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At the age of 91, shortly before his death, Picasso painted this remarkable self-portrait. He faces his death with eyes wide open–no pretenses, some fear, some wonder.

CHAPTER

14

ELDERHOOD (75 UNTIL DEATH)

CASE STUDY FRED HALE, SUPERCENTENARIAN

Fred Hale was born December 1, 1890 in New Sharon, Maine. His biography and photo portrait are included in a book on "supercentenarians," people who have lived to be 110 or more.

Earth's Elders: The Wisdom of the World's Oldest People, *by Jerry Friedman*.

Perhaps the most amusing story from Fred came about when he was 107 and still living on his own. At that age, he was the world's oldest licensed driver.

There had been a heavy snowfall in Maine and Fred was up on his porch roof shoveling off the snow. When he finished, he hopped off into a snow bank and then went into his house to change his wet clothes. Suddenly he noticed there were flashing lights outside. When he opened the door, there were the firemen and police who'd come to his rescue. When he was told that a passerby had seen someone fall of the roof, Fred quipped, "I didn't fall, I jumped" and slammed the door.

Fred has been confined to a wheelchair and the assisted care facility after he tripped and broke his hip. That hasn't dulled his mind however. He still jokes and plays cards with his son of eighty. He read a little and loved to watch the Red Sox. Clearly, he was the oldest Red Sox fan in the world. When asked why he had lived so long he jibed, "Oh, I don't know, punishment I guess. I've enjoyed all my years, each one. I even like the recent one."

The last time we spoke I asked, "If there was one piece of wisdom you'd like to pass on to your grandchildren what would it be?"

"You have one life to live, live it well, and don't disgrace your family."

Source: Jerry Friedman, 2005, p. 80.

CASE STUDY: Fred Hale, Supercentenarian

The Longevity Revolution
- Secrets to Longevity
- The Gender Gap Among the Very Old
- A New Psychosocial Stage: Elderhood

Developmental Tasks
- Coping with the Physical Changes of Aging
- Developing a Psychohistorical Perspective
- Traveling Uncharted Territory: Life Structures in Elderhood

CASE STUDY: Mr. Z

The Psychosocial Crisis: Immortality Versus Extinction
- Immortality
- Extinction

The Central Process: Social Support
- The Benefits of Social Support
- The Dynamics of Social Support
- The Social Support Network

The Prime Adaptive Ego Quality and the Core Pathology
- Confidence
- Diffidence

Applied Topic: Meeting the Needs of the Frail Elderly
- Defining Frailty
- Supporting Optimal Functioning
- The Role of the Community
- The Role of Creative Action

Chapter Summary

Key Terms

CHAPTER LEARNING OBJECTIVES

1. Explain the rationale for identifying elderhood as a unique developmental stage for those of unusual longevity with its own developmental tasks and psychosocial crisis.
2. List the physical changes associated with aging, and evaluate the challenges that these changes pose for continued psychosocial well-being.
3. Describe the concept of an altered perspective on time and history that emerges among the long-lived.
4. Summarize elements of the lifestyle structure in elderhood, especially living arrangements and gender roles, and analyze the impact of these life structures for continued well-being.
5. Define and explain the psychosocial crisis of immortality versus extinction, the central process of social support, the prime adaptive ego quality of confidence, and the core pathology of diffidence.
6. Apply research and theory to concerns about meeting the needs of the frail elderly.

CASE ANALYSIS Using What You Know

1. Summarize your assumptions about the lifestyle and behaviors of elders. How does this case confirm or disconfirm those assumptions?
2. List five of Fred's personality characteristics. Explain how these qualities may contribute to longevity.
3. Analyze Fred's final wisdom. What are the implications of this advice for you and your family? For others in your generation?

PABLO PICASSO, WHOSE works illustrate this book, lived to be 91 years old. When he was 79, he married Jacqueline Roque with whom he enjoyed 12 years of married life. During the last 20 years of his life, he remained productive and energetic, persistently experimenting with new art forms and ideas.

Here are some other examples of people who achieved major accomplishments after the age of 80 (Wallechinsky & Wallace, 1993; Wallechinsky, Wallace, & Wallace, 1977):

At 100, Grandma Moses was still painting.

At 99, twin sisters Kin Narita and Gin Kanie recorded a hit CD single in Japan and starred in a television commercial.

At 94, George Burns, who won an Oscar at age 80 for his role in *The Sunshine Boys*, performed at Proctor's Theater in Schenectady, New York, 63 years after he had first played there.

At 93, George Bernard Shaw wrote the play *Farfetched Fables*.

At 91, Eamon de Valera served as president of Ireland.

At 91, Hulda Crooks climbed Mount Whitney, the highest mountain in the continental United States.

At 89, Arthur Rubenstein gave one of his greatest piano recitals in New York's Carnegie Hall.

At 88, Konrad Adenauer was chancellor of Germany.

At 87, Mary Baker Eddy founded the *Christian Science Monitor*.

At 81, Benjamin Franklin provided leadership for the political compromises that led to the adoption of the U.S. Constitution. ●

The Longevity Revolution

We are entering a period in which increasing numbers of people are living into old age. As the previous examples illustrate, it's not that we have no models of the long-lived in earlier periods of history, but that so many more adults are living into their80s and 90s than ever before. In 2010, 6% of the U.S. population was 75 and older, and as the baby boomers (those born between 1946 and 1964) mature, this age group is expected to reach 11% of the population. In 1980, more than 2 million people were 85 and older; by 2010, this group had grown to 5.5 million. Of these, 53,364 were 100 years and older. The 85-and-older population, which is the fastest-growing age group in the United States, is expected to reach 6.6 million in 2020 (Werner, 2011).

The 20th century was unique in human history in the large percentage of people who lived well beyond their reproductive and childrearing years into later adulthood and elderhood. This new facet of life raises questions about the pattern of mortality after achieving reproductive success and about what, if any, limit there might be to the human life span. Current projections suggest that in the United States the average life expectancy at birth will be 80 by the year 2020 (U.S. Census Bureau, 2010i). Genetically based diseases that emerge only in the second half of life, such as breast and colon cancer or adult-onset diabetes, become more common as larger numbers of people reach advanced age. At the same time, the mapping of the human genome along with medical and technical innovations hold the promise of preventing some of the diseases now associated with later life. Life expectancy is most influenced by interventions that prevent infants and children from dying, ensuring that more people will reach advanced ages of 70 or older. Interventions that influence the life expectancy at ages 70 and older, however, will increase overall life expectancy by only a few years. Nonetheless, significant discoveries that might prevent death

from cancers or cardiovascular diseases could affect large populations and continue to extend human longevity.

From an evolutionary perspective, the human species is a highly complex organism designed to survive over a relatively long period in order to find a mate, reproduce, and rear and nurture the young until they are old enough to reproduce. The adaptive value of life after this sequence is not well understood. One hypothesis is that the extended family—composed of grandparents as well as parents—provides more resources for the support of the young and forms an added protective layer against crises that might leave the younger generation vulnerable (Baudisch & Vaupel, 2012).

It is clear that there is a genetic basis to longevity. Studies of centenarians (people 100 years old and over) find that there is a relatively large number of genetic markers involving over 130 genes that predict extreme longevity. These markers become increasingly accurate in predicting which individuals will live to advanced ages of 100 and older. Studies of these centenarians find three different patterns of resilience that are associated with longevity. One group has many of the same diseases of aging before age 80 as those who are not so long lived, but they recover and continue on to advanced age. One group has delayed age-related illness after the age of 80. And one group had no age-related illnesses even at age 100. Genetic factors contribute to the compression of illness toward the very end of life and enhanced capacities for recovery (Anderson, Sebastien, et al., 2012; Sebastian, Solovieff, DeWan, et al, 2012).

Each new cohort of the very old will benefit from the information and technologies that are being developed. The more knowledge is gained about the biological processes of aging and the genetic basis of diseases and health that emerge in later life, the more likely it is that human longevity can be extended. Those adults in the current baby boom generation (born between 1946 and 1964) are quite likely to be high school graduates, to have benefited from many of the health-related innovations of the late 20th and early 21st centuries and to be even more vigorous than our current older population. The projections of increased numbers of people reaching advanced age are due to increases in longevity due to improvements in health care and fitness and to the size of the baby boom cohort.

George Gobet/Getty Images

FIGURE 14.1 Jeanne Calment, who died in 1997 at the age of 122, was the world's longest living person whose birth date could be verified. Mme. Calment liked chocolates, smoked cigarettes, and had a wonderful sense of humor. Here she displays her Guinness certificate acknowledging her record-winning longevity.

Secrets to Longevity

The very long lived, like Jeanne Calment (Figure 14.1), inspire others to ask about the factors that contribute to a long life. Jim Heynen (1990) interviewed 100 people who were 100 years or older. He found wide variations in their lifestyles and philosophical perspectives. Some of the advice they offered on how to live a long life follows:

> "Mind your own business, have a good cigar, and take a shot of brandy." *Brother Adelard Beaudet, Harrisville, Rhode Island*
>
> "I've lived long because I was so mean." *Pearl Rombach, Melbourne, Florida*
>
> "I always walked several miles a day. I'd talk to the flowers." *Mary Frances Annand, Pasadena, California*
>
> "Don't smoke before noon. Don't drink or smoke after midnight. The body needs 12 hours of the day to clear itself." *Harry Wander, Boise, Idaho*
>
> "I've been a tofu eater all my life; a mild, gentle man, never a worrier." *Frank Morimitsu, Chicago, Illinois*
>
> "I picked my ancestors carefully." *Stella H. Harris, Manhattan, Kansas*
>
> "Regular hours, taking it easy, smiling, whistling at the women when they walk by." *John Hilton, Fort Lauderdale, Florida*

A team of nutritionists, psychologists, physicians, and gerontologists interviewed 12 Cuban men and women who were reported to be more than 100 years old about their daily diets and lifestyles. The one theme they all agreed upon was the importance of an optimistic outlook on life. The coordinator of the meeting, Dr. Eugenio Selman, said that the six basic elements to longevity are (1) motivation to live, (2) appropriate diet, (3) medical attention, (4) intense physical activity, (5) cultural activities, and (6) a healthy environment. In this analysis, one sees the interaction of the biological, psychological, and societal systems (CNN.com, 2005). Surprisingly absent from this list is the role of social integration and social support. A growing literature highlights the contribution of a sense of belonging to overall health and resilience in the face of crisis (Gow et al., 2007).

The Gender Gap Among the Very Old

A discussion of aging in the United States must acknowledge the shifting sex composition of the population at older ages. In 2010, 60% of those 75–84 were women, 70% of those 85–94 were women, and 80% of those 95 and older were women (Werner, 2011). This **gender gap** in longevity is observed in virtually all countries of the world, but the differences are accentuated in the developed countries. The imbalance in the sex composition is much more noticeable today than it was 50 years ago when there were about as many men as women in the older-than-65 category. Because those currently at the stage of elderhood are predominantly women, many of the social issues of aging—especially poverty, health care, the future of social security, and housing—are also viewed as women's issues.

FURTHER REFLECTION: *The majority of the elderly are women. Generate some implications of this for social policy and community development.*

A New Psychosocial Stage: Elderhood

OBJECTIVE 1. Explain the rationale for identifying elderhood as a unique developmental stage for those of unusual longevity with its own developmental tasks and psychosocial.

The fact that an increasing number of people are reaching advanced years and that they share certain personal and behavioral characteristics leads us to hypothesize a new stage of psychosocial development that emerges at the upper end of the life span after one has exceeded the life expectancy for one's birth cohort. This is the stage of life that is experienced by the long-lived in a community who have outlived most of their age-mates. Drawing on the concept of village elders who share their wisdom and help resolve community disputes, we call this stage elderhood. Although it was not specifically identified in Erikson's original formulation of life stages, Erikson began to characterize the dynamics of psychosocial adaptation in this period of life in the book *Vital Involvement in Old Age* (Erikson et al., 1986). Throughout this chapter, we have drawn on Erikson's insights to enrich our appreciation of the courage, vitality, and transformations that accompany elderhood.

We have formulated a psychosocial analysis of development in elderhood based on research literature, firsthand reports, and personal observations to describe the developmental tasks, psychosocial crisis, central process, prime adaptive ego quality, and core pathology of this stage. We approach this formulation of a new stage realizing that in many domains—especially physical functioning, reaction time, memories, and cognitive abilities—variability increases significantly with age. With advanced age, a person is less constrained by pressures of institutionalized roles and social demands. As a result, personal preferences and genetically based sources of individuality are freer to be expressed (Figure 14.2). In addition, individual differences reflect the diversity of educational experiences, health or illness, exposure to harsh conditions, and patterns of work and family life.

Issam Rimawi/ZUMA Press, Inc./Alamy

FIGURE 14.2 Former U.S. President Jimmy Carter continues to function in an informal role as a diplomat and advocate of peaceful solutions to world problems. In 2002 he was awarded the Nobel peace prize. Here he is at age 88 coming to the West Bank town of Ramallah to meet with the president of the Palestinian Authority. In 1982 he established the Carter Center, focusing on efforts to resolve conflict, promote democracy, protect human rights, and prevent disease. The center has spearheaded the international effort to eradicate Guinea worm disease which is poised to be the second human disease in history to be eradicated.

The concept of *norm of reaction* introduced in chapter 4 (The Period of Pregnancy and Prenatal Development) offers a framework for understanding the enormous variability in vitality and functioning during elderhood. The quality of functioning in elderhood is a product of the interaction between genetic factors, lifestyle choices, and environmental supports. Genetic factors influence longevity, vulnerability to illnesses, intelligence, and personality factors that contribute to coping (Pollack, 2001). Support for a genetic basis to longevity is provided from observations from the New England Centenarian Study that found that half the centenarians had grandparents, siblings, and other close relatives who also reached very advanced ages (Perls, Kunkel, & Puca, 2002). Lifestyle factors include physical activity, diet, control over one's life, smoking, alcohol and drug use, and the quality of one's social network.

Environmental conditions include poverty, discrimination, social alienation, and lack of social support. Data comparing the life expectancy across countries suggest that environmental conditions, including air and water quality, health care services, housing, and educational resources, all contribute to longevity beyond what the individual person can control (Katch, 2013).

Variations in life experiences and outlook among the very old are great. As a result, chronological age becomes less useful as an indicator of aging. Neugarten (1981) offered a distinction that helps clarify the functional differences among the very old. She described two groups: the **old-old** and the **young-old**. The old-old have "suffered major physical or mental decrements" which increase their dependence on health and social services. This group will grow as the number of adults over 75 increases. Currently, it forms a minority of the very old. The majority of people over 75 can be described as young-old. They are competent, vigorous, and relatively healthy. They live in their own households and participate in activities in their communities. For example, among the New England centenarians studied, 90% were functionally independent and relatively healthy up until age 92 (Perls & Terry, 2007).

Our intention is to discuss some of the most salient characteristics of life after age 75 and to articulate what appears to be a psychosocial crisis specific to this period. We report evidence of common challenges and successful strategies for coping amid the great diversity of individual experiences.

FURTHER REFLECTION: *Evaluate the argument that it is necessary to introduce a new stage of elderhood in the life-span perspective. What evidence supports the need to differentiate elderhood from the stage of later adulthood?*

Developmental Tasks

Despite the wide variability in capacities, lifestyles, and worldviews in later life, three themes characterize the challenges that face individuals in elderhood. First, they must adapt to *physical changes*, monitoring their health and modifying their lifestyles to accommodate these changes. Second, they must conceptualize their lives within a new *time frame*, realigning their thoughts about past, present, and future in order to stay connected to the present in a meaningful way. Third, they must develop new **life structures**—especially living arrangements and social relationships—that provide comfort, interest, and appropriate levels of care.

Coping with the Physical Changes of Aging

OBJECTIVE 2. List the physical changes associated with aging, and evaluate the challenges that these changes pose for continued psychosocial well-being.

There is no way to avoid the realization that with advanced age one's body is not what it used to be. Erikson described it as follows:

> With aging, as the overall tonus of the body begins to sag and innumerable inner parts call attention to themselves through their malfunction, the aging body is forced into a new sense of invalidness. Some problems may be fairly petty, like the almost inevitable appearance of wrinkles. Others are painful, debilitating, and shaming. Whatever the severity of these ailments, the elder is obliged to turn attention from more interesting aspects of life to the demanding requirements of the body. This can be frustrating and depressing. (Erikson et al., 1986, p. 309)

Aging, which is a continuous process over the life span, includes both development and decline. In later life, some physical changes are considered to be normal or expected, and not especially related to disease. People who are well educated, have access to health care and other resources, and have observed healthy lifestyle practices in earlier stages of life are still going to experience some of the normative changes of aging when they reach advanced age, such as some loss of muscle strength or difficulty returning to normal respiration after periods of exertion. However, certain lifestyle practices including smoking cigarettes, alcohol and drug abuse, poor diet, and a sedentary life are likely to accelerate these patterns of normal decline. Other changes are disease related and not a result of normal aging. Some genetic factors appear to increase vulnerability to these diseases, but so do lifestyle factors, exposure to toxins, and stress. Thus, we want to emphasize that the **physical changes of aging** are multidimensional and variable across individuals. Some people who have observed a healthy lifestyle in early and middle adulthood still experience diseases whereas others who have led a more risky lifestyle do not experience these diseases. We do not fully understand the extent to which genetic, environmental, social, and lifestyle factors help support continued health or vulnerability to disease in elderhood.

The theme of the physical changes of aging can be approached much like its counterpart in early adolescence. Although the rate of change may be slower, older adults notice changes in a wide range of areas, including appearance, body shape, strength and stamina, and the accumulation of chronic illnesses. Just as in adolescence, the rate and sequence of changes vary from person to person. This section will identify major areas of physical change. The patterns of change described here are average trends. Not all adults experience all of these changes, nor to the same degree. Important issues include the meaning that adults attribute to their physical condition and the coping strategies they invent to adapt to these changes.

Most of us know older adults who are vigorous and zestful. On the other hand, we also know older adults who are painfully limited in their ability to function because of physical disabilities. Many factors influence the progression of physical changes associated with aging, not the least of which is the level of fitness that was established and maintained during early and middle adulthood. The topics of fitness, sleep and rest, behavioral slowing, sensory changes, health, illness, and functional independence combine to provide a picture of the physical changes of aging.

Fitness

There is a great deal of variation in **fitness** among people after age 75 as patterns of activity or inactivity, endurance or frailty, and illness or health take their toll. What is described here might be thought of as the usual patterns of aging. However, these changes are not inevitable and, in many instances, are reversible or modifiable with appropriate intervention (Dobek, White, & Gunter, 2007).

