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**Photo Courtesy Overstreet**

**Lesson 10: Late Adulthood**

**Objectives: At the end of this lesson, you will be able to**

1. **Differentiate between impaired, normal, and optimal aging.**
2. **Report numbers of people in late adulthood age categories in the United States.**
3. **Discuss changes in the age structure of society in the U. S. and globally.**
4. **Report life expectancies in the United States based on gender, race, and ethnicity.**
5. **Explain the reasons for changes in life expectancies.**
6. **Identify examples of ageism.**
7. **Compare primary and secondary aging.**
8. **Report on the leading sources of secondary aging.**
9. **Describe changes in the senses in late adulthood.**
10. **Discuss the impact of aging on the sensory register, working memory, and long-term memory.**
11. **Describe theories of aging.**
12. **Define Hayflick Limit.**
13. **Evaluate previous ideas about aging and cognition based on new research.**
14. **Describe abnormal memory loss due to Alzheimer's disease, delirium, and dementia.**
15. **Differentiate between organic and nonorganic causes of dementia.**
16. **Describe Erikson's psychosocial stage for late adulthood.**
17. **Contrast disengagement, activity, and continuity theories of aging.**
18. **Describe ways in which people are productive in late adulthood.**
19. **Describe grandparenting styles.**
20. **Compare marriage, divorce, being single, and widowhood in late adulthood.**
21. **Report rates at which people in late adulthood require long-term care.**
22. **Examine caregiving for dependent older adults.**
23. **Define socioemotional selectivity theory.**
24. **Classify types of elder abuse.**

**Physical Development in Late Adulthood**

**Defining Late Adulthood: Age or Quality of Life? (Ob1)**

We are considered in late adulthood from the time we reach our mid-sixties until death. In this lesson, we will learn how many people are in late adulthood, how that number is expected to change, and how life changes and continues to be the same as before in late adulthood. About 13 percent of the U. S. population or 38.9 million Americans are 65 and older (U. S. Census Bureau, 2011).  This number is expected to grow to 88.5 million by the year 2050 at which time people over 65 will make up 20 percent of the population.  This group varies considerably and is divided into categories of 65 plus, 85 plus, and centenarians for comparison by the census.  Developmentalists, however, divide this population in to categories based on health and social well-being.  **Optimal aging** refers to those who enjoy better health and social well-being than average.  **Normal aging** refers to those who seem to have the same health and social concerns as most of those in the population.  However, there is still much being done to understand exactly what normal aging means.  **Impaired aging** refers to those who experience poor health and dependence to a greater extent than would be considered normal.  Aging successfully involves making adjustments as needed in order to continue living as independently and actively as possible.  This is referred to as **selective optimization with compensation** and means, for example, that a person who can no longer drive, is able to find alternative transportation.  Or a person who is compensating for having less energy, learns how to reorganize the daily routine to avoid over-exertion.  Perhaps nurses and other allied health professionals working with this population will begin to focus more on helping patients remain independent than on simply treating illnesses.  Promoting health and independence are important for successful aging.

**Age Categories:  65 to 74 (Ob2)**

These 18.3 million Americans tend to report greater health and social well-being than older adults. Having good or excellent health is reported by 41 percent of this age group (Center for Disease Control, 2004). Their lives are more similar to those of midlife adults than those who are 85 and older. This group is less likely to require long-term care, to be dependent or to be poor, and more likely to be married, working for pleasure rather than income, and living independently. About 65 percent of men and 50 percent of women between the ages of 65-69 continue to work full-time (He et al., 2005).    Physical activity tends to decrease with age, despite the dramatic health benefits enjoyed by those who exercise. People with more education and income are more likely to continue being physically active. And males are more likely to engage in physical activity than are females. The majority of the young-old continue to live independently. Only about 3 percent of those 65-74 need help with daily living skills as compared with about 22.9 percent of people over 85. (Another way to consider think of this is that 97 percent of people between 65-74 and 77 percent of people over 85 do not require assistance!) This age group is less likely to experience heart disease, cancer, or stroke than the old, but nearly as likely to experience depression (U. S. Census, 2005).

**75 to 84**

This age group is more likely to experience limitations on physical activity due to chronic disease such as arthritis, heart conditions, hypertension (especially for women), and hearing or visual impairments. Rates of death due to heart disease, cancer, and cerebral vascular disease are double that experienced by people 65-74. Poverty rates are 3 percent higher (12 percent) than for those between 65 and 74.   However, the majority of these 12.9 million Americans live independently or with relatives. Widowhood is more common in this group-especially among women.

