ALFs range from a standalone residence to one level of care in a continuous continuing care retirement community (independent living to skilled nursing home level). The physical environment of assisted living is often more a homelike atmosphere. They can be apartment style, typically including studio or one-bedroom models with kitchenettes that usually feature a small refrigerator and microwave to allow for all individual preparation of food.

Assisted living communities are designed to provide residents with a life as independent as possible. To maintain this independence, ALFs may provide assistance with basic ADLs such as bathing, dressing, and grooming. In some states, they are allowed to offer medication assistance and reminders. Assisted living communities differ from nursing homes in that they do not offer complex medical service. Typically, assisted living communities offer their residents prepared meals three times a day, and help with light housekeeping and laundry (these may be fee-for-service items).

Depending on the community, residents may have access to fitness area swimming pools, beauty salons, a post office, and transportation. Communities also have planned events, activities, and trips that residents can purchase. In some ALFs they have anything from happy hour to concerts. Assisted living communities range from small homes to large campuses. Some allow residents to keep pets to maintain a more home-like atmosphere, if they can care for them.

Assisted living residents usually have a slight decline in health or need assistance in performing one or more activities of daily living. Those who live in assisted living usually want to live in a social environment with little responsibility. Ideally, a facility works to provide supportive services to meet the residents’ needs to avoid discharge to a nursing home.

Assisted living is typically paid for out of private funds but there are a few exceptions. Some long-term care insurance policies cover assisted living facilities. If a resident was a war veteran or a spouse, they may qualify for veterans’ benefits that can help pay for assisted living. A limited number of state Medicaid programs fund waiver programs to help with assisted living costs.

An assisted living facility is not a permanent home but a step along the continuum of long-term care. Most residents (77 percent) move on to nursing home care.

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See Also: Caring for the Elderly; Elder Abuse; Nursing Homes.

Further Readings

Assisted Reproduction Technology

Assisted reproductive technology (ART) is an overarching term that refers to the methods used to achieve a pregnancy through artificial or partially artificial means (i.e., when intercourse is not used to achieve pregnancy). A broad range of ARTs have emerged since the 1960s. Established technologies such as artificial insemination (AI) and in vitro fertilization (IVF) as well as a newer technique of egg donation, have created opportunities for many previously infertile couples to have genetic children or to rely on the gametes of others to produce a child who has a genetic connection to only one—or neither—parent.

Because these technologies have been made available to a broad variety of individuals, including single mothers by choice and both gay and lesbian couples, a broader variety of families have become more commonplace. Simultaneously, the growing labor-force participation of women has led many to postpone their first pregnancies. The new technology of egg freezing may make it possible for these women to counteract the natural decline in fertility that comes with age. All of these technologies—and the family forms to which they
Family Secrets
About 10 to 15 percent of heterosexual couples in the United States have difficulty becoming or staying pregnant after one year of having unprotected sex. In earlier eras, there were limited methods available to assist these couples. Although artificial insemination is hundreds of years old, it only became common in humans in the second half of the 20th century, and for many years after that it was the only method that successfully treated infertility caused by a primary deficit in the husband's gametes. The doctor secured donor sperm, often from local medical students, to impregnate the wife. Sometimes, husbands were not told about this procedure; sometimes, their sperm was mixed with that of another; often, couples were told to have intercourse after the insemination. Whatever the arrangement, marriage law made the husband the legal father.

Because DNA tests were not widely available until the 1990s, the use of another man's gametes was shrouded in secrecy. As donor conceived (DC) children grew up, they might wonder who they resembled, but few families discussed their method of conception. Only recently have families begun to be more open about these issues. Now, families grapple with questions about whether or not to disclose AI to their children (and if so, when), whether a donor should be allowed to remain anonymous, how much importance to accord the donor, and whether the donor should be viewed as genetic matter alone, or as some sort of social relative.