What are the elements of physical fitness that are typically assessed in older populations? Seven components are often included in measures intended to assess fitness among the elderly: coordination, reaction time, balance, muscle strength, muscle endurance, flexibility, and cardiorespiratory endurance (Hilgenkamp, van Wijck, & Evenhuis, 2010). Among those 75 and older, elders who exhibit high levels of fitness are also likely to report a better overall quality of life, higher cognitive functioning, lower levels of depression, and a lower likelihood of encountering physical disabilities as they age (Tainaka, Takizawa, Katamoto, & Aoki, 2009; Takata et al., 2010; Voelker-Rehage, Godde, & Staudinger, 2010).

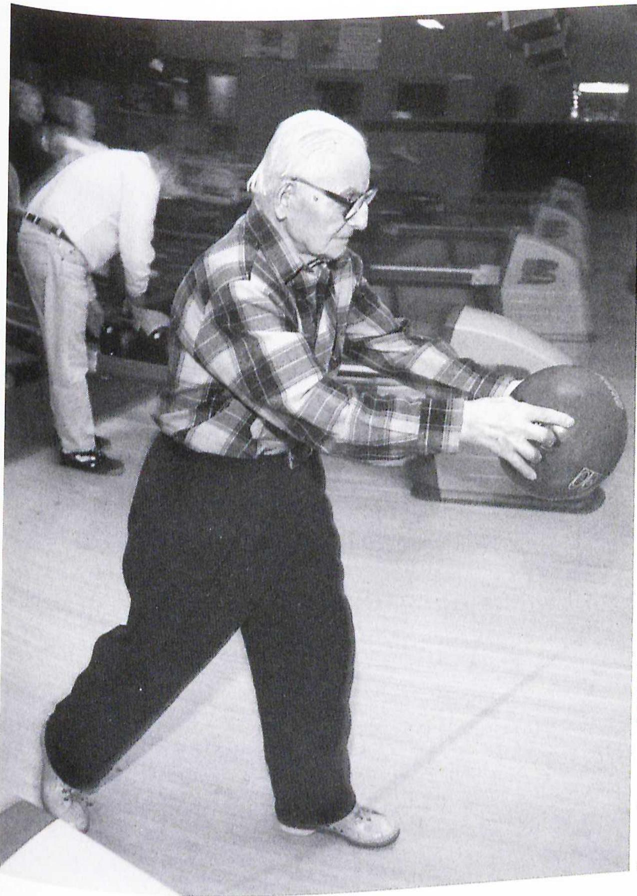
Most people begin to notice declines in their physical health and fitness in their late 20s and early 30s. As those who love baseball are likely to claim, "The legs are the first to go." On a more positive note, most people's strength and capacity for moderate effort are about the same at age 70 as they were at age 40 (Stevens-Long & Commons, 1992). However, older people are less resilient after a period of prolonged exertion. The respiratory and circulatory systems usually degenerate to some extent and are less capable of providing the heart and muscle tissue with oxygenated blood as quickly as they once could. One result is that sudden changes in posture can cause an older person to feel lightheaded. In order to adapt successfully to this kind of bodily change, an older person may find it necessary to move more slowly and to change positions more deliberately. This observable change in the tempo of movement may be incorrectly interpreted as fatigue or weakness when, in fact, it is often a purposeful strategy for preventing dizziness.

Slowed metabolism reduces the need for calories, but there are new risks. Blood sugar levels are likely to rise after eating and body fat increases. These conditions increase the risk of type 2 diabetes. Reduction in food intake—particularly the elimination of foods such as milk—may result in the lack of essential vitamins and minerals in an older person's diet. The resulting malnutrition may then contribute to osteoporosis and iron deficiencies which produce feelings of weakness, fatigue, and a lack of resilience (Klesges et al., 2001). In order to cope successfully with a diminished appetite, a very old person must become more conscientious in selecting foods that will provide the nutritional elements necessary for healthy functioning.

Many health concerns of later adulthood that may have been attributed to the aging process itself are in fact a direct or indirect result of malnutrition. In the years from 2007 to 2009, a period of severe economic downturn in the United States, researchers reported substantial increases in food insecurity among adults including those in middle and later adulthood as well as elderhood (Ziliak and Gunderson, 2011). Food insecurity is associated with lower nutritional intake, fewer calories, less protein, fewer essential vitamins, greater likelihood of reporting poor or fair health, and significant increases in functional limitations, requiring assistance in activities of daily living (Lee & Frongillo, 2001). There is speculation that adults who suffered from food insecurity in their middle and later adult years may reach elderhood in a state of greater frailty and in need of more health services.

A number of factors make it difficult to maintain a high level of physical fitness in later life. Some aspects of aging that impact fitness are a result of the body's natural process as cells replicate again and again and, through metabolism, produce by-products that can be harmful to the body itself. Some aspects of aging that reduce fitness are a result of choices and circumstances such as a sedentary lifestyle, smoking, a diet heavy in fats, too much time in the sun, exposure to environmental toxins, and lack of health care.

Commitment to physical fitness is important for adults in order to face their later years in the best possible physical condition. In its report *Healthy People 2020*, the U.S. government identified physical activity as a key factor in promoting health and preventing illness (U.S. Department of Health and Human Services, 2013). A primary goal is to improve health, function, and quality of life for older adults. Among the recommendations to achieve this goal is to encourage regular, daily physical activity. The recommended level of physical activities includes:2 hours and 30 minutes a week of moderate aerobic activity; strengthening activities 2 days a week; and balancing activities 3 days or more a week (Figure 14.3).



Syracuse Newspapers/C.W. McKeen/The Image Works

FIGURE 14.3 Those who survive into their 90s demonstrate surprising good health. Solly has been bowling since he was 10; at age 96, he still enjoys the sport and carries a 123 average in the 80 and older league.

Regular physical activity is associated with decreased rates of death from heart disease, lower risk of diabetes and colon cancer, and prevention of high blood pressure. Physical activity also improves muscle and bone strength, contributes to weight control, and improves strength, flexibility, and balance. These latter factors all reduce chances of serious injury, thereby preserving functional independence. Despite these advantages, 55% of those ages 75 and older do not engage in any leisure time physical activity, and 87% say that they never engage in vigorous physical activity (National Center for Health Statistics, 2010).

With advancing age, some people tend to become more sedentary and lose interest in physical activity. In order to maintain optimal functioning and to retard the degenerative effects of aging, very old adults must continue to have frequent and regular opportunities for physical exercise. A regular program of walking or other aerobic exercise can enhance cardiovascular functioning and reverse some of the effects of a sedentary adult lifestyle. Research on weight, or resistance, training shows that even among the very old, a steady program of exercise builds muscle strength, which contributes to agility and an overall sense of well-being (Ades, Ballor, Ashikaga, Utton, & Nair, 1996). Weight-bearing exercises help offset the normal processes of loss of muscle tone and bone density, improving balance and reducing the likelihood of falls. Experimental studies of the effects of exercise on cognitive functioning show that it also leads to improvements in various central nervous system functions. These benefits of exercise are attributed in part to higher levels of oxygen that improve the metabolism of glucose and neurotransmitters in the brain, as well as to increased levels of arousal that increase response speed (Newell, Vaillancourt, & Sosnoff, 2006).

Sleep and Rest

Older adults seem to need about the same amount of sleep, 7 to 9 hours a night, as younger adults. However, older adults tend to go to sleep earlier and wake up earlier than when they were younger and spend less time in deep sleep which may be why older adults often report being light sleepers (National Institute on Aging, 2009c). More significant sleep problems occur for older adults who have various medical conditions that involve pain, sleep apnea, movement disorders, and urinary problems (Ohayon, Carskadon, Guilleminault, & Vitiello, 2004).

The most common sleep problem in elderhood is *insomnia* which involves difficulties falling asleep or staying asleep. Insomnia may be a temporary problem associated with particular worries, excitement over an upcoming event, or preoccupation with an unresolved challenge. On the other hand, insomnia may be a symptom of other medical conditions, such as unmanaged pain, or difficulty breathing. An interesting problem is that people who have had a bout of insomnia may exacerbate their problem by worrying about whether they will be able to fall asleep (National Institute on Aging, 2009c).

Many older adults take daytime naps; an estimated 15% of those ages 55–64 and 25% of those ages 75–84 nap. There may be benefits from the practice of napping. In a study that tracked over 23,000 Greek adults for 6 years, those who napped 3 times a week or more for about half an hour had a substantially lower risk of heart attacks than those who did not nap (Naska et al., 2007). Napping may help reduce stress and allow a person to engage the remainder of the day with more energy. In a study of napping among older adults, those who had a regular habit of sleeping at about the same time each day and waking themselves up after about half an hour had a greater sense of self-efficacy and less experience of sluggishness in the afternoon and evening (Kaida et al., 2006).

The relationship of napping to well-being is not fully understood. People who are able to nap during the day may also be in greater control of their lives and less exposed to stress. On the other hand, taking a nap may be a deliberate way to reduce stress, relax, and prepare to engage more fully in the remaining hours of the day. Not surprising, napping several times a day is associated with unusual feelings of sleepiness during the day, depression, and pain (Foley et al., 2007).

Behavioral Slowing

One of the most commonly noted markers of aging is a gradual slowing in response to stimuli. **Behavioral slowing** is observed in motor responses, reaction time, problem-solving abilities, memory skills, and information processing (Salthouse, 1996). Reaction time is a composite outcome of the time it takes to perceive a stimulus, retrieve related information from memory, integrate it with other relevant stored information, reason as necessary about the required action, and then take action—whether that means the time it takes to press a button after detecting a signal, or the time it takes to complete a crossword puzzle or solve a math problem. Age-related slowing is more readily observable in complex tasks requiring mental processing than in routine tasks (Lemaire, Arnaud, & Lecacheur, 2004). The more complex the task, the greater the **processing load**—that is, the more domains of information called into play, the more time it takes to select response strategies.

The number of tasks presented in a sequence and the complexity of choice required to make a response are all factors that influence response time. Under conditions where a choice of response is required, older adults do not show evidence of slowing in the early phase of processing the stimuli, but in the executive functions associated with enacting the appropriate response (Yordanova, Kolev, Hohnsbein, & Falkenstein, 2004). In many studies, older adults show improvements in response time when given opportunity for practice. However, when older and younger adults are both given opportunities for practice, the older adults do not improve as much as the younger adults, and the performance gap may actually increase (Hein & Schubert, 2004).

Biological, learned, and motivational factors have been identified to account for behavioral slowing. At the biological level, there is evidence of the slowing of neural firing in certain brain areas which may result in a slower speed of information processing. This is due in part to age-related damage to the myelin sheath that insulates neurons and facilitates speed of firing (Salat, 2011). The extent of this slowing depends on the kinds of tasks and specific cognitive processes involved. Speed of processing may be only one of many factors responsible for age-related changes in cognitive processing (Hartley, 2006). Older adults appear to be effective in recruiting various brain regions to compensate for declines in processing speed which stimulates new patterns of connections across the hemispheres of the brain. Research on brain functioning in later life finds evidence for plasticity and adaptive reorganization (Davis, Kragel, Madden, & Cabeza, 2012).

The slowing of responses may also be a product of learned cautiousness. With experience, people learn to respond slowly in order to avoid making mistakes. When confronted with new, experimental problem-solving tasks, older adults may take longer because they are not confident in using a new strategy. They may revert to a more familiar, if more time-consuming, approach in order to solve the problem correctly. Thus, a conservative orientation to the selection of problem-solving strategies may result in slower responses but not be strictly due to neurological causes (Touron & Hertzog, 2004). Depending upon the task, cautiousness may be related to prior experiences of instability or falling. As older adults step down from the sidewalk to the street, or step off an elevator or onto an escalator, they move more slowly to ensure that they have good footing and will not slip or fall. Finally, response slowing may be a product of a low level of motivation to perform a task. In experiments in which reaction time is being tested, adult participants may be uninterested in the task and thus unwilling to try to respond quickly.

The implications of the consequences of behavioral slowing are currently being examined. Some researchers have argued that even the slightest reduction in the speed of neural firing may result in reduced sensory and information-processing capacities. Furthermore, response slowing may reduce a person's chances of survival if a situation arises in which a sudden evasive action or immediate response is required. Others have suggested that if a moment of thought is required before an action is taken, slowness may increase a person's chances of survival.

A common consequence of slowing is its impact on cognitive functioning. If the nervous system functions at a slower rate, it takes more time to scan and perceive information, search long-term memory, integrate information from various knowledge domains, and make a response (Madden, 2001). However, mental abilities that rely on speed, which are often assessed under laboratory conditions, do not predict cognitive functioning for elders in their real-world environments. Although it is well established that speed of performance declines with age, there are few real-world situations that require the rapid speed that is typically measured in laboratory conditions. As they age, people typically create living conditions that are adapted to their abilities, allowing them to preserve effective problem-solving strategies as well as possible (Salthouse, 2012). Recall from chapter 13 (Later Adulthood) that crystallized intelligence tends to increase with age, whereas fluid intelligence declines. When the factor of speed of responding was removed from the tests of fluid intelligence, the decline with age was significantly less. These studies support the claim that changes in the speed of responding account for much—though probably not all—of the documented evidence of decline in intellectual performance with age.

The debate continues, however, about whether this slowing is general—influencing all types of cognitive and motor activity—or specific to certain domains. There is considerable evidence that contemporary circumstances—especially physical fitness and health, as well as the kinds of medications one is taking and the presence of immediate stressors in one's life—influence the speed of responding. In each situation, motor performance results from the adaptive self-organization of responses that are a product of how the person assesses the situation; the person's physical strength, flexibility, and endurance; and the person's ability to control posture, movement,

and dexterity. Speed of responding will vary depending on what type of response is required and which systems constrain behavior (Newell, Vaillancourt, & Sosnoff, 2006). One 80-year-old woman may be able to walk through an airport quickly to get to her gate but may be slow in reading and evaluating the information that tells whether her flight is on time or delayed. Another 80-year-old woman may be able to read the information about the flight and quickly assess whether her flight is on time but may take much longer to get to the departure gate.

Because slowing occurs gradually, most adults compensate for it by making their environments more convenient or by changing their lifestyles. However, slowing becomes more hazardous in situations that require the older adult to keep pace with a tempo that cannot be modified, such as highway driving or crossing the street with the light. For instance, some older people encounter problems because the amount of time the light stays green at a pedestrian crosswalk is insufficient to permit them to get to the other side of the street safely. As older people recognize some situations in which they have trouble responding quickly, they must review the tempo of their day. Elders may become more selective in their choice of activities so that they can allocate enough time for the tasks most important to them and perform them satisfactorily. This means exercising greater control over their time and being less concerned about whether they are in harmony with the tempo of others (Figure 14.4).

Noel Hendrickson/Jupiter Images

FIGURE 14.4 As a result of behavioral slowing, it takes longer for elders to perform daily tasks. Her trips to the market take May more time than they did 10 years ago, but she still enjoys her shopping and the satisfaction of preparing her meals with the best ingredients.

Sensory Changes

Every sense modality—vision, hearing, taste, touch, and smell—is vulnerable to age-related changes. With age, greater intensity of stimulation is required to make the same impact on the sensory system that was once achieved with lower levels of stimulation. Some of the changes in vision, hearing, and taste and smell are given in Table 14.1. These changes begin in early adulthood, and their effects increase throughout the remainder of life (Erber, 2005).

Vision. **Visual adaptation** involves the ability to adjust to changes in the level of illumination. Pupil size decreases with age, so that less light reaches the retina. Thus, older adults need higher levels of illumination to see clearly, and it takes them longer to adjust from dark to light and from light to dark. Many older adults are increasingly sensitive to glare and may draw the shades in their rooms to prevent

TABLE 14.1 Changes in Sensory Systems After Age 20

AGE GROUP	VISION	HEARING	TASTE AND SMELL
20–35	Constant decline in accommodation as lenses begin to harden at about age 20	Pitch discrimination for high-frequency tones begins to decline	No documented changes
35–65	Sharp decline in acuity after 40; delayed adjustment to shifts in light and dark	Continued gradual loss in pitch discrimination to age 50	Loss of taste buds begins
65+	Sensitivity to glare; increased problems with daily visual tasks; increases in diseases of the eye that produce partial or total blindness	Sharp loss in pitch discrimination after 70; sound must be more intense to be heard	Higher thresholds for detecting sour, salt, and bitter tastes; higher threshold for detecting smells, and errors in identifying odors

Source: Based on Newman & Newman, 1983.

bright light from striking their eyes. Slower adaptation time and sensitivity to glare interfere with night driving. Some of the visual problems of people older than 75 are difficulties with tasks that require speed of visual performance, such as reading signs in a moving vehicle; a decline in near vision, which interferes with reading and daily tasks; and difficulties in searching for or tracking visual information (National Institute on Aging, 2009a). About 16.5% of those 75 and older report that they have trouble seeing (National Center for Health Statistics, 2010).

Several physiological conditions seriously impair vision and can result in partial or total blindness in old age. These conditions include cataracts, which are a clouding of the lenses, making them less penetrable by light; deterioration or detachment of the retina; corneal disease, which can result in redness, watery eyes, pain, and difficulties seeing; and glaucoma, which is an increase in pressure from the fluid in the eyeball. The incidence of visual impairments, especially cataracts, increases dramatically from later adulthood (65 to 74) to elderhood (beyond 75) (He, Sengupta, Velkoff, & Barros, 2005).

About 18% to 20% of elders experience problems with cataracts. According to vision experts, recent medical innovations have made cataract surgery much less complicated than it was in the past. Nine out of 10 people who have cataract surgery regain very good vision, somewhere between 20/40 and 20/20 (Lee, 2002). Problems with glaucoma can be treated with eyedrops, lasers, or surgery. Retinal disorders, especially age-related macular degeneration, can be prevented or treated with dietary supplements.

Loss of vision poses serious challenges to adaptation—it has the effect of separating people from contact with the world. Such impairment is especially linked with feelings of helplessness. Most older adults are not ready to cope with the challenge of learning to function in their daily world without being able to see. For them, the loss of vision reduces their activity level, autonomy, and willingness to leave a familiar setting. For many older adults, impaired vision results in the decision to give up driving altogether, or at least night driving, causing a significant loss of independence. However, this loss can be minimized by the availability of inexpensive, flexible public transportation.