**85 plus**

The number of people 85 and older is 34 times greater than in 1900 and now includes 5.7 million Americans. This group is more likely to require long-term care and to be in nursing homes. However, of the 38.9 million American over 65, only 1.6 million require nursing home care.  Sixty-eight percent live with relatives and 27 percent live alone (He et al., 2005; U. S. Census Bureau, 2011).

**Centenarians**

There are 104,754 people over 100 years of aging living in the United States.  This number is expected to increase to 601,000 by the year 2050 (U. S. Census Bureau, 2011).   The majority is between ages 100 and 104 and eighty percent are women. Out of almost 7 billion people on the planet, about 25 are over 110. Most live in Japan, a few live the in United States and three live in France (National Institutes of Health, 2006). These "super-Centenarians" have led varied lives and probably do not give us any single answers about living longer. Jeanne Clement smoked until she was 117. She lived to be 122. She also ate a diet rich in olive oil and rode a bicycle until she was 100. Her family had a history of longevity. Pitskhelauri (in Berger, 2005) suggests that moderate diet, continued work and activity, inclusion in family and community life, and exercise and relaxation are important ingredients for long life.

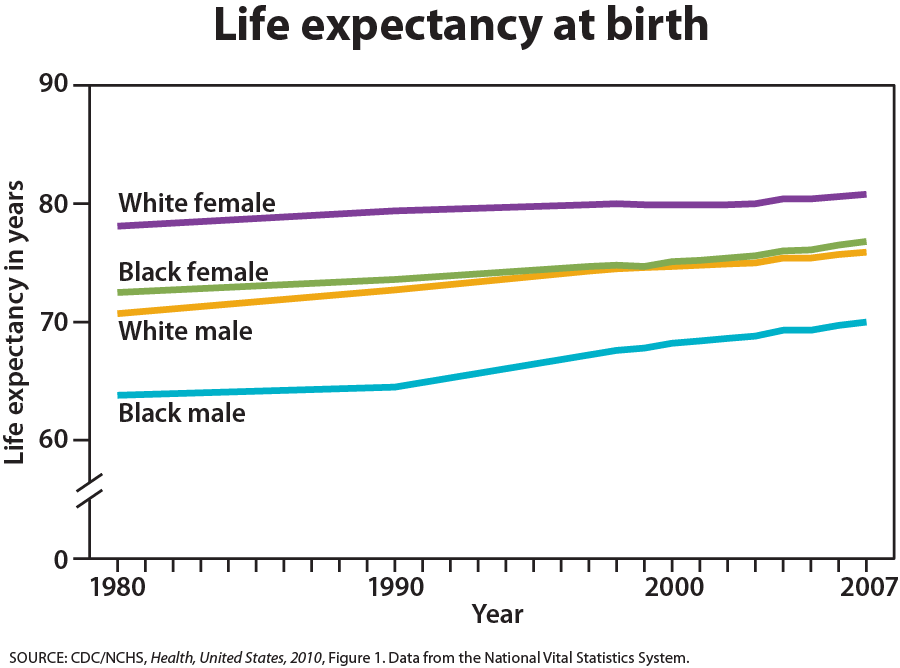
**The "Graying" of America and the globe: (Ob3)**

This trend toward an increasingly aged population has been referred to as the "graying of America." However, populations are aging in most other countries of the world. (One exception to this is in sub-Saharan Africa where mortality rates are high due to HIV/AIDS) (He et al., 2005). There are 520 million people over 65 worldwide.  This number is expected to increase to 1.53 billion by 2050 (from 8 percent to 17 percent of the global population.)  Currently, four countries, Germany, Italy, Japan, and Monaco, have 20 percent of their population over 65.  China has the highest number of people over 65 at 112 million (U. S. Census Bureau, 2011).

As the population ages, concerns grow about who will provide for those requiring long-term care. In 2000, there were about 10 people 85 and older for every 100 persons between ages 50 and 64. These midlife adults are the most likely care providers for their aging parents. The number of old requiring support from their children is expected to more than double by the year 2040 (He et al., 2005). These families will certainly need external physical, emotional, and financial support in meeting this challenge.

