and genealogy. Seven of the ten male retirees played duplicate bridge as one of their hobbies; two enjoyed golf, and two were readers. These retirees played other games like dominoes, cribbage, canasta, and pinochle. One liked to swim; one liked to square dance; one liked shuffleboard; one liked to fish, and another liked to go on gambling ships. The females at that center had different hobbies. Nine of the ten enjoyed duplicate bridge; two enjoyed swimming, and two played tennis. Two liked to garden, one mentioned knitting, while others enjoyed investing. Four indicated that reading was a favorite hobby.

Five of the eleven female retirees at the other enjoyed duplicate bridge; eight read everything available; two enjoyed

sewing and one enjoyed knitting; one collected cat figures; two painted; one grew orchids, one was a gourmet cook; one played the organ; one was a bell ringer; and one played bingo. Eight of the nine males enjoyed duplicate bridge. Four people played golf, two went fishing, and two said their favorite hobby was reading. One collected books and jazz records; liked to garden; traveled 2 months out of the year; did woodworking; and enjoyed crossword puzzles.

Few of the respondents reported doing volunteer work. One stated she waited, "She waited to be asked to help." Others felt that their health conditions would not allow them to volunteer. Of course, that is a legitimate reason not to do so. Places with familiarity dominated the places these retirees volunteered. One did maintenance at his church; one taught bridge; and two were volunteer officers at their senior center.

The question turned to motivation and satisfaction: "Are you satisfied with your way of life? Do you plan to make any changes?" Most affirmed their satisfaction, though one missed his wife; one wished he had more mobility; and one said he was only moderately satisfied. The females were also satisfied, though one wished she had more money. At the other center, one male was dissatisfied, and that was because he had difficulty breathing. None of the ten planned to make a change in their lifestyle. Six of the female retirees were satisfied, and four were not. One of the four wished she were younger. Three of the ten planned to make a change in the future. One would move in with her daughter; a second would move to a different part of Florida; and a third would move to a different state.

When asked if they felt they had aged well, the 11 females of the one center answered with seven "yes" answers. The four others said "average," "usually," "not in the last few years," and "yes," emotionally, but "no" physically. Six of the nine males said, "yes," but three said, "average," "reasonably," and "fairly." Seven of the ten males at the other center said, "Yes." The other three had different "no" answers. One said, "on and off"; another said, "reasonably"; and the third said he had smoked for 50 years and now had breathing problems. Again, seven of the ten females said, "Yes." One who said "no" qualified it by saying "yes physically" but "no cosmetically." The two others answered "no" because their joints and knees hurt, making it difficult to get around.

Are you wiser now? All nine males said "yes" with some interesting comments. One said, "He took more time to make decisions." Another said, "he didn't smoke or drink or abuse his body as much." "I look back at how stupid I had been but had learned my lesson on gambling." The 11 females had 11 "yes" answers, but they added their thoughts after they had said "yes." Several felt that experience was a good teacher when you learn life's lessons.

Four of the males at the other center said "no." One did not know if he was wiser or not. Four of that center's females also said "no." Of the other six, one had learned by having a lot of responsibility thrust upon her. Another did not jump to conclusions as quickly as she once did. One was more observing and less judging. One saw things from a different perspective, and the last one was wiser in every way.

Of the nine males, four said they were never lonely. One of the other five said "yes" but did not explain. A second one said "sometimes" without explanation, and a third said that he had had terrible spells of loneliness since his wife died. A fourth enjoyed having people around, and when he was alone, he was lonely. Four of the eleven females said "no" to the question of loneliness. Three of the other seven said, "Yes, but they handled it." Two said they needed someone to talk to or discuss their problems. Two also said they felt lonely around holiday times. Eight of the ten other center males were never lonely. One said "yes" to the question without explanation, while the other said "sometimes" because his children were far away. Three of the ten females said "no." One of the other seven said "seldom," while another said "a little." One said weekends were very bad, and the other said she was bored, not lonely. A third said, "Once in a while." The last two missed male companionship.