Hearing. Hearing loss increases with age. About 45% of those ages 75 and older have some trouble with their hearing (National Center for Health Statistics, 2010). The most common effects of hearing loss are a reduced sensitivity to both high-frequency (high-pitched) and low-intensity (quiet) sounds and a somewhat decreased ability to understand spoken messages. Certain environmental factors—including exposure to loud, unpredictable noise, and injuries, such as damage to the bones in the middle ear—influence the extent of hearing loss.

Loss of hearing interferes with a basic mode of human connectedness—the ability to participate in conversation. Hearing impairment may be linked to feelings of isolation or suspiciousness. A person may hear things imperfectly, miss parts of conversations, or perceive conversations as occurring in whispers rather than in ordinary tones. There are a variety of devices that can help support individuals who have hearing loss. These include hearing aids, amplifying devices that can make it easier to hear on the phone, alert systems coordinated with doorbells or smoke detectors, and cochlear implants that are surgically implanted to help overcome certain specific types of hearing loss (National Institute on Aging, 2009b).

Being aware of one's hearing loss and its impact on social interactions is the first step in learning to compensate for diminished auditory sensitivity. Knowing the people one is with and believing that one is valued by them can help reassure a person about the nature of conversations and allay suspicions. Elders with hearing loss may ask for a quiet spot in a restaurant, or ask friends to speak one at a time in a group setting. Self-esteem plays an important part in this process. The older person with high self-esteem is likely to be able to make the intellectual adjustment needed to interpret interactions and to request clarification when necessary. Such requests may even serve to stimulate greater interaction and produce greater clarity in communication. Older people with a hearing loss and high self-esteem tend to insist that people who want to communicate with them should face them when they speak.

In contrast, older people who have low self-esteem are likely to be more vulnerable to suspicions about the behavior of others because they doubt their own worth. They are more likely to perceive inaudible comments as attempts to ridicule or exclude them. These experiences contribute to feelings of rejection and can produce irritability and social withdrawal.

About 20% of those ages 75 and older have multiple sensory impairments. Those who have both visual and hearing impairments are more likely to report reduced social interactions, difficulty getting together with friends, and are at greater risk for falls, possibly due to the lack of sensory cues that help support navigation in unfamiliar settings (He et al., 2005).

Taste and Smell. There are taste receptors throughout the mouth, including on your tongue, the roof of your mouth, and your throat. These taste receptors detect flavors of food based on five tastes: sweet, salty, bitter, sour, and tangy. In addition, the smell of food contributes to its flavor, and many would argue that the appearance of food contributes to its appeal. With age, the number of taste buds decreases. Older adults have a higher threshold than young adults for detecting sweet, sour, bitter, and salty tastes. Some of this reduced sensitivity may be related to the impact of certain medications, gum disease, dentures, some infections, cancer treatments, or alcohol consumption (National Institute on Aging, 2009d). In order to improve the taste of food, older adults may add salt or sugar, which may aggravate existing conditions such as high blood pressure or diabetes (Figure 14.5).

FIGURE 14.5 The sense of smell continues to be a source of pleasant memories and invigorating daily experiences. Here, Greta smells the lilacs, a delightful sign that spring has come.

Older adults also require greater intensity to detect odors and are more likely to misidentify them (Receputo, Mazzoleni, Rapisarda, & Di Fazio, 1996). The sense of smell can keep a person safe. Smells related to smoke, gas leaks, spoiled food, or household chemicals are important indications of a possible environmental problem. Loss of smell in older adults can increase their vulnerability to illness or accidents if they ignore these cues. Changes in the senses of smell and taste may result in a loss of appetite or a disruption of normal eating habits. Loss of appetite (which may accompany illness and new medications), pain due to dental problems, and changes in the digestive system all contribute to malnutrition among the elderly.

Coping with Sensory Changes. As a result of the various patterns of aging among the very old, it is impossible to prescribe an ideal pattern of coping. The SOC model, which was introduced in chapter 13 (Later Adulthood), becomes increasingly relevant as sensory and motor functions are impaired. According to this model, in order to cope effectively, older adults must select the areas where they are most invested in sustaining optimal functioning and direct their resources to enhancing those areas while compensating for the areas in which functioning is more limited. What one hopes to achieve is a balance between self-sufficiency and willingness to accept help, preserving one's dignity as much as possible and optimizing day-to-day mobility. This is described in the following excerpt from Erikson's study of the very old:

> Appropriate dependence can be accommodated and accepted by elders when they realistically appraise their own physical capacities. One of our more practical elders simply states, "Of course, you're still interested in everything. But you don't expect yourself to do everything, the way you used to. Some things you just have to let go." However, inappropriate restriction can be, in its way, insulting and belittling. In describing his current life, one widowed man expresses both his refusal to accept restriction and his willingness to rely on appropriate assistance: "I can stay up here in the woods because I know if I really need help, my son will be here inside of three hours. Now, this deal with fixing my own water pipes, I'd have never tried that without my son so nearby, and I didn't even need him." (Erikson et al., 1986, pp. 309–310)

Health, Illness, and Functional Independence

How can we characterize the level of health, illness, and **functional independence** in later life? A mild but persistent decline in the immune system is observed as a correlate of aging. As a result, older adults are more susceptible to infections and take a longer time to heal. Substantial numbers of older adults are afflicted with one or more chronic conditions, such as arthritis, osteoporosis, diabetes, or high blood pressure which may require medication and interfere with daily functioning. Older adults are at increased risk for developing chronic conditions, the most common of which are: diabetes, arthritis, congestive heart failure, and dementia (U.S. Department of Health and Human Service, 2013). Nonetheless, 39% of those aged 75 and older describe their health as very good or excellent, and 35% report their health as good (Schiller, Lucas, Ward, & Peregoy, 2012).

Osteoarthritis is the most common type of arthritis for older adults. This type of arthritis results when the cartilage that pads bones in a joint wears away. The joints may feel stiff when a person has not moved for a while. Other symptoms include temporary or chronic pain and gradual loss of mobility in the affected joints. Fifty-four percent of those 75 and older have osteooarthritis. *Osteoporosis* is a disease that weakens bones so that they break easily. Bone tissue is continuously broken down and replaced. With age, more bone is lost than is replaced. Although women are at greater risk of osteoporosis than men, after age 70 men and women lose bone at about the same rate (National Institute on Aging, 2009e, 2009f).

Data from the National Health Interview Survey (Schiller, Lucas, Ward, & Peregoy, 2012) provide a look at the relationship of age to difficulties in physical functioning. Participants were asked about whether they had certain upper-body and lower-body limitations. Upper-body limitations included such things as reaching up over one's head or using one's fingers to grasp a handle. Lower-body limitations included walking for a quarter mile or stooping, crouching, or kneeling. The percentage of respondents who reported difficulty

in one or more areas increased from 30% of those ages 65 to 74, to 46% among those 75 and older. The area of most difficulty was standing for 2 hours, with 30% of those over age 75 reporting difficulties. This suggests that many elders would not go to an outdoor concert without bringing a chair.

One of the most difficult health challenges of elderhood is a group of disorders referred to as **organic brain syndromes**. These conditions, which result in confusion, disorientation, and loss of control over basic daily functions, present obstacles for adaptation to the person with the disease as well as the caregivers who are responsible for the older person's well-being (see the **Applying Theory and Research** box Dementia).

Do people generally experience a rapid, general decline in health after age 65 or 70? Not according to self-ratings. In a national survey of older adults, people were asked to rate their health from poor to excellent. In the 75 to 84 age range, 76% of non-Hispanic Whites, 57% of non-Hispanic Blacks, and 60% of Hispanics rated their health as good, very good, or excellent. Among those 85 and older, the percentage who rated their health as good, very good, or excellent declined somewhat for the three groups, to 69%, 55%, and 52%, respectively (Federal Interagency Forum on Aging Related Statistics, 2012). However, the majority continue to view their health in a positive light.

Among those in their 80s and early 90s, one health-related crisis may result in a marked decline in other areas. For example, the loss of a spouse may result in social withdrawal, loss of appetite, sleep disturbance, loss of energy, unwillingness to take medication, and decline in physical activity. All these changes can produce a rapid deterioration of the respiratory, circulatory, and metabolic systems.

Studies of people in their later 90s and older find that these elders demonstrate unexpectedly good health. They appear to be more disease free than those who are 10 or 15 years younger. Perls (2004) suggested that a combination of genetic factors protect some people from the diseases of aging through two complementary processes. First, they are less vulnerable to some of the damaging effects of *oxygen radicals* that destroy DNA and cells. Thus, during their 70s and 80s,they do not suffer from the major diseases such as heart disease, cancer, stroke, or Alzheimer's disease. Second, they have a greater *functional reserve*, meaning that they require less of their organs to perform basic adaptive functions so they can tolerate a degree of damage without losing basic capacities. Studies of centenarians confirm this view of aging; they typically have a short period of poor health before death rather than suffering from prolonged disease-torn illness and disability.

In contrast to negative stereotypes about later life, the level of independent functioning among adults 80 years and older is high. Figure 14.6 shows the percentages of noninstitutionalized people in three age groups who needed help in six **activities of daily living** (ADLs): bathing/showering, dressing, eating, getting in and out of bed or a chair, walking, and using the toilet. The area of greatest limitation is

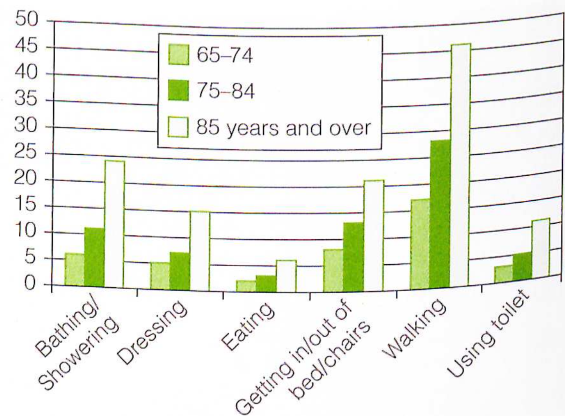


FIGURE 14.6 Percent of Persons with Limitations in Activities of Daily Living by Age Group: 2010
Source: Administration on Aging (2012).

walking, The percentage of adults needing assistance is small for those ages 65 to 74, increases slightly for those 75 to 84, and increases further for those 85 and older. However, even among this oldest group, fewer than half require help with walking, and fewer than 25% need help with other basic tasks of self-care (Administration on Aging, 2012). Over the past decade, the proportion of elderly people reporting such needs has declined. Many factors may account for this improvement in daily functioning for recent cohorts of the very old, including improved design of interior space in senior housing, new devices that make it easier for older adults to compensate for physical limitations, and medications that help alleviate the symptoms of chronic illness.

FURTHER REFLECTION: *Describe someone you know well who is in the life stage of elderhood. What physical challenges is this person facing? How is he or she coping with these challenges? What environmental and/or social supports are required to help sustain this person's optimal functioning?*

Developing a Psychohistorical Perspective

OBJECTIVE 3. Describe the concept of an altered perspective on time and history that emerges among the long-lived.

Development in elderhood includes gains as well as losses. Through encounters with diverse experiences, decision making, parenting and other forms of tutoring or mentoring of younger generations, and efforts to formulate a personal philosophy, adults reach new levels of conscious thought. Very old adults are more aware of alternatives; they can look deeply into both the past and the future and can recognize that opposing forces can exist side by side (Kunzmann & Baltes, 2005; Riegel, 1973). The product of this integration of past, present, and future is the formation of a **psychohistorical perspective**. Through a process of creative

FIGURE 14.7 Wendell tells his young listeners what it was like to be a soldier in World War II. Through his stories, he makes this period of American history come alive for a new generation.

Bill Aron/PhotoEdit

coping, elders in each generation blend the salient events of their past histories with the demands of current reality. They are able to consider the contextual variations and uncertainties that are inherent in trying to make sense of life's challenges. Having lived a long time, and envisioning less time in the future, elders are more likely to be more forgiving, less interested in material accumulation, and more focused on the emotional satisfactions of life (Allemand, 2008; Brandtstädter, Rothermund, Kranz, & Kühn, 2010).

Think about what it means to have lived for 75 or more years. Those adults who were 80 years old in 2011 were born in the Great Depression. They lived through World War II; the Korean war; the Vietnam war; the Gulf war; the Afghan and Iraqi wars; the assassinations of President Kennedy, Robert Kennedy, and Martin Luther King, Jr.; Watergate; the Clinton impeachment trials; the AIDS epidemic; the terrorist attacks of September 11, 2001; the floods that destroyed much of New Orleans; and the election of the first African American president. They have experienced the political leadership of 14 presidents. During their lives, they have adapted to dramatic technological innovations in communication, transportation, manufacturing, economics, food production, leisure activities, and health care. They have also experienced striking changes in cultural and political values.

One consequence of a long life is the accumulation of experiences. Another is the realization that change is a basic element of all life at the individual and societal levels. Sometimes, these changes appear cyclical; at other times, they appear to bring real transformations. For example, people who are now age 80 lived during World War II when women were involved in the labor market while men served in the military; the 1950s, when many women withdrew from the labor market and committed themselves to working at home; and the 1970s up to the present when it has become normative for women to be employed outside the home, even when they have very young children. The patterns of behavior that younger adults might view as normative and necessary, elders may recognize as part of fluctuating social or historical conditions (Figure 14.7).

Within the framework of an extended life, elders have opportunities to gain a special perspective on conditions of continuity and change within their culture. In the process of developing such a psychohistorical perspective, they develop a personal understanding of the effects of history on individual lives and of one's place in the chain of events. As society becomes more accustomed to having a significant group of elders functioning in the community, some scholars anticipate that a *culture of aging* will emerge in technological societies. This culture is likely to provide more opportunities for the expression of the pragmatic wisdom accumulated over a long lifetime through theater, music, the arts, and critical commentary. At the same time, new roles will evolve for successful agers as mentors and advisors to the young (Kunzmann & Baltes, 2005). In the United Kingdom, pensioners have created the Retirement Lounge, an online setting where retirees can interact and share their experiences:

> Social interaction is extremely important when we leave work for good. We are no longer in the working environment to share a joke or gossip with our colleagues. Sadly, many retirees get trapped in their home environment with no one to talk to apart from their family members, if they are fortunate to have them around. With that in mind, this portal is set up to serve the needs of senior citizens. This is a Pensioners Corner. With our pool of experience and knowledge base we should be able to help each other. (retirement-lounge.com, 2013)

APPLYING THEORY AND RESEARCH TO LIFE

Dementia

Dementia is the loss of thinking, memory, and reasoning skills that significantly impairs a person's ability to carry out daily tasks. Symptoms include the inability to remember information, asking the same questions over and over again, becoming lost or confused in familiar places, being unable to follow directions, or neglecting personal safety, hygiene, or nutrition (National Institute on Aging, 2009g). Two of the most common causes of dementia in older people are vascular dementia or repeated small strokes and Alzheimer's disease. With **vascular dementia**, the supply of blood to the brain is disrupted, resulting in the death of brain cells. The loss of function may be gradual or relatively sudden. The symptoms vary depending upon which area of the brain has been damaged. Memory, language, reasoning, or motor coordination can be disrupted. Supportive counseling, attention to diet, and skilled physical therapy to reestablish control of daily functions may restore much of the person's previous level of adaptive behavior provided that additional strokes do not occur.

Alzheimer's disease produces a more gradual loss of memory, reduced intellectual functioning, and an increase of mood disturbances—especially hostility and depression. An estimated 5.4 million Americans had Alzheimer's disease in 2012. The incidence of this disease increases with age, with few people below the age of 60 affected by it, whereas an estimated 45% of those ages 85 and older have the diagnosis. The severity of the disease also increases with age (Alzheimer's Association, 2013).

A person with Alzheimer's disease experiences gradual brain failure over a period of 7 to 10 years. Symptoms include severe problems in cognitive functioning, especially increased memory impairment and a rapid decline in the complexity of written and spoken language; problems with self-care; and behavioral problems, such as wandering, asking the same questions repeatedly, and becoming suddenly angry or stubborn (Kemper, Thompson, & Marquis, 2001; O'Leary, Haley, & Paul, 1993). Currently, there is no treatment that will reverse Alzheimer's disease. Treatments address specific symptoms—especially mood and memory problems—and attempt to slow its progress.

As the number of older adults with Alzheimer's disease and related disorders has grown, the plight of their caregivers has aroused increasing concern (Roth et al., 2001; Zarit, Femia, Kim, & Whitlatch, 2010). Most Alzheimer's patients are cared for at home, often by their adult children and their spouse. The caregiving process is ongoing, with an accumulation of stressors and periodic transitions as the patient's condition changes. As the symptoms of the disease progress, caregivers have to restructure their personal, work, and family life. Caregivers often experience high levels of stress and depression as they attempt to cope with their responsibilities and assess the effectiveness or ineffectiveness of their efforts. Over time, they are likely to experience physical symptoms of their own, associated with the physical and emotional strains of this role.

When people with dementia are cared for at home by their spouse, children, or other relatives, three spheres of functioning intersect: home life, intimate or close relationships, and custodial care. Custodial care, often involves routinization, surveillance, and indignities as a result of lost capacities, such as needing help with toileting, bathing, or dressing. Observations and interviews with caregivers and care recipients who live together suggest that these features of custodial care disrupt intimate relationships and home life, making daily experiences more monotonous, restrictive, and constraining. As their symptoms worsen, care recipients gradually lose many of the functions that support their identities as homemakers, parents, or intimate partners (Askham, Briggs, Norman, & Redfern, 2007).

The care of an older person with some form of dementia is fraught with problems and frustrations, but it also provides some opportunities for satisfaction and feelings of encouragement (Pinquart & Sörensen, 2003). The uplifts and hassles frequently reported by caregivers give some insight into the typical day-to-day experience of caring for a person who is

Another online resource is sponsored by TIAA, myretirement.org. It has over 13,000 members who share ideas about weekly topics, access information about current trends, respond to surveys about topics of relevance to older adults and read about the results, share aspirations, thoughts, and photos with others. Other sites where older adults are sharing their expertise include coolgrandma.com, senior.com, eldercareonline (econline.com), seniornet.org, and senioryears.com.

An international group of leaders, *The Elders*, is a different example of how people can bring their life experiences to bear to address critical issues (www.theelders.org). *The Elders* was formed to help address some of the serious and seemingly intractable problems that plague our world. A premise of this group is that in traditional societies, the oldest members of the group were looked to for their wisdom and guidance in efforts to resolve difficult conflicts. In today's

suffering from Alzheimer's disease (Donovan & Corcoran, 2010; Kinney & Stephens, 1989).