**Life Expectancy and Quality of Life (Ob4, Ob5)**

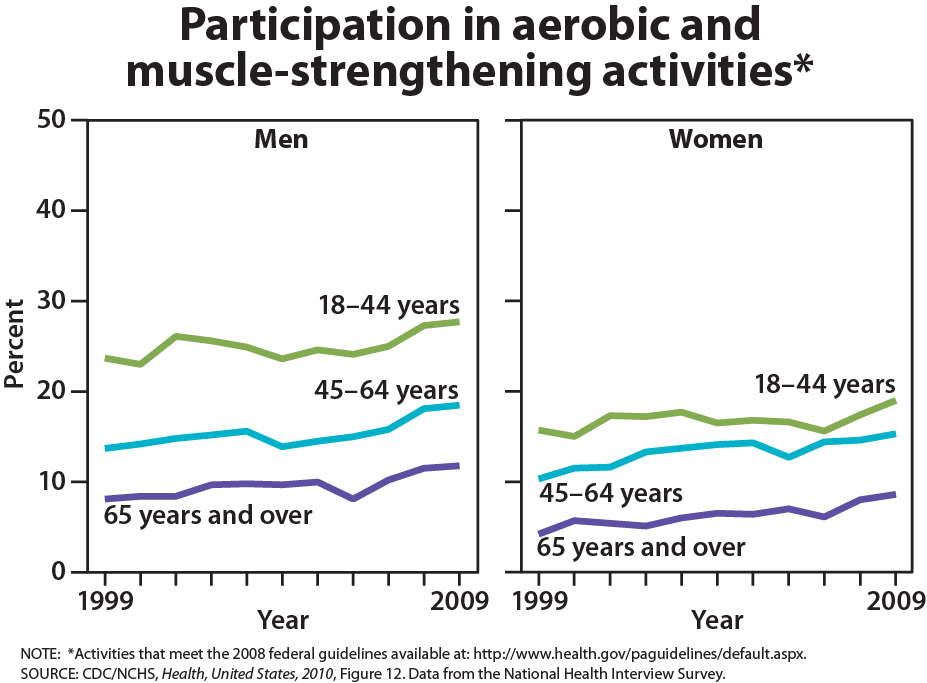
One way to prepare for the future is to find ways to improve quality of life. Life expectancy in 1900 was about 47 years.  Today, life expectancy for all races is 77.9 (75.4 for males and 80.4 for females.)  For whites, life expectancy is 75.9 for males and 80.8 for females.  For black males, life expectancy is 70 and is 76.8 for black females (U. S. Census Bureau, 2011).  **Historic racism** or years of living under oppressive prejudice and discrimination can increase the incidence of stress-related illness and contribute to a lower life expectancy. The United States ranks 17th among other countries for its life expectancy for women and 19th for men.   Japanese women and Swedish men have the longest life expectancies (He et al., 2005).



Increased life expectancy brings concern over the health and independence of those living longer.  Greater attention is now being given to the number of years a person can expect to live without disability which is referred to as **active life expectancy**. When this distinction is made, we see that although women live longer than men, they are more at risk of living with disability (Weitz, 2007). What factors contribute to poorer health? Marriage has been linked to longevity, but spending years in a stressful marriage can increase the risk of illness. This negative effect is experienced more by women than men and seems accumulates through the years. Its impact on health may not occur until a woman reaches 70 or older (Umberson, Williams, et. al., 2006).  **Sexism** can also create chronic stress. The stress experienced by women as they work outside the home as well as care for family members can also ultimately have a negative impact on health. Poorer health in women is further attributed to an increase in rates of smoking by women in recent years (He et als, 2005).

The shorter life expectancy for men in general, is attributed to greater stress, poorer attention to health, more involvement in dangerous occupations, and higher rates of death due to accidents, homicide, and suicide. Social support can increase longevity. For men, life expectancy and health seems to improve with marriage. Spouses are less likely to engage in risky health practices and wives are more likely to monitor their husband's diet and health regimes. But men who live in stressful marriages can also experience poorer health as a result.

Key players in improving the quality of life among older adults will be those adults. By exercising, reducing stress, stopping smoking, limiting use of alcohol, and consuming more fruits and vegetables, older adults can expect to live longer and more active lives. (He et. als, 2005). Stress reduction both in late adulthood and earlier in life is also crucial. The reduction of societal stressors can promote active life expectancy. In the last 40 years, smoking rates have decreased, but obesity has increased, and physical activity has only modestly increased.



**Attitudes about Aging (Ob6)**

Stereotypes about people of in late adulthood lead many to assume that aging automatically brings poor health and mental decline. These stereotypes are reflected in everyday conversations, the media and even in greeting cards (Overstreet, 2006). The following examples serve to illustrate.