This question came to break up any tension that might have occurred; "Can you program your VCR?" The answers were affirmative and helped dispel stereotypes of retirees unfamiliar with technology, though five could not. Two others said, "with difficulty." The balance answered proudly with a "yes."

Another set of questions about lifestyle but also health was about drinking habits. This question, as with others, elicited many different answers. Two of the eleven females at the one center did not drink anything. Four had a glass of wine every day. Of the others, one drank very little, and one had bourbon before dinner; another had a drink once a week, and the last had something to drink once a month. Of the nine males, three did not drink at all. One had one gin drink, two glasses of wine, and one beer daily. Another had a martini every day and either beer or wine with dinner. One had two glasses of Scotch a day. A fourth had one beer daily, wine with dinner, and hard liquor twice a week. A fifth sometimes drank at a party, while a sixth had two beers and two glasses of wine daily.

All ten men drank some at the other center, but there were definite limits. One had gin and tonic twice a week; another had a cocktail every day and wine with dinner. One Scotch every day was the limit for a third, while three others had wine with dinner. Beer seemed to be the most popular drink; two retirees drank one or two beers daily, another two beers a week, and a fourth drank beer on cruises. One final retiree had wine thrice a month and a highball once a month. Two of the females drank nothing. There were three occasional drinkers. One drank a cocktail, another drank Scotch, and the final one drank a vodka drink. One said she had two drinks every day before dinner, and the last one had two glasses of beer and half a container of wine every week.

As seen in the earlier responses, health is a significant driver of choices and motivation in retirees' lives. Health was even a reason for early retirement. However, the responses

fluctuated from "good to fair to poor." One of the males died of a massive heart attack before completing this project.

The retirees were not hesitant to discuss health and were willing to elaborate on their health status after retirement. They listed all the ups and downs they had faced since retirement. Five of the ten males said no significant changes had occurred in their health since they retired. However, it was pretty different from the other five. One had had a heart attack, spinal surgery, and foot and eye surgery. Another had severe breathing problems. The third had had radiation treatment for the prostate. The fourth had a heart problem and was due for surgery shortly. The fifth had had heart surgery and phlebitis. Of the five females from that center, four reported various serious problems. The first had gained excessive weight, had had gall bladder and foot surgeries, and had had three joints fused. A second female had had three heart by-pass surgeries, a heart valve replacement, and esophageal cancer. The fourth had had a mastectomy, arthritis, and osteoporosis.

In the other center, one male had problems with bones and joints. A second male had had a heart attack, a quadruple by-pass surgery, and four strokes. A third took 15 pills a day to counteract diabetes and high blood pressure. Unfortunately, he had also lost a kidney and his gall bladder. A fourth male had high blood pressure and edema and was on medication for diabetes. The females fared better, with one having a seizure disorder and pre-penicillin rheumatic fever. The other had had a fractured hip, which caused her to use a cane.

Beyond medical issues, sight, hearing, and dental problems are common complaints. Of the 40 interviewees, 10 had no problems. Nine of the males either had cataracts or had had surgery. Three had glaucoma but were using drops to control the pressure. One had an undeclared problem. The females stated that one had macular degeneration. Five had cataracts, at present or after cataract surgery, two had glaucoma, and four had corrected lenses.

Four males wore hearing aids, two had tinnitus, and one had a high decibel problem. Three females had to ask people to repeat what had been said in a conversation; one had a blockage in the Eustachian tube; one used a hearing aid.

Fifteen of the nineteen males had no dental problems. Two had dentures. One took his out to eat! One would lose a tooth shortly, and one still had 20 of his 32 teeth. Of the 21 females, 15 had no dental problems. Three had dentures; one had had tooth implants; one had painful dry mouth; and one still had 24 of her teeth.

Despite these obvious health challenges and the literature suggesting longevity was not desired by retirees, the response to whether they wanted to live to be 100 was mainly affirmative but dependent on current and future health. Seven of the ten males from the one center said "yes," and three said "no." There were some qualifications to the "yes" answers, but they all followed the same line—they wanted to be healthy, mentally and physically. One liked life so well that he wanted to continue it. One wanted to see his grandchildren grow up. One felt there was "lots to look forward to." Of the three who did not want to live to be a hundred, one said he was having a hard time now with his aches and pains; the second said the quality of his life was poor; and the third said, "Hell no. I won't be mobile." Six of the females wanted to live to be 100 if healthy. Quoting one of the six who said, "It seems like a good thing to do. I haven't decided what to be when I grow up." One of the four who answered "no" said it was because of poor health now. The other three were adamant when they replied, "No."