The uplifts include the following:

- Seeing care recipient calm
- Sharing a joke, laughing together with the care recipient
- Seeing care recipient responsive
- Care recipient showing affection
- Friends and family showing understanding about caregiving
- Care recipient recognizing familiar people, smiling, or winking
- Care recipient being cooperative
- Leaving care recipients with others at home

Some of the hassles include:

- Care recipient being confused or not making sense
- Care recipient's forgetfulness, asking repetitive questions
- Care recipient's agitation, anger, or refusing help
- Care recipient's bowel or bladder accidents
- Seeing care recipient withdrawn or unresponsive
- Dressing and bathing care recipient, assisting with toileting
- Care recipient declining physically
- Care recipient not sleeping through the night

Two of the symptoms that are most difficult to manage are sleep disturbances and wandering. As cognitive functioning declines, the pattern of sleep deteriorates. A person with Alzheimer's disease sleeps for only short periods, napping on and off during the day and night. Often, the napping is accompanied by wakeful periods at night, during which the person is confused, upset, and likely to wander. Caregivers must therefore be continuously alert, night and day. Their own sleep is disturbed as they try to remain alert to the person's whereabouts. When the disease reaches this level, family caregivers are most likely to find it necessary to institutionalize the family member. Alzheimer's disease is a major cause of hospitalization and nursing home placement among the elderly; an estimated 50% of nursing home residents have Alzheimer's disease or a related form of dementia (He, Sengupta, Velkoff, & DeBarros, 2005).

A woman who remembers her mother as independent, with strong views and a deep commitment to social justice, describes some of the ups and downs as she witnesses her mother's condition:

> My mother also had strong views on quality of life issues for the elderly. We had often spoken about the importance of being able to die in a dignified way. She has a living will and opposes heroic measures to prolong life. I am convinced that Mom wouldn't want the quality of life she now has. She can't express herself, is unable to hold a knife or fork, has no control over her bodily functions and can't walk.

However, on a recent visit to her mother, who is living in a group home, she describes the following scene:

> I worried.... that Mom wouldn't recognize me this time. But when I got there, she looked up at me and broke into a huge smile. She was truly excited to see me. She laughed and as I hugged her, we both cried. Then she began to speak nonstop gibberish. Although she can't tell us otherwise, my mother appears to be happy.... I honestly don't know if she has any thoughts about quality of life. (Simon, 2002, p. B7)

Critical Thinking Questions

1. Imagine that you are responsible for the care of a loved one who has Alzheimer's disease. What steps could you take to help support their optimal functioning?
2. Hypothesize about psychosocial development for adult caregivers. How might the responsibilities of care contribute to or impede their psychosocial development?
3. Explain why sleep disturbances and wandering are the symptoms that are most likely to lead to institutionalization for those with Alzheimer's disease?
4. Hypothesize about why an adult child may want to care for a parent who has Alzheimer's disease rather than place him or her in a nursing home or extended care facility.
5. Imagine that you were to take on the responsibilities for someone with dementia. Describe how you would prepare for this role. How would you plan for the long-term nature of this responsibility and cope with the continuing deterioration of your loved one?

world, where the conflicts are often of an international and intercultural nature, the global community is in need of a group of respected and trusted leaders who can offer guidance without a vested interest in a particular national, industrial, or religious advantage. The founding members of the *The Elders* are characterized as "trusted, respected worldly-wise individuals with a proven commitment and record of contributing to solving global problems." The current group of *Elders* includes Martti Ahtisarri, Nelson Mandela, Graça Machel, Desmond Tutu, Kofi Annan, Ela Bhatt, Lakhdar Brahimi, Gro Brundtland, Jimmy Carter, Fernando H. Cardoso, and Mary Robinson. *The Elders* hopes to share their wisdom, forged over a long lifetime, and opportunities for international leadership.

As the example of *The Elders* suggests, a psychohistorical perspective contributes to the wisdom that the very old bring

to their understanding of the meaning of life. As a result of living a long time, a person becomes aware of life's lessons as well as its uncertainties. The integration of a long-term past, present, and future combined with an appreciation for the relativistic nature of human experience allows these adults to bring an acceptance of alternative solutions and a commitment to essential positive values.

We are all part of the process of psychosocial evolution. Each generation adds to the existing knowledge base and reinterprets the norms of society for succeeding generations. Elders are likely to be parents, grandparents, and great-grandparents. Many are seeing their lines of descent continue into the fourth generation, which will dominate the 21st century. The opportunity to see several generations of offspring brings a new degree of continuity to life, linking memories of one's own grandparents to observations of one's great-grandchildren. We can expect the value of the oral tradition of history and storytelling to take on new meaning as the elders help their great-grandchildren feel connected to the distant past. We can also expect a greater investment in the future, as elders see in their great-grandchildren the concrete extension of their ancestry three generations into the future.

Erikson (Erikson et al., 1986) identified the emergence of these tendencies in the very old in the following excerpt:

> The elder has a reservoir of strength in the wellsprings of history and storytelling. As collectors of time and preservers of memory, those healthy elders who have survived into a reasonably fit old age have time on their side—time that is to be dispensed wisely and creatively, usually in the form of stories, to those younger ones who will one day follow in their footsteps. Telling these stories, and telling them well, marks a certain capacity for one generation to entrust itself to the next, by passing on a certain shared and collective identity to the survivors of the next generation: the future. (p. 331)

FURTHER REFLECTION: *Explain the concept of a psychohistorical perspective and evaluate how it contributes to psychosocial development in elderhood. Reflect on any conversations you have had with someone that offered a unique perspective on time, history, and self-awareness.*

Traveling Uncharted Territory: Life Structures in Elderhood

OBJECTIVE 4. Summarize elements of the lifestyle structure in elderhood, especially living arrangements and gender roles, and analyze the impact of these life structures for continued well-being.

How should elders behave? What norms exist to guide their social relationships or the structure of their daily lives? What does a healthy 85-year-old woman consider appropriate behavior, and what expectations do others have for her? When we talk about traveling uncharted territory, we are assuming that elderhood is a time of life for which there are few age-specific social norms. The very old are creating their own definitions of this life stage. You may have heard the expression "Life begins at 80." One interpretation of this adage is that because there are so few norms for behavior and so few responsibilities when one reaches elderhood, one can do whatever one wants.

Changes in role relationships—especially role loss in later adulthood—present significant challenges to the preservation of a coherent self-concept. In early adulthood, there is an opportunity to engage in many new roles and to establish a lifestyle that expresses the priorities of one's personal identity. In middle adulthood, the pressure of life roles and their competing demands may be at their peak. During later adulthood, the challenge is to establish an integrated sense of self that helps to compensate for the loss of salient life roles and to protect the person from a sense of despair. In elderhood, those who cope most effectively have been able to focus on certain valued characteristics of the self and to optimize them despite difficult changes in their social and physical resources (Diehl, Hastings, & Stanton, 2001).

The MacArthur Foundation Research Network on Successful Aging (Rowe & Kahn, 1998) has offered a new, interdisciplinary perspective on the distinction between usual and successful aging. Those characterized by **usual aging** may be functioning well but are at high risk for disease, disability, and reduced capacity for functional independence. In contrast, the **successful agers** are characterized by three interdependent features (see Figure 14.8). They have a "low risk of disease and disease-related disabilities; high mental and physical function; and active engagement with life" (p. 38). This last feature, **active engagement**, is a frequently repeated theme in the field of gerontology.

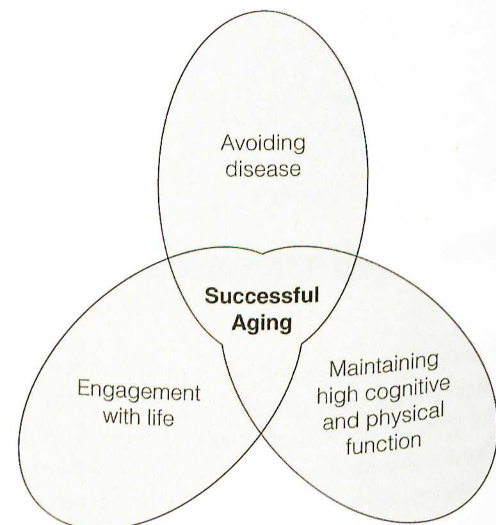


FIGURE 14.8 Components of Successful Aging
Source: Adapted from *Successful Aging*, by J. W. Rowe & R. L. Kahn, 1998, New York: Pantheon.

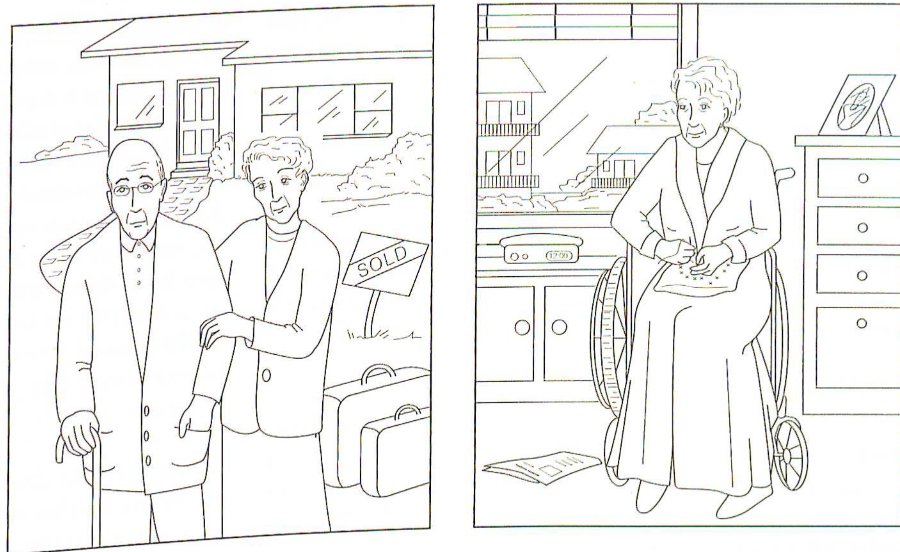


FIGURE 14.9 Typical Drawings That Researchers Might Use to Establish the Social Norms of Very Old People
Source: Drawings based on Offenbacher and Poster, 1985.

In an effort to describe the norms that older adults use to guide their conduct, researchers asked older adults from New York City and Savannah, Georgia, to respond to six pictures similar to the two drawings in Figure 14.9 (Offenbacher & Poster, 1985). The responses to the following two questions were used to construct a code of conduct: "How do you think that people who know this person, such as family or friends, feel about him or her?" and "How do you feel about this person?" Four normative principles were found in the responses:

1. Don't be sorry for yourself.
2. Try to be independent.
3. Don't just sit there; do something.
4. Above all, be sociable.

This code of conduct suggests that older people believe that being sociable, active, and independent constitute successful living in later life. Of course, older adults are not alone in valuing these qualities. However, these norms are important as sources of self-esteem for this age group. They promote a sense of vigor and a shield against depression or discouragement.

The themes "Don't be sorry for yourself" and "Don't just sit there" suggest that elders continue to see their lives as precious resources that are not to be wasted in self-pity and passivity. The emphasis on activity as opposed to meditation reflects the Western cultural value of a *sense of agency*—thinking is not as highly valued as action. In contrast, doing things, having an impact, and receiving the feedback that action stimulates provide the keys to successful living. Subsequent studies have supported the idea that finding meaning in one's existence, continuing to experience a sense of social competence, and perceptions of self-efficacy help older adults maintain a sense of well-being (Onedera & Stickle, 2008). For example, by continuing to participate in intellectually complex and challenging leisure activities—such as reading stimulating books and magazines; going to museums, concerts, and plays; or participating in hobbies that require decision making and problem solving—older adults contribute to preserving their intellectual flexibility (Schooler & Mulatu, 2001).

The desire to preserve a sense of control and agency is expressed across ethnic groups despite differences in health problems, loss of loved ones, and poverty. However, the ways that women define empowerment and experience successful aging is related, in part, to their cultural values and worldview. In a study of women between the ages of 60 and 80, nine different ethnic groups were self-defined by the participants: English, British Muslim, African Caribbean, Dominican, British Irish, Pakistani, British Polish, Indian, and Bangladeshi (Wray, 2003). For some of these women, freedom from the burdens of care for their aging family members or children was a valued opportunity for empowerment in later life. A number of women engaged in forms of group religious services and the related opportunities for social interaction, volunteer work, and prayer which created feelings of social inclusion and agency.

> I am baptized Sikh and value religion to guide me and have focus in life. My religion has influenced my life very positively; this has helped me to care for my husband and cope with stressful events. I have planned days when I visit friends and attend religious activities. These are also my means of socializing. We offer each other support and get involved in charity work. (Wray, 2003, p. 519)

For some women, paid employment or volunteer work keeps them connected to society and provides feelings of being in control of their daily lives. Finally, some women spoke of their time with their grandchildren and the responsibilities they had for their grandchildren's care as contributing to a sense of purpose and well-being. In some cultural groups, the opportunity to strengthen their connection with their

religious and ethnic communities created a form of collective agency. In other cultural groups, the opportunity to continue to express self-reliance and control over daily life was especially significant. Among most of the women, some form of interdependence and participation in meaningful social relationships played a key role in sustaining feelings of agency and continued self-worth.

The fact that older adults must carve out new patterns of adapting to later life is illustrated in the following sections in three specific areas of functioning: living arrangements, gender-role definitions, and romance and sexuality.

Living Arrangements

Approximately 78% of U.S. adults ages 75 and older own their own homes. However, the pattern of **living arrangements** changes after age 75, especially for women (see Figure 14.10). Before that age, the majority of older adults live in family households, mostly as married couples. Among adults ages 75–84, however, only 53% live with a spouse; the others either live alone or with family or nonrelatives. The pattern differs by gender. Among women ages 75–84, 37% are married and live with their spouse; among men ages 75–84, 71% are married and live with their spouse (U.S. Census Bureau, 2013b). Older women are less likely than men to remarry after the death of their spouse, and older women are less likely to live with other family members than they were in the past. For unmarried elders, functional status and cognitive functioning are key factors that lead to living with one's children or other relatives (Liang et al., 2005).

Living arrangements among older adults are linked to cultural values associated with individualism and independence or collectivism and interdependence. In a comparison of living arrangements of older adults in 43 countries, older adults were the most likely age group to live alone. However, in Africa it was more common for older adults to head up a large household that included young children than in other countries. In Asia co-residence with adult children was more common than in Africa. When older adults lived with their children, co-residence with adult sons and their families was more common in Asia and Africa, but co-residence with adult daughters and their families was more common in Latin America. In countries with higher levels of education for the general population, families were more likely to have nuclear households with older adults living alone (Bongaarts & Zimmer, 2002).

Living Alone. One implication of these trends in living arrangements is that increasing numbers of women are establishing a new single lifestyle in which they function as heads of households at ages 75 and older. Though still in need of social interaction and support services, they are often relieved of the responsibilities of caring for spouses who were ill. Depending on their own health, these women may be freer to direct their time and interests toward their friends, grandchildren, hobbies, and activities than they have been at any other time in their lives. In a qualitative study of older widows' experiences, four themes emerged: (1) making aloneness acceptable, (2) going my own way, (3) reducing my risks, and (4) sustaining myself (Porter, 1994). One aspect of this process of adaptation, often linked to "going my own way" and "reducing my risks," is a decision to move from one's residence. In a longitudinal study of residential mobility, individuals were interviewed over a 20-year period. Widowhood was found to be a significant event that triggered a decision to move, often within the first year after becoming widowed (Chevan, 1995).

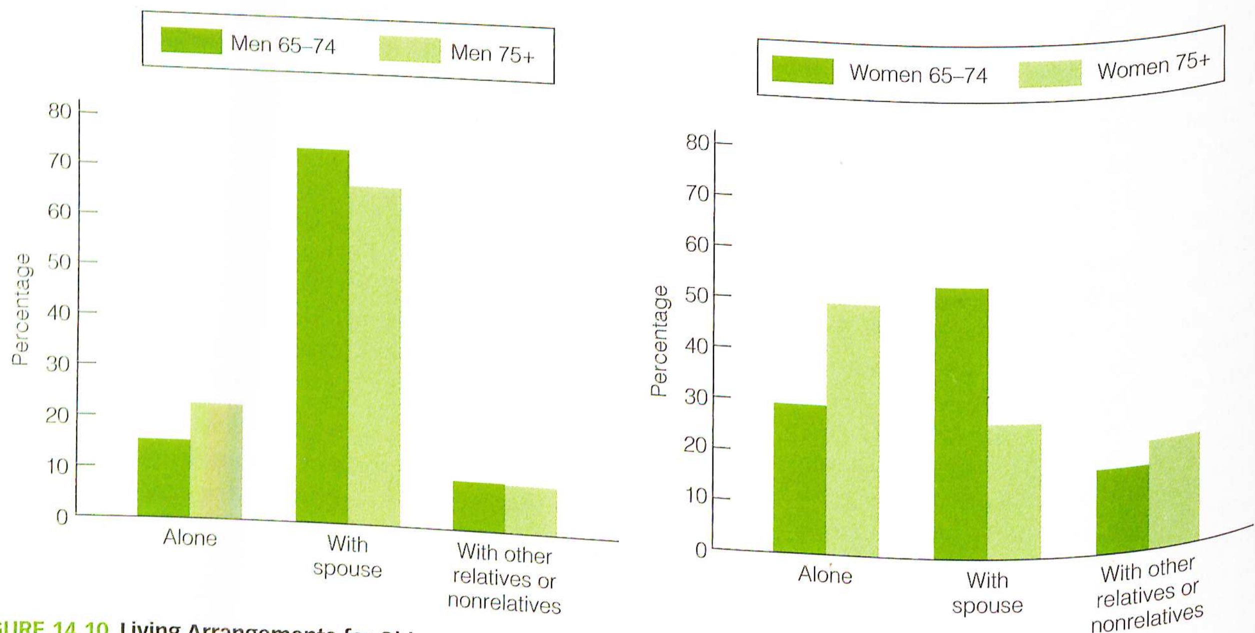


FIGURE 14.10 Living Arrangements for Older Adults by Age and Sex: 2003
Source: U.S. Census Bureau, 2004.