The New Medical Era
The births of Louisa Joy Brown in 1978 in England and Elizabeth Jordan Carr in 1981 in the United States ushered in a new era of reproductive medicine. These births relied on the manipulation of a couple's gametes, and were dubbed “test tube babies” because the embryo was created outside the mother's womb and then implanted in her. This new technology of IVF was greeted by some with moral repugnance: the Catholic Church opposed IVF because the marital embrace of love and the conception of children were separated by the technology; others (including many feminists) worried that this new technology could allow wealthy women to hire women of lower social classes to have children for them.

IVF initially offered women with medical conditions, such as blocked fallopian tubes, a way to become pregnant with their own eggs. IVF was also sought by couples with a combination of infertility issues and couples with genetic problems who wished to avoid passing them on to a child (because they could select embryos that did not have certain markers). In the early years, the success rates were low, the procedure was only offered to heterosexual married couples, and few could afford it. Some of this has changed: success rates have risen to approach natural fertility for women under 38 years old (30 percent of all ART cycles result in a live birth), the procedure is more widely available, and more states now require insurance policies to cover infertility treatments. Women over 38 may also rely on IVF, but donor eggs increase their chances of having a child. And whether young or old, individuals desperate to have a child through a mother's pregnancy rather than by adoption, often risk financial insecurity in repeated rounds of IVF, which though less costly than it once was, is still expensive.

Commercialization of Gametes
The commercialization of gametes to be used in AI and IVF began slowly, and major shifts have occurred in the access to such gametes. In 1980, there were only 17 sperm banks across the country that sold frozen sperm to their customers. These banks offered limited information to clients, who used the banks to select donors for appropriate genetic and physical characteristics, including height, weight, and looks. By way of contrast, as of 2013, there are over 100 banks that supply frozen sperm. Even though the majority of sperm donors remain anonymous, banks now provide clients with extensive information about the donor's physical characteristics, personality, and interests.

Although the first successful use of an egg donation leading to a live birth occurred in 1984, the practice of freezing unfertilized eggs is still in its infancy. When clients purchase eggs, they go through the same IVF procedure that is used with their personal eggs (whether they are using their partner's sperm or donor sperm) to create embryos that are placed either into the mother-to-be or a surrogate. Extra embryos are frozen for
later use. Egg donation is a more invasive procedure than sperm donation, and involves extracting large quantities of eggs that are produced through the hormonal manipulation of the female patient. The purchase of younger women’s eggs, mostly by older women (and couples), is highly controversial; among the reasons for concern is the lack of research on the long-term effects of this procedure on the health and future fertility of the donor.

New Families
As family diversity has become more accepted, single mothers by choice and lesbian and gay couples are now major consumers of new reproductive technologies. In order to create families, these couples need to purchase gametes, as well as some form of assisted reproduction, even if it is AI. (Although heterosexual couples continue to use ARTs, a major technological development—intracytoplasmic sperm injection—in the mid-1990s for men with low sperm counts has led to fewer heterosexual couples seeking sperm donors.

Norms have also changed about issues of disclosure of sperm and egg donation. Among lesbian couples and single mothers, disclosure is likely to occur as part of a child’s birth narrative. When disclosure is early, children view donor conception as a natural part of their lives; when disclosure is later, children report feeling surprised and shocked. Later disclosure and its disruptive effects are both more frequent among two-parent, heterosexual families than among other family forms.

Some parents of donor conceived (DC) children and some DC children believe that the donors should not be anonymous. Parents want information so that they know more about hereditary conditions that might affect their children’s health and well-being. Children want information to satisfy their curiosity and to learn more about issues of identity. As a byproduct of the commercialization of gamete banks, the parents of DC children—and the children—can list their donor’s number on registries provided by sperm banks and independent agencies; DC children can now meet offspring who share their donor.

New Technology
Egg freezing has only been commercially available in U.S. IVF clinics since October 2012, when the American Society for Reproductive Medicine (ASRM) lifted the experimental label on that technology. Because the technology is so new, few live births have been achieved with it compared to those achieved through other well-established ART procedures. There is little data about the effectiveness of egg freezing and any possible health risks.