The nine other males were divided into five who did not want to live to be 100 and four who did, with qualifications. One "no" person said, "Physical and mental deterioration is no fun." Another said he did not want to be incapacitated, and a third said he did not think he would have all his faculties. One last retiree wanted to live to be 100 but not in a nursing home. I quote one of the "yes" responders who said, "I don't want to check out early." Five of the eleven females said, "yes," but only if they stayed healthy. Five of the six who said "no" had seen close relatives outlive their usefulness, which had made a definite impression on them. One said, "The world would be singularly unpleasant."

It did not seem that mental health challenged the respondents. Two females said they had depression but were not on medication. One answered "yes," and she was on medication. Three males admitted to being depressed sometimes, while one said he became depressed when he thought he had no control over death. Two of the males took medication for depression. Those answering that they did not have depression had various answers like "seldom," "not excessively," and "occasionally."

Many retirees have noticed a change in their sleep patterns. Thirteen of the twenty females now took naps, while sixteen of the males reported taking naps. Frequency ranged from "occasionally" to 3−4°days a week to every day. One said vehemently, "Never." At one center, six males reported changes in their sleep patterns. One used to sleep 8−10°h a night but now has insomnia and sleeps three to four. A second person blamed arthritis for causing breaks in his sleep. A third retiree sleeps more; a fourth used to rise early but sleeps late now. A fifth found sleeping challenging, while a sixth had to get up in the middle of the night. Only three females at the center reported changes, such as getting up in the middle of the night, but one said she goes back to sleep.

Seven males report changes, with two saying they sleep more; another sleeps less. One has no schedule, so he sleeps when he can. A fourth is awake for 2 or 3°h during the night. A fifth has never been a good sleeper, so he takes medication at night. The sixth had a trace of narcolepsy. One female at that center takes medication to help her get to sleep. Another needs help because she gets wound up, but she did not specify what kind of help she uses. A third said her bladder made a difference, and a fourth said her sleep patterns had changed, but she did not elaborate.

As noted in the literature discussed earlier, exercise is a significant benefit to older health and is seen positively by retirees. Five of the males answered "no" to the question of whether they exercise—with four having no explanation and one because of breathing. Six of the females did not exercise. Those that did exercise were quite active in various ways.

- playing golf two to four times a week
- walking 3 to 5 miles a week
- going to the gym thrice a week, using barbells and treadmills
- swimming and water aerobics were very popular
- tennis and low-impact exercise was mentioned once each
- one mentioned riding a bike

The literature suggested hesitancy by retirees in discussing arthritis. Therefore, the question about arthritis was purposely put later in the discussion. The goal is to differentiate other health issues from the pain associated with arthritis Twelve of the males had arthritis, but only two categorized it as "moderate" or "some." Eighteen of the females had the disease. It is noteworthy that none had brought up arthritis in earlier health discussions.

Of those with the disease, two had the disease in all joints; two had it in the shoulders and neck; two had it in their hands; and two had it in their fingers. Some reported various pelvis, neck, shoulders, and spine locations. The disease was found all over one retiree's body in one instance. The impact of the disease on retirees is evident in that five females could not open medicine bottles, five had "great difficulty" in their attempts, and four males could open the bottles "with great difficulty." Six of the eleven females from Melbourne could open the bottles, while the other four had difficulty; one could not open the bottles.

Other health conditions such as diabetes and high cholesterol were not prevalent among these retirees. However, those with these conditions took the needed medications. Medications mentioned were for arthritis, high cholesterol, high blood pressure, diabetes, and ulcers. Some noted how expensive the medications were.

The question about memory sparked joking responses about having "senior moments." It seems to many that the things that are not too important, such as names, phone numbers, and the like, are the ones that are apt to be momentarily lost. This lack of memory frustrated others, whose brains had continuously operated rapidly and correctly.