The pattern of elderly women living alone is similar in Canada, the United Kingdom, and many other northern European countries, but it is not as common in southern Europe and developing countries where both older men and women, whether married or widowed, live in multigenerational families. For example, data gathered in four Asian countries—Thailand, Singapore, Philippines, and Vietnam—in the mid-1990s found that from 60% to 90% of older adults lived with their children and grandchildren. The case of Japan illustrates the possible impact of modernization on the living arrangements of the elderly. In 1960, about 90% of older adults lived with their children (or one might say that the children lived with them in their households). By 1990, this type of living arrangement had declined to 50%. Both the increasing longevity and improved financial resources of older adults contribute to this trend toward independent housing, which is coupled with a continued desire for close kinship ties (Kinsella & Velkoff, 2001) (Figure 14.11).

In the United States, living arrangements for older women differ by race and ethnic group. Older unmarried Asian American women, for example, are much more likely to live with other family members than to live alone in comparison to European American women of similar economic and educational backgrounds. Within the Asian American ethnic groups, acculturation appears to increase the likelihood of choosing to live alone. Those who immigrated to the United States before 1965 or who were born in the United States are more likely to live alone than the more recent immigrants. In a comparison among the Asian American cultures, older Japanese women were more likely to live alone than the Chinese, Filipino, and Korean women. Consistent with patterns for European American women, the more children these Asian American women had, the less likely they were to be institutionalized (Burr & Mutchler, 1993).

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FIGURE 14.11 Most older women who live alone adapt well to this independent life style. Charlotte enjoys her needlepoint, has frequent visits from family and friends, and does not have to take care of anyone but herself.

Older African Americans are more likely than other ethnic groups to live in large households where the membership is changing over time. In a sample of older Floridians, the African American elders were more likely than other groups to form co-resident relationships with their grandchildren and other nonrelatives. As marital status, aging, and disability or health needs of family and fictive kin dictated, African American households were more likely to add new members (Peek, Koropeckyj-Cox, Zsembik, & Coward, 2004).

The majority of men aged 75–84—about 72%—are married and live with their spouses; only 16% are widowed. In contrast, 37% of women in this age range are married and living with their spouse, and 48% are widowed (U.S. Census Bureau, 2012a). Widowed men are much more likely to remarry, which they tend to do quickly. However, remarriage among the very old is still a new frontier. Sexual and social stereotypes inhibit some older people from considering remarriage. Also, potential financial consequences may make remarriage undesirable. For instance, a widow may lose her husband's pension or her social security benefits if she remarries. However, some older couples cope with this problem by living together instead of marrying. From 2000 to 2010, in the U.S. the number of unmarried, heterosexual couples over the age of 65 who were living together increased from 193,000 to 575,000 (Creamer, 2011).

In contrast to those older women who live alone and those who live with a male partner, an emerging strategy is for several older women to live together. This alternative addresses the increasing costs of housing in many communities as well as the growing research evidence about the health and mental health risks of social isolation and loneliness in later life. Women of the baby boom generation are more likely to have experienced divorce and have smaller families than the previous generation of older adults. Many of these women have developed and nurtured friendships with other women from their high school and college years, in the workplace, and through community participation. As they begin planning for later adulthood, the idea of sharing the costs and responsibilities with good friends can be quite appealing. "We lived together in dorms and sororities. We shared apartments after graduation. We traveled together. We helped each other through divorce and the death of our parents. Why not take it to the next level?" (Gross, 2004, p. 1).

Interstate Migration. The great majority of older adults (more than 95%) remain in their home communities as they age, many preferring to stay in their own home, even after their children move out and their spouse dies. Yet the trend toward interstate migration has increased since the mid-1960s. Each year, roughly 1% to 2% of those 75 and older move to a

new residence across state lines (U.S. Census Bureau, 2012a). Many of these older interstate migrants will live out their lives in communities in which they did not grow up, work, or raise their children. They are pioneers, establishing new friendships, community involvements, and lifestyles. Another group of older adults return to their birth state, especially after one's spouse dies or, in the case of serious disability, in order to be close to family caregivers (Stoller & Longino, 2001). In the face of some new physical limitations, older adults may want to be able to remain independent but require more help. By moving back to their home community, they are more confident about being able to draw on needed support from family and friends (Rowles & Ravdal, 2002). In addition to these permanent moves, many older adults participate in seasonal migration—residents from southern states go north for the summer, and residents of northern states go south for the winter. Over time, some of these seasonal migrants decide to establish a permanent residence in the state they visit. This is especially likely for northern residents who establish permanent residence in the South (Smith & House, 2006).

Housing Options. Differences in lifestyle, health, interest, ability to perform daily activities, marital status, and income enter into the very old person's preference for housing arrangements. Housing for the elderly—sometimes referred to as *retirement housing*—has expanded dramatically, and developers have experimented with a great variety of housing configurations that are intended to meet the special needs of particular aging populations (Shapiro, 2001). These options range from inner-city hotels for those with minimal incomes to sprawling luxury villages with apartments, medical clinics, and sponsored activities. Retirement communities are typically age-restricted residences. They may be apartments in a high-rise, townhouses, or homes with shared recreational resources, like a fitness center, pool, or golf course, and social and cultural programming. Often, they provide the option for prepared meals or a communal dining center. Life satisfaction in a retirement community may depend on the fit between one's marital status and the demographics of the community. For example, one study assessed the life satisfaction of widows who were living alone in retirement communities. When widows outnumbered married couples in the community, the widows had a high frequency of seeing friends and participating in activities. However, when married couples outnumbered widows, the widows experienced less satisfaction and were more socially isolated (Hong & Duff, 1994).

The majority of older adults live in urban areas, and 31% live in inner-city neighborhoods. As a result, any economic factors that affect the **housing options** in urban communities have a significant impact on the living arrangements of older adults (see the **Applying Theory and Research** box The Impact of Gentrification on the Elderly). Because older adults tend to have a limited income and depend on the quality of community resources and social support for their well-being, moving can be an especially difficult life event, adversely affecting their overall well-being (Pynoos, Caraviello, & Cicero, 2010).

Institutional Care. About 1.3 million adults older than 65 live in **skill care facilities** (sometimes referred to as nursing homes). This includes any arrangement with three or more beds that provides nursing and personal care services (U.S. Census Bureau, 2012). **Nursing homes** provide nursing care and rehabilitation for people who have severe functional limitations as a result of acute illness, surgery, or advanced dementia. The likelihood of institutionalization increases with age and limitations in family support. In 2010, about .9% of those ages 65–74 were living in a nursing home; but almost 25% of those 95 and older were in this kind of facility. About 75% of people in nursing homes do not have spouses. The likelihood of a person living in a nursing home increases when there is no family member who can help to manage daily living needs. People tend to think that once older adults are admitted to a nursing home, they stay there until they die. In fact, there is a high annual turnover among nursing home residents. The average length of stay is 6 months. The U.S Department of Health and Human Services estimates that about 37% of people will use some type of nursing or assisted living care facility in their lifetime, and that people use this type of care for an average of 12 months in their lifetime (longtermcare.gov, 2013). Often, a person enters a nursing home for a period of convalescence after hospitalization and then returns home or to a setting that provides less intensive care (Figure 14.12).

Many nursing homes are part of a **continuing care retirement community**—a residential setting offering housing and medical, preventive health, and social services to residents who are well at the time they enter the community. Once admitted, they are guaranteed nursing care if they become ill or disabled (Shapiro, 2001). In an analysis of nursing home use among residents in continuing care retirement communities, the risk of being transferred to the nursing home facility appeared to be greater than the rate for older adults in the local community, but the length of stay per admission was shorter (Cohen, Tell, Bishop, Wallack, & Branch, 1989). The nursing home may be used for recuperative purposes rather than having patients stay in the hospital for a longer period. This practice may reduce overall medical costs and provide a better recovery environment than being discharged to one's home before one can fully manage all the demands of self-care.

The advantages of a continuing care community are described by Glenn Smith:

> "We'd seen a lot of people our age struggle when one went into a skilled nursing facility 6 miles away," says 76-year-old Glenn Smith. "Then someone has to drive Momma over to see Daddy every day." So Smith and his wife, Kathleen, moved to a CCRC (continuing care retirement community) atop a hill overlooking Oregon's Rogue River Valley. A nursing home is just a short walk from their spacious three bedroom cottage. Smith, who is a retired college administrator, has one bit of advice: Move in while you are younger and healthy in order to take full advantage of the activities—and pay a lower entry fee. (Shapiro, 2001, p. 60)

Susan Woog/Science Source

FIGURE 14.12 At 97 years of age, Stella has had to move into a nursing home because she can no longer walk. Periodic visits from her great-grandson keep her in good spirits. He plays, and she is a most appreciative audience.

The costs of a continuing care community can be extensive and vary depending on the level and extent of services provided. Recent economic conditions have created financial difficulties for some of these facilities, which raises the possibility that people who have invested in a long-term contract may find themselves in a facility that faces bankruptcy (Greene, 2010).

Aging in Place. The fastest growing component of the Medicare program is **community-based long-term health care** which provides medical and social services to those who are chronically ill and eligible for institutionalization but who, nevertheless, live in the community. An estimated 42% of older adults use some type of paid home health care service (longtermcare.gov, 2013). At their best, these programs are designed to complement and support informal caregiving, supplementing and providing relief for family members and friends who are trying to care for the very old. They bring comfort to the very old clients who prefer to remain in their homes.

These programs also offer flexibility by providing needed services and modifying them as a person's condition changes. For example, a home health service may provide a case manager who can identify the required services and coordinate a program of home care providers, services, and adult day care to meet the needs of the client and the client's support system. Funding is person-centered, rather than institution-centered which allows services to be altered in order to support movement from institution to home-based care. Long-term home health care programs evolve in response to the pattern of need that emerges in a community and the quality of the services available. As the programs develop, their emphasis tends to shift from providing services to those who would otherwise be institutionalized to preventing institutionalization among a high-risk population (Kasper, 1997; Kaye, 1995; Medicaid.gov, 2013; U.S. Department of Health and Human Services, 2005).

The benefits of remaining in one's home, despite serious limitations in functional independence, are (1) preserving one's sense of autonomy and dignity, (2) reducing expenses, and (3) sustaining relationships with family and friends. By remaining in one's home, a person has greater control over the way the environment is adapted to one's changing abilities and needs. The personal and private meaning of the home environment supports one's identity and helps preserve a sense of "keeping up with dignity and pride (Rowles & Bernard, 2013; Witse, Vik & Ytterhus, 2012). In contrast, the move to a nursing home tends to be associated with higher levels of dependence and greater emphasis on "going along with the program" rather than on initiating one's own plans and projects.

In a comparison of older women living in their homes and those living in a nursing care facility, researchers were interested in how the living arrangements might influence cognitive problem solving. The home-based group became more engaged in the hypothetical problems, their solutions suggested a greater sense of perceived control over the solutions, and they approached the problems in a more abstract, relativistic manner (Collins, Luszcz, Lawson, & Keeves, 1997). The results of this work suggest that the nursing home environment may operate to undermine cognitive functioning by reducing the need for independent problem-solving activity. However, as the case study about Mr. Z suggests, there are nursing home residents who retain their positive spirit and are able to help others while receiving the level of support they require given their serious physical disabilities.

APPLYING THEORY AND RESEARCH TO LIFE

The Impact of Gentrification on the Elderly

Gentrification is a process of urban renewal or renovation in which new home owners and developers invest in the rehabilitation of neighborhoods that have been declining or deteriorating due to lack of maintenance and upkeep of the properties. Middle and upper income residents move into areas that have been deteriorating, often displacing poorer residents who have lived in that area for some time. To make investment in new construction and rehabilitation of older housing stock profitable, developers must be able to attract residents who can pay higher rents such as professionals and managers (the urban gentry). Once this process gets under way, landlords have an incentive to evict low-income residents who may have lived in the neighborhood for a long time in favor of more affluent tenants who can afford higher rent (Renn, 2013).

Several consequences of gentrification can have a negative impact on the housing options of older adults. First, rental apartments are converted to condominiums that older adults cannot afford. Second, in areas where there is no rent control, the rent rises above the rate that the older person is able to pay. Where there is rent regulation, some landlords use harassment to force out the original residents. Third, properties that have been used as single-room-occupancy hotels are demolished and new structures are built. Single-room-occupancy hotels provide low-cost housing and social support to many older adults who live alone. From 1970 to 1982, more than half the single-room-occupancy units in the United States were lost to various urban gentrification projects (Hopper & Hamberg, 1986). A similar study of gentrification in London found a significant displacement of the elderly, with the hidden costs of overcrowding in family, friends', or relatives' homes; homelessness; and expanded unmet housing needs (Atkinson, 2000).

In addition to reducing access to affordable housing, the disruption in older adults' living arrangements can have health implications due to dispersion of the person's social support network, reduced access to public transportation, and less readily accessible sources of basic goods and services (Centers for Disease Control and Prevention, 2012a).

Although gentrification poses threats to housing for the elderly, the alternative of ongoing neglect and decay in urban neighborhoods brings its own risks—especially increased crime, health and safety hazards, and lack of services. Over time, people with more resources leave these neighborhoods, making them vulnerable to continued deterioration. Writing about the process of gentrification in Los Angeles, David Zahniser described it as follows:

> That, in a nutshell, is the most maddening thing about gentrification—its very duality, the way in which it simultaneously delivers pleasure and pain, miraculous benefits and terrible consequences. As middle-income residents move in, neighborhoods that once heard low-flying helicopters and automatic-weapons fire have found a greater measure of peace. Working-class families who scraped together the money to buy homes in the mid-1990s have happily cashed out, making hundreds of thousands of dollars en route to a five-bedroom home in Fontana, Las Vegas or Phoenix. Those who stay behind, however, frequently find themselves in a neighborhood they don't recognize. And those who rent in a rapidly gentrifying neighborhood discover that they gained physical security while losing economic security, with rents rising steadily and the inventory of reasonably priced homes shrinking (Zahniser, 2006, p. 2)

More positive approaches suggest a gradual rehabilitation or redevelopment of urban communities that preserves the identity of the neighborhood but encourages new building and new businesses at a slower rate of growth (Centers for Disease Control and Prevention, 2012a). One idea is to offer developers incentives to include rental or sale units for low- and moderate- income residents as part of their design. Some cities have placed a freeze on the conversions of rental units to condominiums. Others have created community land trusts where residents own the units or homes they live in, but the community owns the land, thus helping to control its use. This strategy is intended to help protect the neighborhood atmosphere and tone that have been created by its long-term residents.

Critical Thinking Questions

1. Explain why older adults are especially likely to be impacted by gentrification. Why might the increased housing costs be especially difficult for them?
2. Describe the particular stressors that an older adult might face if gentrification results in a loss of their long-term residence.
3. Speculate about impact on psychosocial development of moving to a new neighborhood for people who are in their 80s or 90s.
4. Hypothesize about why the elderly might want to remain in their apartment or home, even if the neighborhood is deteriorating.
5. State your opinion about the obligations that local governments and developers should assume for the housing needs of the elderly when older housing stock is renovated or replaced.

CASE STUDY

MR. Z

The following case illustrates the importance of psychological attitudes in allowing a person with serious physical problems to play a meaningful role in a social setting for the frail elderly. Mr. Z's outlook helps him maintain his vitality and express his love of life.

Mr. M. L. Z is an 89-year-old White male of Eastern European origin. He lives in a midsized nursing home in the Midwest. Many of his daily activities revolve around circulating among the facility's residents, chatting, playing cards, reading to them, and "fetching things." Most important, Mr. Z carries his old battered violin with him and at the drop of a hat will play a tune or break into song in a surprisingly strong, clear, melodic voice. He claims to be able to sing songs in any one of seven languages, and with the least encouragement will try out several for anyone who will listen.

Mr. Z is small (5′ 3″), frail looking, and completely bald. He has facial scars and wears extremely thick-lensed glasses. He seems to be known and well liked by practically all residents and staff of the facility in which he resides, and by many visitors there as well.

He recalls a colorful history. He "escaped" his homeland at the tender age of 16 to avoid compulsory military service and fled to Russia. There he was inducted into the army, and was subsequently sent off to duty in Siberia, where he lived for about 6 years. After another tour of duty in a border patrol he deserted, he made his way across Europe, and eventually came to the United States. Here he took odd jobs, educated himself, and in time "got into show business"; he became a vaudeville prompter. In time his contacts in entertainment took him around the world. Yet time took its toll.

He tells of marrying a woman with whom he lived for almost 40 years. They had no children and she died some 15 years ago. Following her death, he began to experience a series of physical difficulties. An operation for cataracts left him with the need for very thick glasses. At one time he had a toupee made, which he has not worn for some time. One leg was amputated because of a diabetic condition, and he now wears a prosthetic leg. In addition, he wears a hearing aid, false teeth, and, for the last year, a heart pacer. Several years ago he experienced what he calls a small stroke, which left him "mixed up" for a few days. But he "worked this out," he reports, by "walking a lot," an activity in which he engages frequently.

Mr. Z says he has never smoked and drinks only on occasions or holidays, and then only to a limited degree. He scorns food fads, and eats mostly fresh fruits and lots of vegetables; he loves fish and drinks lots of tea.

Despite all his troubles, Mr. Z maintains what is apparently a cheerful, optimistic view of life and circumstances, while he pursues his hobby of energetically helping his fellow residents keep their spirits up and their interests high. He is very highly regarded and seen as filling a very important role in his nursing home as a storyteller and entertainer.

Source: Excerpt from *Aging and Life: An Introduction to Gerontology* (2nd ed.), by A. N. Schwartz, C. L. Snyder, and J. A. Peterson, pp. 33–34. Copyright © 1984. Austin, TX: Holt, Rinehart & Winston, Inc. Reprinted by permission of the publisher.

CASE ANALYSIS Using What You Know

1. Imagine that you were having lunch with Mr. Z. What questions would you want to ask him?
2. Summarize the physical challenges of aging with which Mr. Z must cope.
3. Based on your reading, explain why Mr. Z might be living in a nursing home.
4. Describe Mr. Z's psychohistorical perspective. What insights does he have about history, time, and self-awareness?
5. Analyze the unique, creative adaptations that characterize Mr. Z's story.
6. Evaluate how well the nursing home is optimizing Mr. Z's functioning.

Gender-Role Definitions

The way in which very old adults view masculinity and femininity is yet another aspect of traveling uncharted territory. How do the very old define gender roles? How does gender influence behavior? Do very old adults make the same distinctions as college-age individuals about the behaviors that are appropriate or desirable for men and women? These questions remain to be answered.