Even so, it is likely to become an increasingly widespread practice by women who wish to have biological children, but want to postpone childbearing until a later age. Oocyte cryopreservation is medicine’s newest answer to the “fertility penalty” that forces women to choose between furthering their careers or starting a family during their prime childbearing years; egg freezing thus mutes the ticking of the biological clock. However, egg freezing is an individual medical solution to what is in reality the collective, social problem of gender inequality in the workplace. As is the case for IVF, this is a procedure largely available to those who are wealthy: Clients must upward of $15,000 for the retrieval and freezing procedures alone.

Conclusion
More and more individuals (alone and as part of couples) are now turning to the use of purchased gametes or their frozen gametes, in combination with the full range of assisted reproductive technologies, to make a family. The families that result give new possibilities for constructing narratives about the meaning of nature versus nurture, or biological and social influences on individuals and the relationships among them. Technological innovation has combined with the market in donor gametes and the new possibility of contact between donors and recipients and individuals who share the same donor to give rise to a brave new world of social arrangements. These new arrangements have not yet acquired legal standing, even as they expand the boundaries of kinship in novel ways.

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See Also: Artificial Insemination; Fertility; Genetics and Heredity; Infertility; Technology.
Further Readings

Association of Family and Conciliation Courts

The Association of Family and Conciliation Courts (AFCC) is a worldwide organization of professionals in several disciplines who work with family courts and troubled families. It is of the only major organizations working in that field, which represents several professions. The AFCC has been a major force in many of the innovations for families over the past 50 years, including marriage counseling, divorce mediation, family courts, joint custody, court-referred family therapy, collaborative divorce, child representation, divorce education, parent coordinators, and child custody evaluations.

The group was founded as the California Conference of Conciliation Courts in 1963. It consisted of California judges and marriage counselors, mostly from the conciliation courts, a separate court system that helped reconcile people in troubled marriages before they reached the point of filing for divorce. In 1965 “California” was dropped from the title as interest spread outside the state.

By 1970, the organization’s mission was expanding. As the group’s newsletter editor Meyer Elkin put it in the title of an editorial, “A Conciliation Court Is More Than A Reconciliation Court.” California had enacted a no-fault divorce law, drafted by a commission with the original mission to reduce divorce by expanding the conciliation courts’ work. The commission’s proposal paired (1) the abolition of “fault” divorce with (2) an array of family courts providing both legal and counseling services, achieving reconciliation whenever possible, and a simple, dignified divorce when not. However, that second prong of the proposal required government funding, so it was never enacted.

No-fault divorce led to a flood of additional conflicts that cried out for the methods and skills that had developed in the conciliation courts. More unilateral forms of divorce, and fairer, more comprehensive laws about children and finances, gave courts far more issues to decide in a divorce. In the old system, economic and child-related issues were usually settled as part of a couple’s divorce agreement, but now the decision to divorce came first, with those issues litigated later. The era’s focus on justice and equality opened up more economic and child-related issues for wider and fiercer litigation. This and the increasing divorce rate moved court professionals’ daily work, and the exciting frontiers of innovation, away from reconciliation, toward family therapy, child custody evaluations, and mediation of economic and child custody issues.

In 1973, the Los Angeles Conciliation Court began a pilot program of mediation of custody and visitation. Many conciliation courts started divorce education workshops. In 1976, the conference changed its name to the Association of Family Conciliation Courts (AFCC). By the late 1970s, it had grown to approximately 900 members in the United States and Canada, with several state chapters. By the 1980s, mediation, joint custody, domestic violence, and stepfamilies had become key issues for the AFCC. An “and” was added to the name, changing from “Family Conciliation” to “Family and Conciliation.”

By the 1990s, the group was a longstanding authority on services for families. It conducted leading studies of such topics as custody, mediation, and domestic violence. It began a project to improve the education of family lawyers, and developed standards for family mediators. It worked with organizations in other countries to co-host international conferences, notably the World Congress on Family Law and the Rights of Children and Youth.

As of 2013, the AFCC had over 4,800 members in 19 countries, from many different occupations including judges, lawyers, mediators, psychologists, psychiatrists, researchers, academics, counselors, court commissioners and administrators, custody evaluators, parenting coordinators, social workers, and financial planners.