Some said their memories were "good and bad," "have dropped some," "so-so," and "getting worse." While one realized Alzheimer's was a potential outcome, the other nine did not worry about it. One of the females said her memory had always been bad and had not improved. However, the second one said her memory was excellent. The others ran the gamut of replies from "fair" to "O.K." to "good." Fourteen of the retirees had concerns and worries about Alzheimer's. One female spoke about her fear of "losing contact with the outside world."

Very few of the interviewees had any knowledge of HIV/AIDS among retirees. Fourteen females did not know about this problem and had read nothing about it. Those who had had responses, such as one saying it was nature's way of taking care of overpopulation. The last one said that we needed more education. Twelve of the males knew nothing about this issue. One did know but had no comment. Another had not given the problem any thought. Finally, one responded, "Let them do their thing if they want to take chances."

The final questions concerned the retirees' feelings about PAS. Seven of the forty interviewees were against PAS. Their reasons include the following: Two said, "You don't have the right to kill anyone, not even yourself." A third did not believe in PAS. Another did not believe it but did not condemn anyone. Number five did not think it was a good idea. It was against the sixth person's religion. Another said, "The Lord did not put us on this earth to commit suicide." The last comment was, "When the Lord says it is time to die, the person will die."

However, the 33 other retirees favored PAS, and their reasons were varied. Several said it had to be a personal choice. Two believed people should have control over their own lives. In addition, it was an appropriate option for a mentally competent person. "Anyone against physician-assisted suicide was trying to impose his/her beliefs on another person," said one. Most others who spoke about patients being in terrible pain believed there was no reason to let people continue suffering.

One interesting sidelight to this question was that three people who were pro-PAS were so if proper controls were used. They indicated that there had been cases of organ harvesting after a person's death, so this should not be a reason to persuade an ill person to agree to PAS.

Conclusions and implications

In this century, we are experiencing a biotechnological revolution. In the book *Life Script* (39), the author predicts that this revolution will wash over us in three overlapping waves. First will come what has been called individualized medicine. Doctors will match drugs to our specific genotypes, and instead of fixing diseased organs, they will grow and implant new ones. The second wave will bring breakthroughs in gene therapy as it applies to reproduction. Fertilized eggs will be treated *in vitro*, for example, to increase the person's height or intelligence or to prevent depression or other illnesses. Finally, these advances will result in a third wave, increasing how long people will live. Wade suggests we may expect 320 years to be an average life span.

Such an outcome would attenuate the relevance of this study's findings. Future retirees would have to reimagine their financial and living arrangements. Lifestyle choices would have a very different time horizon. Furthermore, medicine would have to prolong life and reduce disease and suffering. Finally, marketers would have to adjust to new needs and wants.

The retirees of this study were undoubtedly not homogeneous. While there were clear tendencies around family and maintaining health, no topics achieved unanimity. Instead, most feelings and responses had majorities, with a substantial minority having differing views. More variation in outlooks seems likely under the scenario outlined earlier of longer lifespans.

This study indicated that acquiring goods beyond specific medicines seemed to be a low priority for these retirees. In addition, wealth accumulation was not a significant concern. It seemed this group of respondents had planned well and had sufficient, if not excess wealth, in contrast to some literature (40). Instead, retirees desired time spent with family, many desired to travel, and the majority desired relief from the pain caused by health issues.

Most of the interviewees had endured no traumatic experiences. Some have had to abandon their exact plans for the future. However, as the saying goes, nothing is ever assured in this life except death and taxes. Furthermore, the responses did not indicate differences between genders. This lack of gender differences in responses is particularly salient for marketers.

The qualitative nature of the response will assist marketers in seeing and understanding retirees' hopes and fears. The findings note the adjustments they made, which they felt were significant. Many other adaptations appeared to be minor from these retirees' perspectives. The responses give insight into the planning of their retired lives.

The responses should be considered a starting point for segmentation and targeting. Additional work to refine specific value propositions would be necessary. However, the themes of experience, family, and health are all solid foundations for messaging and appeals.