Evaluating the Concept of Gender-Role Convergence. The idea of **gender-role convergence** suggests a transformation of gender-role orientation during midlife. According to this theoretical perspective, men become more nurturant and more concerned with social relationships. Women become more assertive and concerned with independence and achievement. As a result, men and women become more androgynous and, in that sense, more similar in gender orientation during later life (Gutmann, 1987).

The extent to which men and women become more similar in outlook and behavior in later adulthood and elderhood is a subject of controversy. Unfortunately, few data from longitudinal or cohort sequential studies are available to address this topic. Cross-sectional data collected from men and women across a wide age span from early adulthood to elderhood have focused on men's and women's endorsement of affiliative and instrumental values. Men and women appear to be similar in their **affiliative values**—that is, the values placed on helping or pleasing others, reflected in the amount of time they spend and the degree of satisfaction they achieve in such actions. At each age, men are more invested than women in **instrumental values**—that is, the values placed on doing things that are challenging, reflected in the amount of time they spend and the degree of satisfaction they achieve in such actions. However, the youngest age groups value instrumentality more highly and devote more time to it than the oldest age group. Thus, gender differences in instrumentality persist, but instrumentality becomes somewhat less important for older men and women. Affiliative behavior is equally important for men and women at both ages (Fultz & Herzog, 1991).

The stereotypes that are applied to aging men and women reflect similar patterns. College students and older adults (with a mean age of 70) were asked to generate characteristics in response to one of four target stimuli: a 35-year-old man, a 35-year-old woman, a 65-year-old man, and a 65-year-old woman (Kite, Deaux, & Miele, 1991). Age stereotypes were more prevalent than gender stereotypes. The attributes that were used to characterize older men and women were similar and distinct from the attributes used to characterize younger men and women.

In general, the older target people were evaluated more negatively by the younger participants, but not as negatively by the older participants. These negative judgments included unattractive physical qualities as well as irritable and depressed personality qualities. Moreover, younger participants were more likely to characterize both male and female older target people as lacking in instrumental traits, such as achievement orientation and self-confidence. However, they did not view older target people as lacking in affiliative traits, such as caring about others or being kind or generous. Thus, the gender-role convergence that has been hypothesized as taking place with advanced age is reflected in the stereotypes that younger people apply to older adults.

Gender-role convergence, where it is observed, may be due to changing circumstances rather than to a normative pattern of development in later life. For example, many older women experience a transition from living with their husbands to living alone after age 75. This change is linked to new demands for independence, self-reliance, and agency. Women who are able to meet these challenges by developing independent living skills, making effective use of social supports and community resources, and initiating new relationships are likely to experience a heightened sense of well-being.

For many older married couples, the physical effects of aging bring new needs for assistance in some of the tasks of daily living. Because men usually marry younger women, they are more likely to require the assistance of their wives in the later years of marriage, thus shifting the balance of power and increasing their sense of **dependency**. This may be especially true when husbands retire while their wives continue to work; when husbands can no longer drive and must depend on their wives for transportation; or when, due to health constraints, husbands are restricted from performing the types of household tasks that once were their domain, such as mowing the grass, shoveling snow, repairing the home, or other tasks requiring muscle strength and endurance. On the other hand, among adults of 75 years and older, more women than men have difficulties with mobility and require assistance in the tasks of independent living. Thus, health and fitness more than gender may guide the nature of dyadic interactions among older couples. As men and women become more equal with respect to power and resources in their marital relationship, there may be fewer clear-cut gender expectations. Still, to the extent that gender-role distinctions help stabilize a relationship, older adults may be reluctant to make dramatic changes to the way their relationships have been structured (Silver, 2003).

Romance and Sexuality

Romance, intimacy, and sexuality remain important among older married couples. The majority of couples who have enjoyed a close, sexually active relationship report little change in satisfaction from age 60 to 85. Some couples explore different ways of experiencing sexual pleasure in later life, and others report a more relaxed, sexually satisfying quality in their lovemaking. Using Sternberg's (1988) model of the three dimensions of love relationships (see chapter 11, Early Adulthood), long-lasting marriages tend to be more companionate in nature, emphasizing intimacy and commitment over passion. In this model, lovemaking may take on a different intensity and quality over time. Current research on **sexuality** in later life confirms that older adults have sexual needs, benefit from sexual expression, and are able to be sexually active. A national survey of adults ages 60 and older found that more than half were sexually active, meaning that they had intercourse, oral sex, anal intercourse, or masturbated at least once a month (Dunn & Cutler, 2000). This study found that sexual activity declined with age, but that 20% to 25% of those in their 80s were still sexually active. Older couples may find greater satisfaction in intimate physical contact, such as kissing and caressing, and experimentation with new ways of experiencing sexual stimulation as genital intercourse becomes less frequent. Following along with the idea of gender-role convergence, men and women become more similar in their sexual behavior and more harmonious in their lovemaking (Crooks & Bauer, 2013) (Figure 14.13).

Today's cohort of older men and women tend to be tied to many of the traditional gender-role standards of their historical era. For example, older women are likely to believe that the only kinds of relationships that are possible between men and women are romantic or courtship relationships. Few very old women have friendships with very old men, partly because few older men are available, but also because most older women have no models for independent friendship relationships with men. During their early and middle adult years, their friendships with men were either formed while they were part of a couple or mediated by some other situation, such as a work setting. Many men in the current elderhood cohort also behave in accordance with the gender-role standards of their young adulthood. Although women far outnumber men at advanced ages, men still seem to prefer to remarry rather than play the field, although they have become a scarce and valuable commodity. The norm of serial monogamy guides these men's behavior. They are probably motivated to remarry by a desire to continue to be taken care of as well as to satisfy their sexual needs.

One of the greatest challenges to continued romantic and sexual intimacy in later life is widowhood. Despite the fact that older men are much more likely to remarry than older

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FIGURE 14.13 After 60 years of marriage, Ann and Ted still get quite a kick out of being together. Their lives are sprinkled with many moments like this, when a glance or an expression brings out a loving smile.

women, remarriage is relatively uncommon in later adulthood and elderhood. Do elders hope for a romantic relationship after widowhood? This question was addressed in a study of older couples that followed men and women 6 and 18 months after widowhood (Carr, 2004). Participants were asked two questions about their romantic interests: "At this point do you have any interest in dating?" which was answered *yes* or *no*, and "Some day I would like to remarry," answered on a scale from *not true at all* to *very true*. They were also asked if they were dating. At 6 months after widowhood, men were more likely to want to be dating than women (17% vs. 6%), more likely to want to remarry (30% vs. 16%), and more likely to be dating (15% vs. less than 1%). At 18 months after widowhood, men were still more likely to want to be dating (37% vs. 15%) and more likely to be dating (23% vs. 9%), but about equally likely to want to remarry (26% vs. 19%). The most important predictor of whether men or women wanted to date or remarry was the quality of their social support system. In general, women had more supportive relationships with friends than did men prior to widowhood. The more social support men had, the less likely they were to express interest in remarriage. Men and women who had comparable levels of social support from friends were equally disinterested in remarriage.

This research suggests that the picture we have about gender differences in motivations to find a new partner after widowhood needs to be revised. First, although more men than women are interested in new romantic relationships, the majority of men do not express this interest. Second, when social support systems are comparable, men and women are about equally likely to reject the idea of a new romantic relationship. One limitation of this research was the way in which interest in a new partner was defined, limiting the alternatives for romantic relationships to dating and marriage. Given the potential costs of remarriage in later life, older adults may be looking for a different kind of intimacy that does not require the responsibilities of co-residence or the legal and financial considerations of marriage (Davidson, 2002; Ghazanfareeon, Karlsson, & Borrell, 2002; Moorman, Booth, & Fingerman, 2006).

Ageism and Sexuality. Older adults continue to face negative, ageist social attitudes about sexual activity that may inhibit their sexual behavior. These social attitudes include assumptions that very old adults do not have sexual desires, they cannot have intercourse because of sexual dysfunction, sex may be dangerous to their health, they are physically and sexually unattractive, and it is morally wrong or perverted for older adults to be sexually active (Crooks & Bauer, 2013). Current cohorts of very old adults have limited knowledge about sexuality and aging. A number of studies have demonstrated that increasing knowledge through various types of sex education programs can increase permissive attitudes about sexuality among older adults (Hillman & Stricker, 1994). These interventions have involved the elderly people themselves, nursing students, college students, nursing home staff, and adult children of aging parents. However, increased knowledge does not always result in more permissive attitudes. Especially among health care staff in institutional settings, the institutional regulations, personal moral values, and practical problems of permitting sexual activity among residents may combine to promote a more negative attitude even with advanced information about sexuality and aging.

Cohort factors may change the current societal attitudes toward sexuality among the very old. Because so many more

adult women are in the workplace, they have more experience with male colleagues. Also, changing sexual norms have already led many more adults to experience nonmarital sexual relationships. A growing openness about homosexual relationships may reduce some of the stigma against forming same-sex bonds in later life. Acceptance of new sexual relationships in later life is more likely because many adults will have experienced a larger number of sexual relationships in their earlier years of adulthood. The high divorce rate since the mid-1970s means that in the future more women will have had the experience of developing a single lifestyle that includes a network of both male and female friends. As the value of intimacy for health and well-being is more fully recognized, we may expect future groups of older adults to be more comfortable about forming homosexual as well as heterosexual intimate relationships.

FURTHER REFLECTION: *Imagine that you are now 85 years old. Describe the kind of life you hope to be living. What kind of living arrangement, social relationships, and activities would you like to have? What concerns for physical health, safety, intellectual stimulation, and social interaction will you have then? How will you design your life structure to support your needs in these domains?*

The Psychosocial Crisis: Immortality Versus Extinction

OBJECTIVE 5. Define and explain the psychosocial crisis of immortality versus extinction, the central process of social support, the prime adaptive ego quality of confidence, and the core pathology of diffidence.

By the end of later adulthood, most people have developed a point of view about death. Although they may continue to experience anxiety about their impending death, they have found the courage to confront their fears and overcome them. If older adults have achieved integrity, they believe that their life has made sense. This amplifies their confidence about the choices they have made and the goals they have achieved without despair over the failures, missed opportunities, or misfortunes that may have occurred. Thus armed, elders can accept the end of life and view it as a natural part of the life span. They are capable of distilling wisdom from the events of their lives, including their successes and mistakes.

However, elders are faced with a new challenge—a conflict between the acceptance of death and the intensifying hope for immortality. Having lived longer than their cohort of friends, family members, and even, in some cases, their children, elders struggle to find meaning in their survival. All of us face a certain disbelief about our own mortality. Although we know that death is a certainty, an element of human thought prevents us from facing the full realization of death; we continue to hope for immortality. This quality may be adaptive in that people who have a sense of hope cope with the reality of death better than those who do not (Kesebir, 2011).

Immortality

Elders have a unique appreciation of time. They recognize that there is a finite amount of future time until their death, as well as an unlimited transcendental future time that begins with their death and extends onward into infinity (Boyd & Zimbardo, 1996; Zimbardo & Boyd, 2008). They begin to see themselves as links in a long, fluid chain of historical and biological growth and change. The positive pole of this crisis is a confidence in the continuity of life, a transcendence of death through the development of a symbolic sense of immortality. The achievement of this perspective, which may include the incorporation of transcendental goals such as reuniting with loved ones after death or being released from the limitations of an aging body, may be accompanied with sentiments of joy which contribute to feelings of well-being, flexibility, and acceptance of the challenges of aging.

A psychosocial sense of **immortality** may be achieved and expressed in many ways (Lifton, 1973). Here, we explore five possible paths toward immortality. First, one may live on through one's children, sensing a connection and attachment to the future through one's life and the lives of one's offspring. This type of immortality can be extended to include devotion to one's country, social organizations or groups, or humankind.

Second, one may believe in an afterlife, an immortal soul, or a spiritual plane of existence that extends beyond one's biological life (Pereira, Falsca, de Sá-Saraiva, 2012). Most religions espouse the concept of a state of harmony with natural forces, so that after death, one endures beyond this earthly life. (Figure 14.14) Among many indigenous peoples, there is a sacred link between the living and the dead—a responsibility on the part of the living to protect and respect the sacred burial grounds and a responsibility on the part of the dead ancestors to look after the spiritual well-being of the living. This belief is illustrated in the **Human Development and Diversity** box, The Responsibility of Native Hawaiians for Their Ancestors' Remains.

Third, one may achieve a sense of immortality through creative achievements and their impact on others. Many people find comfort in believing that they are part of a chain of positive influences on the lives of others. This sense of immortality is linked to the achievement of generativity in middle adulthood. Adults who have made a commitment to improving the quality of life for others during middle adulthood are likely to see evidence of this effort by the time they reach elderhood.

> Perhaps it was only in the later years of my practice—s I saw the results of my labors in the unfolding lives of my patients—that once again I appreciated the value of my link in the chain of life. (Young, 2011)

HUMAN DEVELOPMENT AND DIVERSITY

The Responsibility of Native Hawaiians for Their Ancestors' Remains

The following narrative describes the crisis of immortality versus extinction in the context of the desecration of a native Hawaiian burial site. In fighting to stop the destruction, those involved were reminded of the commitment that the living have for the care and protection of the burial grounds of their ancestors:

> Hawai'i Nei was born December 1988 from the *kaumah a* (heaviness) and *aokanaka* (enlightenment) caused by the archaeological disinterment of over 1,100 ancestral Native Hawaiians from Honokahua, Maui. The ancestral remains were removed over the protests of the Native Hawaiian community in order to build the Ritz Carlton Hotel. The desecration was stopped following a 24-hour vigil at the State Capital. Governor John Waihe'e, a Native Hawaiian, approved of a settlement that returned the ancestral remains to their *one hanau* (birth sands), set aside the reburial site in perpetuity, and moved the hotel inland and away from the ancestral resting place.
>
> In one sense Honokahua represents balance for from this tragedy came enlightenment: the realization by living Native Hawaiians that we were responsible for the care and protection of our ancestors and that cultural protocols needed to be relearned and laws effectively changed to create the empowerment necessary to carry out this important and time-honored responsibility to *malama* (take care) and *kupale* (protect) our ancestors.
>
> Hui Malama I Na Kupuna O Hawai'i Nei members have trained under the direction of Edward and Pualani Kanahele of Hilo in traditional protocols relating to the care of *na iwi kupuna* (ancestral remains). These commitments were undertaken as a form of *aloha* and respect for our own families, ancestors, parents, and children.
>
> Hui Malama I Na Kupuna O Hawai'i Nei has been taught by the Kanahele family about the importance of *pule* (prayer) necessary to *ho'olohe* (listen) to the calling of our ancestors. Through *pule* we request the assistance of *ke akua* and our ancestors to provide us with the tools necessary to conduct our work:
>
> *E homai ka ike, e homai ka ikaika, e homai ka akamai, e homai ka maopop o pono, e homai ka 'ike papalua, e homai ka man a.*
>
> (Grant us knowledge, grant us strength, grant us intelligence, grant us righteous understanding, grant us visions and avenues of communication, grant us mana.)
>
> Moreover, we have been taught that the relationship between our ancestors and ourselves is one of interdependence—as the living, we have a *kuleana* (responsibility) to care for our *kupuna* (ancestors). In turn, our ancestors respond by protecting us on the spiritual side. Hence, one side cannot completely exist without the other.

Source: Pell (2002), http://huimalama.tripod.com/

Critical Thinking Questions

1. Describe the belief system that connects native Hawaiians and their ancestors. How does this belief system contribute to the resolution of the psychosocial crisis of immortality versus extinction?
2. Predict how the sense of interdependence between the living and the dead might influence the day-to-day behavior of native Hawaiians.
3. Select a culture of interest to you. Investigate and describe the relationship of the living to their ancestors in this culture. Summarize the beliefs, rituals, and actions that reflect this relationship.
4. Analyze the trends of modernization that may explain why Hawaiians have lost touch with the traditional practices associated with the care of ancestral remains. Propose what may be gained by reviving these traditions.

The bond between an individual and community makes death less final. An African proverb advises that you live as long as someone knows your name. The more embedded you are in your community and the more lives you have touched, the greater the sense of continuity or transcendence.

Fourth, one may develop the notion of participation in the chain of nature. In death, one's body returns to the earth and one's energy is brought forth in a new form.

Fifth, one may achieve a sense of immortality through what Lifton (1973) described as **experiential transcendence**:

> This state is characterized by extraordinary psychic unity and perceptual intensity. But there also occurs … a process of symbolic reordering.… Experiential transcendence includes a feeling of … "continuous present" that can be equated with eternity or with

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FIGURE 14.14 Through prayer and inspiration, this minister shares her faith and sense of immortality with her congregation.

"mythical time." This continuous present is perceived as not only "here and now" but as inseparable from past and future. (p. 10)

The notion of **cosmic transcendence** has been developed further in the writings of Lars Tornstam, a Swedish gerontologist, who writes about feelings of cosmic communion with the spirit of the universe, and a redefinition of time, space, life, and death (Tornstam, 2005). This expression of immortality is independent of religion, offspring, or creative achievement. It is an insight derived from moments of rapture or ecstasy in which all that one senses is the power of the moment. In these experiences, the duality of life and death dissolve, and what remains is continuous being.

Extinction

The negative pole of the psychosocial crisis of elderhood is a sense of being bound by the limits of one's own life history. In place of a belief in continuous existence and transformation, one views the end of life as an end to motion, attachment, and change. Instead of faith in the ideas of connection and continuity, one experiences a fear of **extinction**—a fear that one's life and its end amount to nothing. Erikson's advice on coping with aging concerns responding to loss and dealing with diminished capacities (see the **Applying Theory and Research to Life** box Erikson on Coping with Aging). It is not difficult to imagine that as a person reflects on the many losses encountered over a long life, there will be periods when it seems that all the effort, striving, hoping, and struggle did not amount to much. In the process of resolving this psychosocial crisis, it is to be expected that people will have at least momentary thoughts that there is nothing more; that the end is truly an end.

The following quotations from a study of very old men suggest the range in sentiment about immortality and extinction (Rosenfeld, 1978, p. 10). About 28% of the adults in the study were described as having low morale and made statements such as "I feel I'm a forgotten man. I don't exist anymore.... I don't feel old.... I'm just living out my life." About 25% were stoic but not very positive about their condition: "You know you're getting old. You have to put your mind to it and take it as it comes. You can't get out of it. Take it gracefully." Almost half found their lives full and rewarding: "I go home with my cup overflowing. There are so many opportunities to do things for people. These are the happiest days of my life."

Conditions in long-term care facilities may contribute to the sense of extinction for some elders. Imagine living in a facility where the staff consistently mistreats older adults. In one study, incidents of physical abuse, intimidation, and neglect were reported by 44% of nursing care residents. Being a victim of violence or being exposed to violent treatment of others in a setting where a person has no way to retaliate or punish the abuser can certainly produce feelings of despair and withdrawal (National Center on Elder Abuse, 2012).

The possibility of ending one's life with a sense of extinction is reflected in the public health concern about suicide among the elderly. Data from the *World Health Statistical Annual* provide a basis for describing the incidence of suicide for men and women in the age groups from 65 to 74 and 75 years and older (World Health Organization, 2013). Men commit suicide at higher rates than women at all ages, but the discrepancy increases with age. Finally, national and geographic differences are substantial. Korea has the highest national suicide rate.

In Germany more than half the suicides are committed by people ages 65 and older. In the analysis of factors associated with suicide in Germany, severe physical disease, loneliness and isolation, and feelings of meaninglessness were identified as forming a biopsychosocial context for late-life suicide (Schmitz-Scherzer, 1995). In Japan, suicide had been viewed through a cultural perspective as an expression of courage and individual freedom. However, recent increases in the rate of suicide among older adults have become a cause for concern. Changes in Japanese society have led to a reduced valuing of older family members and less extended family support. The rural elderly are less able to accept these changes which undercut their sense of purpose and meaning (Watanabe, Hasegawa, & Yoshinaga, 1996). Without appropriate social support, and in the face of

APPLYING THEORY AND RESEARCH TO LIFE

Erikson on Coping with Aging

The Eriksons' advice (Erikson et al., 1986, pp. 332–333) suggests the achievement of experiential transcendence:

> With aging, there are inevitably constant losses—losses of those very close, and friends near and far. Those who have been rich in intimacy also have the most to lose. Recollection is one form of adaptation, but the effort skillfully to form new relationships is adaptive and more rewarding. Old age is necessarily a time of relinquishing—of giving up old friends, old roles, earlier work that was once meaningful, and even possessions that belong to a previous stage of life and are now an impediment to the resiliency and freedom that seem to be requisite for adapting to the unknown challenges that determine the final stage of life.
>
> Trust in interdependence. Give and accept help when it is needed. Old Oedipus well knew that the aged sometimes need three legs; pride can be an asset but not a cane. When frailty takes over, dependence is appropriate, and one has no choice but to trust in the compassion of others and be consistently surprised at how faithful some caretakers can be.
>
> Much living, however, can teach us only how little is known. Accept that essential "not-knowingness" of childhood and with it also that playful curiosity. Growing old can be an interesting adventure and is certainly full of surprises.
>
> One is reminded here of the image Hindu philosophy uses to describe the final letting go—that of merely being. The mother cat picks up in her mouth the kitten, which completely collapses every tension and hangs limp and infinitely trusting in the maternal benevolence. The kitten responds instinctively. We human beings require at least a whole lifetime of practice to do this.

Source: From *Vital Involvement in Old Age*, by E. H. Erikson, J. M. Erikson, and H. Q. Kivnick (1986), pp. 332–333.

Critical Thinking Questions

1. Critically evaluate the advice provided by Erikson. Do you think it would be good advice to give to older adults to help them cope with the challenges of aging? What advice would you offer in its place?
2. Given the full course of psychosocial development, speculate about why it may be especially difficult for the elderly to accept help and depend upon others when they need it. What lessons from earlier stages of life might prepare a person to do this?
3. Erikson suggests adopting an outlook of playful "not-knowingness" and adventure. Summarize the cultural, religious and personal factors that might help a person attain this view of elderhood.
4. Read more about Erik Erikson. What can you find out about how well he was able to accept this advice in the last years of his life?

substantially reduced physical or psychological resources, a significant number of the very old end their own lives.

Evidence on the outlook of the community-based population of the United States suggests that relatively few of the elderly experience a level of discouragement that is implied by the sense of extinction. Among those ages 75 and older, fewer than 6% report pervasive feelings of worthlessness or hopelessness (National Center for Health Statistics, 2010). A caution about these data is that elders may be reluctant to report feelings of discouragement or hopelessness.

The Central Process: Social Support

Social support has been defined as the social experiences that lead people to believe that they are cared for and loved, esteemed and valued, and belong to a network of communication and mutual obligation (Cobb, 1979). Social support is a broad term that includes the quantity and interconnectedness or web of social relationships in which a person is embedded, the strength of those ties, the frequency of contact, and the extent to which the support system is perceived as helpful and caring (Bergeman, Plomin, Pedersen, McClearn, & Nesselroade, 1990). It is commonly divided into two different but complementary categories: **socioemotional support**, which refers to expressions of affection, respect, and esteem, and **instrumental support**, which refers to direct assistance, including help with chores, medical care, or transportation. Both types of social support—but especially socioemotional support—contribute to maintaining well-being and fostering the possibility of transcending the physical limitations that accompany aging (Rowe & Kahn, 1998).

The Benefits of Social Support

Social support plays a direct role in promoting health, well-being, and life satisfaction even when a person is not facing a specific stressful situation (Gow et al., 2007; White,

Philoogene, Fine & Sinha, 2009). Because social support involves meaningful social relationships, it reduces isolation. People who have intimate companions in later life have higher levels of life satisfaction. They feel valued and valuable. This kind of social support is likely to be most appreciated when it comes from friends and neighbors—members of the community who are not bound by familial obligation to care about the person, but who do so anyway.

The presence of caring, familiar people provides a flow of affection, information, advice, transportation, and assistance with meals and daily activities, finances, and health care—all critical resources. The presence of a support system tends to reduce the impact of stressors and protect people from some of their negative consequences, especially serious illnesses and depression (Krause, 2006).

Social integration and membership in a meaningful social support network are associated with increased longevity. A high level of social integration is associated with lower mortality rates (Cherry, Walker, Brown et al., 2013; Rowe & Kahn, 1997). The support system often serves to encourage an older person to maintain health care practices and to seek medical attention when it is needed. Members of the immediate family, close relatives, and friends provide direct care during times of grave illness or loss, encouraging the older person to cope with difficulties and to remain hopeful. Elders are likely to experience declines in physical stamina. They may also have limited financial resources. In order to transcend the limitations of their daily living situations, elders must be convinced that they are embedded in a network of social relationships in which they are valued. But their value cannot be based solely on a physical exchange of goods and services. Rather, it must be founded on an appreciation of the person's dignity and a history of reciprocal caring (Figure 14.15).

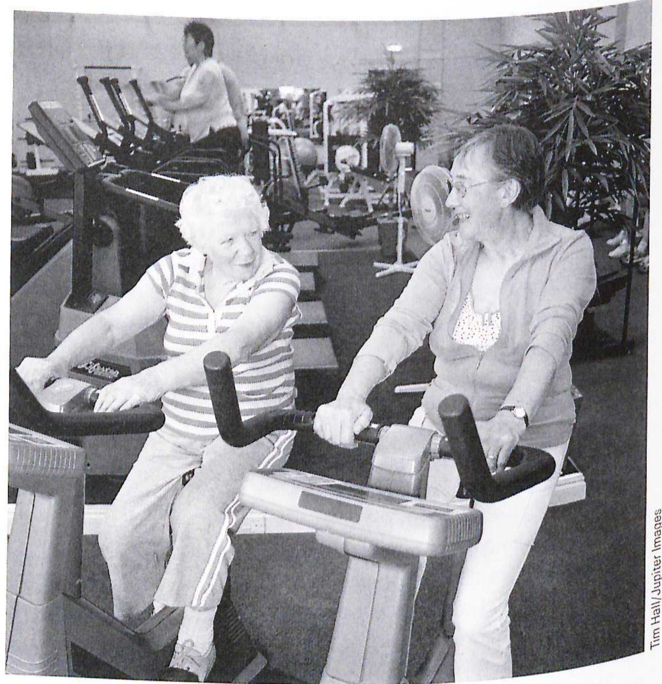
Tim Hall/Jupiter Images

FIGURE 14.15 Social support can contribute to improved health. Jean and Carol exercise together three times a week, talking and laughing as they ride.

The Dynamics of Social Support

The benefits of receiving social support can be diminished if the recipients adhere to a strong cultural norm for reciprocity. The **norm of reciprocity** implies that you are obligated to return in full value what you receive: "One good turn deserves another." People want and expect to be able to give about the same as or more than they receive. What is given does not have to be identical to what is received, but it has to be perceived as having equal worth. Being in someone's debt may be considered stressful and shameful. In a study of Japanese American elderly people, receiving material support from their family was associated with higher levels of depression and less satisfaction in life, especially for those who had very traditional values about reciprocity. The general principle of trying to mobilize social support to enhance the functioning of the very old has to be modified to include sensitivity to the context and meaning of that support (Nemoto, 1998).

Most elders continue to see themselves as involved in a reciprocal, supportive relationship with their friends. Feelings of usefulness and competence continue to be important correlates of well-being in later life. Older adults are especially likely to experience positive feelings of life satisfaction when they are able to provide assistance to others at times of significant life transition or need, such as unemployment or the divorce of a child (Davey & Eggebeen, 1998). Even though they are comforted by knowing that support would be available when needed, older adults are likely to experience negative feelings when the support received is more than was needed or when there is no opportunity for them to reciprocate (Liang, Krause, & Bennett, 2001).

Older adults may expect to receive more care from their children when they are ill than they can provide in exchange. By shifting to a life-span perspective, however, they can retain a sense of balance by seeing the help they receive now as comparable to the help they gave their children at earlier life stages (Ingersoll-Dayton & Antonucci, 1988). When elders are highly valued, it is not as important that they reciprocate in the exchange of tangible resources. Wisdom, affection, joie de vivre, and a positive model of surviving into old age are intangible resources that are highly valued by members of the very old person's social support network. Being valued may also mean that the person's advice and conversation are adequate exchange for some of the services and assistance provided by family and friends.

Social relationships can include both positive and negative interactions. Within one's social network, positive interactions might include enjoying shared activities, confiding about one's worries, or asking for help when one is ill. Negative interactions might include being taken advantage of, having one's privacy invaded, or being insulted. Sometimes, the same people can be sources of both positive and negative interactions.

Not surprisingly, the overall frequency of positive exchanges is related to lower levels of depression. When older adults experience the effects of negative social interactions in one relationship—for example, when they have an argument with their adult child—they can buffer these emotions by having positive interactions with another member of their social network—for example, a friend or spouse (Okun & Keith, 1998).

Many older adults are selective about the people in their social network, striving to interact primarily with people who engage in harmonious interactions. They also take steps to prevent conflict in the relationships they value. For example, they impose certain constraints on their interactions—not criticizing someone in public, respecting others' privacy, and keeping a confidence. These strategies help avoid negative interactions and maximize the satisfaction and stability of their relationships. These strategies are not a sign of weakness or passivity, but a deliberate attempt to protect meaningful relationships and avoid the negative affect associated with interpersonal conflict (Sorkin & Rook, 2004).

The Social Support Network

Of course, being an integral part of a social system does not begin in later life. It has its origins in infancy, with the formation of a mutual relationship with a caregiver. Social support systems are extended in childhood and early adolescence through identification with a peer group, and in early and middle adulthood through marriage, childrearing, and relationships with coworkers and adult friends. In later life, family members are usually the primary sources of social support, especially one's spouse, children, and siblings. The quality of the relationship between an adult child and an aging parent has a long history. Clearly, the nature of the support that an aging parent is able to receive or that an adult child is willing to provide is influenced by the feelings of closeness and connection that were fashioned during the childrearing process and also by the child's relationship to the parents during early adulthood years.

In the United States, age is a predictor of the size of the social support network. Younger people have larger social support networks than do older people. This may be true for a variety of reasons. For elder women, the likelihood of living alone is high. After the death of a spouse, men and women must realign their social support systems from among relationships that include their adult children, friends, relatives, neighbors, and new acquaintances in order to satisfy their needs for interaction and companionship. In a study of social relationships following widowhood, women clearly benefited from the social network that existed prior to their husband's death. However, contrary to expectations, efforts to modify this network by renewing old acquaintances or forming new friendships did not help to reduce feelings of depression or loneliness, even 2 years after the loss (Zettel & Rook, 2004).

Elders differ in the composition of their social networks. Whereas some elders rely heavily on close family members, others are closely linked to friends and neighbors, and others find their closest ties in church or community organizations. What is more, each type of social network component may contribute a unique resource. For example, a sibling might provide emotional support whereas a friend might provide companionship, shared activities, or health-related advice. Elders who are childless or have no surviving children or siblings are especially vulnerable to ending their lives in isolation. In contrast, those who are able to preserve a diverse social network are more likely to be the healthiest, make the most use of appropriate community services, and experience the highest levels of well-being (Antonucci et al., 2001; Bosworth & Schaie, 1997; Litwin, 1997; Litwin & Shiovitz-Ezra, 2011).

For many older adults, religious participation provides an additional source of social support. Older adults are more likely than younger adults to describe themselves as religious in their beliefs and behavior. Mary, who at age 80 has experienced the deaths of three brothers, her husband, and her daughter-in-law, gives and receives emotional support through her faith:

> I always have a lot of faith. The good Lord has always given me the strength to go on. I was raised to believe and pray when I have problems. I go to Mass every Sunday, and we have other special days when we go to Mass. I'm a Eucharistic minister. God makes me do things to feel better—I serve people and God. I go to buildings to give communion to people who can't get out. (Rowe & Kahn, 1998, p. 164)

Members of religious congregations are likely to provide one another with both emotional and instrumental social support. The place of religion in the lives of the very old is especially significant for African Americans, who are more likely than European Americans to attend religious services regularly, even at advanced ages. They are also more likely to describe themselves as very religious—a characterization that reflects the frequency of their private prayer, their strong emotional commitment, and their reading of religious material. Religious involvement among elderly African Americans is not predicted by income or education. Over time, elders who are active in their religious communities give and receive increasing amounts of emotional support to one another and express increased satisfaction from these church-based relationships (Hayward & Krause, 2013).

Ethnic identity itself may also become an important vehicle for social support in later life. It can provide a variety of sources of nonfamilial support, from a loose network of associations to membership in formal clubs and organizations. Members of an ethnic group may feel a strong sense of community as a result of their shared exposure to past discrimination, a realization of common concerns, and a sense of responsibility to preserve some of the authenticity of their ethnic identity for future generations. Participation in such a support network may be another vehicle for contributing wisdom gained through life experiences to those who will follow. Insofar as members of ethnic groups have

felt somewhat marginal in the larger society in the past, their mutual support in later life may protect them from some of the negative stereotypes that the society imposes on the very old.

Involvement in a social support system can be viewed as an essential ingredient in the achievement of a sense of immortality. The social support system confirms the value of elders, providing direct evidence of their positive impact on others and a sense of embeddedness in their social communities. The social support system of elders usually includes adult children. Positive interactions with them contribute to the sense of living on through one's offspring and their descendants. Interactions with members of the social support system—especially those marked by feelings of warmth, caring, and celebration—may be moments of experiential transcendence for elders. They feel the fullness and joy of existence that transcend physical and material barriers.

The Prime Adaptive Ego Quality and the Core Pathology

Confidence

In this discussion, **confidence** refers to a conscious trust in oneself and an assurance about the meaningfulness of life. In this definition, one finds the earliest psychosocial crisis of trust versus mistrust integrated with the crisis of integrity versus despair. In elderhood, after a lifetime of facing challenges and experiencing losses and gains, one has a new belief in the validity of one's intuition, a trust in one's worldview, and a continued belief in one's capacity to participate in the world on one's own terms. Confidence is sustained by a stable, supportive social network (Krause, 2007; Lang, Featherman, & Nesselroade, 1997). Older adults who feel they are able to engage in the activities they enjoy and to interact with people they value are also more likely to believe that they can adapt to the challenges they face. As a result of their confidence, they are less disrupted by stressful events and more hopeful about being able to find successful solutions in the face of negative events (Pushkar, Arbuckle, Conway, Chaikelson, & Maag, 1997).

Physical health and age, per se, are not the best predictors of confidence. One's perceptions of physical health problems and how one sees oneself in comparison to others may be more important predictors of confidence than any objective measure of health status. Some people view themselves as more impaired and dependent than they actually are; others, who may be suffering from serious illnesses, continue to view their situation with optimism (Ryff, 1995). Similarly, one's perception of the adequacy of social support and its appropriateness in response to one's needs is more important to a sense of confidence than the financial value of the resources exchanged (Davey & Eggebeen, 1998).

Over the course of the life span, psychosocial theory predicts that each individual will confront issues related to the negative poles of the psychosocial crisis of each stage. We argue that finding ways to integrate the negative pole of each stage into an overall positive worldview strengthens and humanizes one's character. Encounters with each negative pole provide a deeper sense of empathy for the suffering of others and a more profound appreciation for the courage that it takes to live out one's life with an open, generous, hopeful outlook. Confidence emerges not because of a life of one success after the next, but out of a sequence of struggles in which creative energy is required to find a positive balance between positive and negative forces (Erikson, J. M., 1988).

Diffidence

Diffidence refers to an inability to act because of overwhelming self-doubt. It is considered one of the basic factors underlying personality disorders (Livesley, Jackson, & Schroeder, 1992). Diffidence is evidenced by an unusual amount of difficulty in making daily decisions without advice and reassurance from others, great reluctance in undertaking projects or becoming involved in activities because of lack of confidence, and fears of being unable to care for oneself, which result in the fear of being alone (American Psychiatric Association, 1994).

Diffidence is likely to be associated with hopelessness. Among the elderly, hopelessness is experienced as a negative expectancy about the future and a sense of futility about having an impact on impending events. The combination of hopelessness and depression are strongly associated with suicidal ideation among the elderly (Uncapher, Gallagher-Thompson, Osgood, & Bongar, 1998). Feelings of diffidence can result from increased dependency and loss of control due to physical illness, loss of social support, or marked reduction in the quality of life; or they can be a product of a continuous process of ego pathology, building on the negative resolutions of earlier psychosocial crises. It is clear that in later life, the courage and energy required to remain flexible and adaptive to change must be derived from the well of ego resources established over the life course. For some of the very old, this precious resource is missing, and they face the end of life in a state of passivity and doubt.

FURTHER REFLECTION: *Explain what is meant by the psychosocial concept of immortality. Analyze ways that a person's social support system contributes to the resolution of the crisis of immortality versus extinction.*

Evaluate the notion that spirituality becomes a stronger feature of well-being in later life. Why might this be true? What evidence is there to support this idea?