Limitations

The research sought depth and quality, not quantity. Such an approach limits generalizability. Some questions caused the retirees to think long and hard about their answers. The questions were not meant to be prying, but their answers helped other retirees. Some individuals may have never consciously asked themselves these questions. As a result, there is a possibility of a constructed response. It is also just as likely that the responses were honest answers.

The limited scope of this study does not lend itself to generalizations. There have been honest answers to honest questions and honest discussions where appropriate. Validation of this research will come from the participants' answers and not from confirmation by statistics from other studies.

As the research study began to go forward, it was necessary to gain the blessing of the boards of these two senior centers before posting a sign-up sheet for volunteers. The recruitment process of the two boards' permission to place volunteer sign-up sheets on all bulletin boards may have created a selection bias. This potential was somewhat alleviated by asking for volunteers from two separate senior centers with little or no overlap in membership. The gender balance also helped minimize any resulting bias.

The interviews were not audio or video recorded. A tape recorder was used to document their answers. Retirees could be comfortable speaking directly. Notes were taken very discreetly to keep a conversational attitude. Notes were immediately transcribed, with additional details added from recollection. This approach could have introduced errors that might have limited the study. Debriefs with five subjects after compiling the notes indicate only minor errors.

Author contributions

JW and MW contributed equally to this research and publication.

Conflicts of interest

The authors declare that the research was conducted in the absence of any commercial or financial relationship that could be construed as a potential conflict of interest.

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Appendix A

Structured questions asked of interviewees

1. How old are you?*
2. How old were you when you retired?*
3. What was your job before you retired?
4. What were your plans when you retired?
5. Did you think about where you would live when you retired?
6. How has your income changed since your retirement?
7. Do you live alone or with other family members?*
8. How has your health been since you retired?*
9. Do you have children? How many?
10. Do you own a computer? Do you use it?
11. Do you have a pet or pets?
12. Do you have an investment plan?
13. Do you live in a home, an apartment, a condominium? Do you own or rent?
14. Do you have life insurance?
15. Do you have medical/dental insurance?
16. Do you have a will? Do you have a living will?
17. Do you watch television and if so, how much?
18. What do you watch? News? Quiz shows? Soap operas? Sitcoms?
19. Do you attend the local theater for the performing arts?
20. Do you attend the local community theaters?
21. Can you be more specific about changes in life style because of lower income?
22. Can you be more specific about changes in your health since retirement?
23. How do you use your computer?
24. Do you like living alone or with family members or others?
25. How is your sight? How is your hearing? Do you have dental problems?
26. To what religious, social, or civic organizations do you belong?
27. Do you recycle?
28. Do you have any hobbies?
29. Do you do volunteer work?
30. How often do you see relatives? Do they come, or do you go?
31. Are you satisfied with your way of life? Do you plan to make any changes?
32. Do you want to live to be 100 years old? Why or why not?
33. Do you feel you have aged well?
34. Are you wiser now? In what ways?
35. Are you more spiritual now?
36. Do you have emotional good health? Do you become depressed?
37. Have your sleep patterns changed since you retired?
38. Do you sometimes nap during the day? How often?
39. Have you ever been the victim of a scam?*
40. Do you participate in various lotteries? Florida Lottery, Reader's Digest, Publisher's Clearing House?*
41. Do you exercise? How? Where?
42. Do you ever feel lonely? Explain.
43. Can you program your video cassette recorder (VCR)?
44. Do you have arthritis? How does it affect you?
45. Can you open a "childproof" medicine bottle?
46. Do you have diabetes? Do you administer insulin yourself?
47. Do you have high cholesterol? Do you take medication?
48. Have you been divorced?
49. Has your spouse died?
50. Do you wear a seat belt when you are in your car?*
51. How do you feel about giving away keepsakes, now, to family or friends?
52. Do you drink hard liquor, wine, or beer? How much?
53. Did you plan your funeral after your retirement? Cremation? Below ground?
54. How is your memory? Do you worry about Alzheimer's disease?
55. What is your response to the high rate of HIV/AIDS among retirees?
56. How do you feel about PAS?

*The answers to these questions are in **Table 1**.