Speculate about how positive resolutions of the crises of generativity versus stagnation and integrity versus despair contribute to the resolution of the crisis of immortality versus extinction?

APPLIED TOPIC

Meeting the Needs of the Frail Elderly

OBJECTIVE 6. Apply research and theory to concerns about meeting the needs of the frail elderly.

The goal of providing services or community resources to the frail elderly should be to enhance a realistic level of performance. On the one hand, one should not try to encourage 80-year-olds to live the lives of teenagers or people in their 50s. On the other hand, one should not hold such minimal expectations for the elderly that they are robbed of their autonomy and ability to meet challenges or to strive toward achievable goals. One of the current issues that has become a focus of research and policy debate is the extent to which physical frailty in elderhood is treatable or preventable and how to reduce dependency, especially in long-term nursing care.

In 2004, the U.S. Administration on Aging announced an initiative focused on supporting "Seniors Aging in Place" (ageinplace.org) in response to the strong preference among the very old to remain independent. Innovative projects were funded that provided new resources or access to services in the community so that older adults with a wide range of needs and abilities could retain an optimal level of independent functioning. The National Aging in Place Council is a forum whose mission is to encourage professionals and corporations in specific communities to work together to provide the system of community resources that will permit older adults to remain in their homes as long as possible. The council provides suggestions to individuals about how to modify their homes to make them accessible and how to take advantage of community resources and services. It also sponsors innovative collaboration between health care, transportation, and corporate interests to create products and services that will facilitate optimal residential communities for the very old (National Aging in Place Council, 2013).

Defining Frailty

Frailty has typically been operationalized in terms of dependency. One common approach is to list any difficulties in the ADLs, including bathing, dressing, transferring from the bed to a chair, using the toilet, and eating. Sometimes, these assessments include walking a short distance because this degree of motor ability is usually required to function independently. Beyond these basic types of self-care, an expanded notion of dependency refers to difficulties in managing **instrumental activities of daily living** (IADLs), such as shopping, preparing meals, doing light housework, using transportation, or using the telephone. These tasks, though clearly more complex than the basic ADLs, are essential to maintaining one's daily life without dependence on informal or formal community support services (Figure 14.16).

Dependency or difficulty in managing ADLs increases markedly after age 85. Many factors combine to produce this dependency. In most postindustrial societies, later adulthood is characterized by a sedentary lifestyle. Estimates suggest that only about 10% of older adults are active enough

A. Ramey/PhotoEdit

FIGURE 14.16 Because of his problems walking, Caleb was practically homebound. But once his children bought him this motorized chair he was able to enjoy going outdoors, interacting with neighbors, and taking Pebbles for a walk. What other technological inventions help support optimal functioning in elderhood?

to sustain appropriate levels of muscle strength and cardiovascular capacity. Weakness resulting from disuse combines with certain biological changes, diseases, medications, and malnutrition to produce muscle atrophy, risk of falling, reduced arousal and cognitive capacity, and a gradual decline in confidence in being able to cope with even moderate types of physical exertion.

Measures of functional limitations often fail to differentiate between what people say they might be able to do in a hypothetical context (when completing a survey) and what they actually do in their day-to-day lives. For example, some people may respond to a questionnaire saying that they are able to walk half a mile without help, but they do not actually ever walk that much. Others may respond that they cannot walk half a mile without help, but in fact they walk several blocks on most days to go to the store near their home. When observed in their natural setting, many older adults use compensatory strategies to overcome some physical impairment or integrate the support of others so they can enact certain functions even though they have serious disabilities. For example, in a sample of women who needed assistance in more than three areas of daily living, more than one fourth still managed to get to church services once a week or more. They did not allow their physical limitations to restrict their role involvement (Glass, 1998; Hayward & Krause, 2013).

For many older adults, problems with remaining independent change from time to time. In the winter, when streets are icy and the weather is cold, a person may need more help because it is difficult to walk outside or to wait for the bus. In the event of an acute illness requiring a period of hospitalization, a person may temporarily need support during the posthospital recovery but does not require long-term institutionalization. Full recovery from a week or two of being bedridden may require additional physical therapy, rebuilding muscle tone and endurance and rebuilding confidence in managing daily tasks. The outcome for the older person depends on the patient, caregiver, and health care system—all sharing expectations for recovery and rehabilitation rather than viewing the person as permanently weakened and destined for prolonged dependency (U.S. Department of Health and Human Services, 2013).

Supporting Optimal Functioning

Optimal functioning is what a person is capable of doing when motivated and well prepared. To support optimal functioning of elderly people, one must accurately assess their limitations. One does not want to take away the supports that help very old adults sustain their independence or overreact to their physical or intellectual limitations. This tendency, however, is observed in the responses of some adult children to their aging parents. Once the children realize that their parents are not functioning at the same high level of competence that they enjoyed previously, the children move toward a **role reversal**. The children may infantilize or dominate their parents, insisting on taking over all financial matters or attempting to relocate their parents to a more protective housing arrangement. Gradually, some children take away all their parents' decision-making responsibilities.

Although children may view such actions as being in their parents' best interests, they may fail to take their parents' preferences into account. For example, adult children tend to overemphasize the importance of health and financial considerations for their parents and to overlook the significance of familiar housing in preserving the companionship and daily support that are critical to their parents' sense of well-being (Kahana, 1982). Adult children may also fail to realize how important decision-making tasks and responsibility for personal care are to the maintenance of their parents' personality structure. In mutually satisfying relationships between adult daughters and their aging mothers, the daughters made sure that their mothers were consistently involved in decisions that affected their lives, even when the mothers were heavily dependent on their daughters for daily care (Pratt, Jones, Shin, & Walker, 1989).

In many nursing homes, there is a similar tendency to reduce or eliminate expectations of autonomy by failing to give residents responsibilities for planning or performing the activities of daily life. Routine chores such as cooking, cleaning, shopping for groceries, doing laundry, planning meals, answering the phone, paying bills, and writing letters all give older adults the sense that life is going along as usual. Replacing these responsibilities with unstructured time may subject very old people to more stress than continuing to expect some forms of regular contribution to daily life. Thus, paid work assignments and structured daily responsibilities are activities that an institutional setting can provide to help maintain a high level of social and intellectual functioning among the residents. The Eden Alternative (2009) is an emerging concept in nursing home care that gives residents responsibilities for some aspect of their environment depending on their level of functioning. These responsibilities—such as watering plants, volunteering in a nearby child care center, or reading to other residents—help overcome the negative impact of dependency and institutionalization.

Supporting the optimal functioning of frail elderly people requires an individualized approach. Each person has a unique profile of competencies and limitations. For some, the physical environment presents the greatest barriers to optimal functioning. For example, older adults who are in a wheelchair are likely to experience a fall every so often. However, those who have installed modifications in their home—including widened doorways and halls, railings, and easy-open doors—are less likely to fall than those whose homes have not been modified (Berg, Hines, & Allen, 2002). A person who cannot walk without fear of falling, see well, or grasp objects because of arthritis may need to have modifications in the home that will compensate for these limitations. Many creative strategies have been introduced that permit people with serious physical disabilities to retain an optimal level of autonomy in their homes.

The Role of the Community

Most older adults want to remain in their community as long as possible. Interventions at the community level may be necessary to meet their safety, health, and social needs. Housing, transportation, and health care resources and services are essential elements of a community response. States that invest in these resources are able to reduce the growth in the costs of long-term care expenses for elders (U.S. Department of Health and Human Services, 2013).

It is important for resources to be accessible. In promoting optimal functioning in urban settings, for example, it is important to provide health care settings that are more easily accessible for elderly people with limited mobility. Andrulis (2000) has taken this point of view one step further by arguing that as the number of elderly people in the urban centers of the United States increases, health care organizations and providers supported by local, state, and federal governments must be prepared to reach out to the growing population of elderly people. Many of these people are poor, have physical limitations, and experience psychological barriers such as perceived threat of violence, confusion, fear, and embarrassment over lack of financial resources. As a result, they may be unable or unwilling to leave their immediate environment. Community outreach would have to provide a wide variety of services to a culturally diverse population with special attention to poverty-related concerns.

Community resources that have been found to be useful to elders as they strive to remain in their communities include the following: transportation resources, educational opportunities, senior centers, volunteer opportunities, food and nutrition support, housing and home modification services, in-home health care and services, and the creation of social settings where elders can interact. Information and referral services for elders and their caregivers provide access to a diverse array of resources as needs arise and change. Many people are unaware of programs and services for which they are eligible. The more knowledgeable people are about community resources and services, the longer they are likely to expect to remain living independently in their home (Tang & Lee, 2011).

One example of a community response to the need to improve access to resources is the "Red Tape Cutter," a Chicago program that improves access to over 40 services and benefits for elders. The person completes just one application. Then the Chicago Department of Aging reviews the application and sends the person a printout of the services, benefits and programs for which they are eligible and how to apply (Aging Services Council of Central Texas, 2013).

A unique set of coordinated services for elders is described as Project Care, in San Diego, California. The project supports frail older adults in living independently and feeling secure. This program has several components:

- **Postal Alert:** Postal carriers are trained to keep a watchful eye on older residents. If mail is not collected from mailboxes, carriers will check on residents and report problems.
- **Daily Calls:** Computer generated phone calls at a time selected by the client. If call is not answered, volunteers make follow up calls.
- **Gatekeeper:** Utility workers and sanitation engineers keep an eye on older adults by recognizing signs of trouble such as uncollected newspapers or garbage not set out on collection day. Concerns are forwarded to proper agency.
- **Health Care Info:** Older adults receive a medical information box that affixes to refrigerator. Box contains medical history info, medication records and other health related data. The information is used by paramedics responding to emergencies in a client's home.
- **Home Repairs:** Volunteers and local businesses help make minor home repairs that support health and safety.
- **Safe Return:** A national program of the Alzheimer's Association, Safe Returns, helps local authorities locate, identify and return home individuals with dementia.

In a surprising essay, Clive Thompson (2007) wrote about the features of life in New York City that contribute to longevity. A major theme was the role of walking and climbing stairs as aspects of daily life in the city. "Driving in the city is maddening, pushing us onto the sidewalks and up and down the stairs to the subways. What's more, our social contract dictates that you should move your ass when you're on the sidewalk so as not to annoy your fellow walkers" (p. 31). Living in areas that are densely populated means access to more markets, specialty shops, and interesting things to do in walking distance. People in New York City are more likely to walk a mile to get to something than people who live in suburban or rural areas. In a shift from earlier views of cities as crime-ridden, disease-promoting, alienating environments, some social scientists are starting to write about urban health advantages. Friendship groups are likely to form in neighborhoods; big cities may have bigger, more fully equipped hospitals; and population density can attract more parks, gyms, and recreational facilities. The causal relationship between urban life and health is probably bidirectional. As cities become safer, people with more resources (who generally have greater longevity) want to live there, attracting more of the lifestyle resources that support health (Figure 14.17).

Urban areas are likely to be comprised of "naturally occurring retirement communities" (NORCs), places where over 50% of the residents are over age 60. Communities where people of shared interests and needs live near one another allow community members to voice their collective needs and concerns in order to influence the distribution or creation of appropriate resources. At the same time, a community with a certain density of elders provides an efficient approach for locating services that will meet the needs of the residents.

For some elderly adults, the absence of meaningful interpersonal relationships is the greatest barrier to optimal functioning. The role of the informal social support system in meeting the needs of the frail elderly cannot be

J&L Images/Photodisc/Getty Images

FIGURE 14.17 Many communities are sensitive to the need for informal recreational resources for elderly residents. Bocce Ball is a favorite pastime where friends gather to socialize, get a bit of exercise, and engage in friendly competition.

underestimated. Children, spouses, other relatives, and neighbors are all important sources of help. Within communities, the elderly are themselves likely to provide significant help to age-mates who may be ill, bereaved, or impaired in some way. Most older adults prefer not to have to ask for help. However, they are much better off if they have someone to turn to than if they have no one.

Beyond personal networks of social support, communities have been characterized by different levels of **collective efficacy** which combines a strong sense of social cohesion with a high level of informal social control (Sampson, Raudenbush, & Earls, 1997). People who live in communities characterized by high collective efficacy are willing to take on important community concerns and to intervene on each other's behalf even if they do not know one another on a personal level. Examples of the impact of collective efficacy include reducing violent victimization, child or elder abuse, and illicit drug trafficking in a neighborhood. Communities that are high in collective efficacy will act to draw on the required resources to attract health care services, create new recreational settings, and improve transportation resources. In all these ways, communities characterized by collective efficacy can enhance the health and optimal functioning of the frail elderly (Browning & Cagney, 2003).

The Role of Creative Action

People can do a lot for themselves to promote a fulfilling later life. By identifying meaningful goals and coordinating action to achieve these goals, older adults can create lives that are both meaningful and manageable (Riediger, Freund, & Baltes, 2005). Very old adults can alter the structure of their environment to preserve optimal functioning and enhance their sense of well-being. They may move to a warmer climate, to a homogeneous-age community, or to a more modest home or apartment that entails fewer maintenance responsibilities. They may participate in exercise classes or other guided physical activity to improve their strength, endurance, and flexibility. Elders may select some family and friendship relationships that they sustain through frequent interaction, mutual help giving, and shared activities. They may participate in activities in community settings, including churches, senior centers, libraries, and volunteer organizations through which they retain a sense of purpose and social connection. They may decide to focus their interest on a single role that is most important to them. Maintaining a sense of control over important life roles and activities contributes to longevity and well-being. As at earlier ages, elders make certain choices that direct the course of their lives, provide a sense of meaning, and influence their overall level of adjustment (Figure 14.18).

In summary, the quality of life for the frail elderly depends on four factors: (1) the specific nature and timing of the health-related limitations that accompany aging; (2) the availability of appropriate resources within the home, family, and community to help compensate for or minimize these limitations; (3) the selective emphasis that the person gives to some life experiences over others as being central to well-being; and (4) the person's motivational orientation to continue to find creative strategies to adapt to change.

FURTHER REFLECTION: *Explain the concept of optimal functioning. Based on what you have read about the developmental tasks and psychosocial crisis of elderhood, what suggestions would you make for enhancing the care of the frail elderly?*

Jose Luis Pelaez/Corbis

FIGURE 14.18 At age 85, George preserves his playful outlook by spending time with his great-granddaughter. They take turns surprising each other with new costumes, songs, and games.

CHAPTER SUMMARY

OBJECTIVE 1. Explain the rationale for identifying elderhood as a unique developmental stage for those of unusual longevity with its own developmental tasks and psychosocial crisis.

Elderhood is a period of new challenges and opportunities that will be faced by an increasing number of people in the years ahead. Those who are 80 years old and older are the fastest growing segment of the U.S. population. Having reached a sense of acceptance of one's death, the task is to find meaning and enjoyment in the bonus years of life. This requires ongoing adaptation to changing physical and cognitive capacities, a deepening sense of time and the place of one's life in the history of one's people, and a willingness to find new and flexible solutions to the demands of daily life. This period of life requires ongoing adaptive self-organization.

In attempting to describe the psychosocial development of the very old, we are drawn to concepts that have a strong non-Western philosophical flavor. We have introduced such concepts as psychohistorical perspective, experiential transcendence, immortality, and social support—themes that reflect the need to assume a long-range perspective on life and its meaning.

OBJECTIVE 2. List the physical changes associated with aging, and evaluate the challenges that these changes pose for continued psychosocial well-being.

The quality of daily life for the very old is influenced to a great extent by their physical health. For some, daily activities are restricted by one or more chronic diseases. Nevertheless, the majority of elders continue to live in their own households and perform tasks of daily living independently.

OBJECTIVE 3. Describe the concept of an altered perspective on time and history that emerges among the long-lived.

The concept of time changes with advanced age so that the continuity of past, present, and future becomes clearer.

OBJECTIVE 4. Summarize elements of the lifestyle structure in elderhood, especially living arrangements and gender roles, and analyze the impact of these life structures for continued well-being.

An increasingly wide range of lifestyle alternatives are being invented in elderhood, including opportunities for travel, housing that provides varying levels of care, and patterns of close relationships in which traditional gender roles are modified to take into consideration new capacities and interests.

OBJECTIVE 5. Define and explain the psychosocial crisis of immortality versus extinction, the central process of social support, the prime adaptive ego quality of confidence, and the core pathology of diffidence.

Having lived well beyond their life expectancy, elders face the psychosocial crisis of immortality versus extinction. A key to their quality of life lies in whether they are integrated into effective social support networks. Social support provides help, resources, meaningful social interaction, and a psychological sense of being valued. Elders who survive within a support system can transcend the limitations of their mortality, finding comfort and continuity in their participation in a chain of loving relationships. Those who are isolated, however, are more likely to face the end of their lives bound to the tedium of struggling with their physical limitations and resenting their survival.

OBJECTIVE 6. Apply research and theory to concerns about meeting the needs of the frail elderly.

The topic of the care of the frail elderly illustrates the relevance of a psychosocial framework. The resources and services available in the community can support optimal functioning. Children, grandchildren, and other family members need to be able to interpret the needs of their aging parents without underestimating their capacity or resilience. Finally, older adults can guide the direction of their care by the decisions they make, both in earlier periods of life and as they detect new signs of frailty.

KEY TERMS

active engagement, 582
activities of daily living (ADLs), 578
affiliative values, 589
behavioral slowing, 574
collective efficacy, 602
community-based long-term health care, 587
confidence, 598
continuing care retirement community, 586
cosmic transcendence, 594
dependency, 590
diffidence, 598
experiential transcendence, 593
extinction, 594
fitness, 572
frailty, 599
functional independence, 577
gender gap, 570
gender-role convergence, 589
gentrification, 588
housing options, 586
immortality, 592
instrumental activities of daily living (IADLs), 599
instrumental support, 595
instrumental values, 589
life structure, 571
living arrangements, 584
norm of reciprocity, 596
nursing home, 586
old-old, 571
optimal functioning, 600
organic brain syndromes, 578
physical changes of aging, 571
processing load, 574
psychohistorical perspective, 578
role reversal, 600
sexuality, 590
skill care facility, 586
social support, 595
socioemotional support, 595
successful agers, 582
usual aging, 582
visual adaptation, 575
young-old, 571

CASEBOOK

For additional cases related to this chapter, see "Still Going Strong," in *Life Span Development: A Case Book*, by Barbara and Philip Newman, Laura Landry-Meyer, and Brenda J. Lohman, pp. 215–218. This case highlights the importance of living arrangements for the health and well-being of an active 93-year-old woman.