1) Grandpa, fishing pole in one hand, pipe in the other, sits on the ground and completes a story being told to his grandson with ". . . and that, Jimmy, is the tale of my very first colonoscopy." The message inside the card reads, "Welcome to the gross personal story years." (Shoebox, A Division of Hallmark Cards.)

2) An older woman in a barber shop cuts the hair of an older, dozing man. "So, what do you say today, Earl?" she asks. The inside message reads, "Welcome to the age where pretty much anyplace is a good place for a nap." (Shoebox, A Division of Hallmark Cards.)

3) A crotchety old man with wire glasses, a crumpled hat, and a bow tie grimaces and the card reads, "Another year older? You're at the age where you should start eatin' right, exercisin', and takin' vitamins . . ." The inside reads, "Of course you're also at the age where you can ignore advice by actin like you can't hear it." (Hallmark Cards, Inc.)

Of course, these cards are made because they are popular. Age is not revered in the United States, and so laughing about getting older is one way to get relief. The attitudes are examples of **ageism,** prejudice based on age. Stereotypes such as these can lead to a **self-fulfilling prophecy** in which beliefs about one's ability results in actions that make it come true. A positive, optimistic outlook about aging and the impact one can have on improving health is essential to health and longevity. Removing societal stereotypes about aging and helping older adults reject those notions of aging is another way to promote health and active life expectancy among the old.

**Primary and Secondary Aging  (Ob7, Ob9)**

Healthcare providers need to be aware of which aspects of aging are reversible and which ones are inevitable. By keeping this distinction in mind, caregivers may be more objective and accurate when diagnosing and treating older patients. And a positive attitude can go a long way toward motivating patients to stick with a health regime. Unfortunately, stereotypes can lead to misdiagnosis. For example, it is estimated that about 10 percent of older patients diagnosed with dementia are actually depressed or suffering from some other psychological illness (Berger, 2005). The failure to recognize and treat psychological problems in older patients may be one consequence of such stereotypes.

**Primary aging** refers to the inevitable changes associated with aging (Busse, 1969).  These changes include changes in the skin and hair, height and weight, hearing loss, and eye disease. However, some of these changes can be reduced by limiting exposure to the sun, eating a nutritious diet, and exercising.

**Skin and hair** change as we age. The skin becomes drier, thinner, and less elastic as we age. Scars and imperfections become more noticeable as fewer cells grow underneath the surface of the skin.  Exposure to the sun, or **photoaging,** accelerates these changes. Graying hair is inevitable.  And hair loss all over the body becomes more prevalent.

**Height and weight** vary with age. Older people are more than an inch shorter than they were during early adulthood (Masoro in Berger, 2005). This is thought to be due to a settling of the vertebrae and a lack of muscle strength in the back. Older people weigh less than they did in mid-life.  Bones lose density and can become brittle. This is especially prevalent in women. However, weight training can help increase bone density after just a few weeks of training.

**Muscle loss** occurs in late adulthood and is most noticeable in men as they lose muscle mass. Maintaining strong leg and heart muscles is important for independence. Weight-lifting, walking, swimming, or engaging in other cardiovascular exercises can help strengthen the muscles and prevent atrophy.

**Visual Problems**: The majority of people over 65 have some difficulty with vision, but most is easily corrected with prescriptive lenses. Three percent of those 65 to 74 and 8 percent of those 75 and older have hearing or vision limitations that hinder activity. The most common causes of vision loss or impairment are glaucoma, cataracts, age-related macular degeneration, and diabetic retinopathy (He et al., 2005).

**Hearing Loss** is experienced by 30 percent of people age 70 and older. Almost half of people over 85 have some hearing loss (He et al., 2005). Among those who are in nursing homes, rates are higher. Older adults are more likely to seek help with vision impairment than with hearing loss, perhaps due to the stereotype that older people who have difficulty hearing are also less mentally alert. Being unable to hear causes people to withdraw from conversation and others to ignore them or shout. Unfortunately, shouting is usually high pitched and can be harder to hear than lower tones. The speaker may also begin to use a patronizing form of ‘baby talk' known as **elderspeak** (See et al., 1999). This language reflects the stereotypes of older adults as being dependent, demented, and childlike. Image others speaking to you in that way. How would you feel? I am reminded of a man dying at home and a hospice worker, on shift for the first time, comes to his bedside and shouts, "Hi, baby. Want me to rub your little feet?" His response was an indignant look of disapproval.

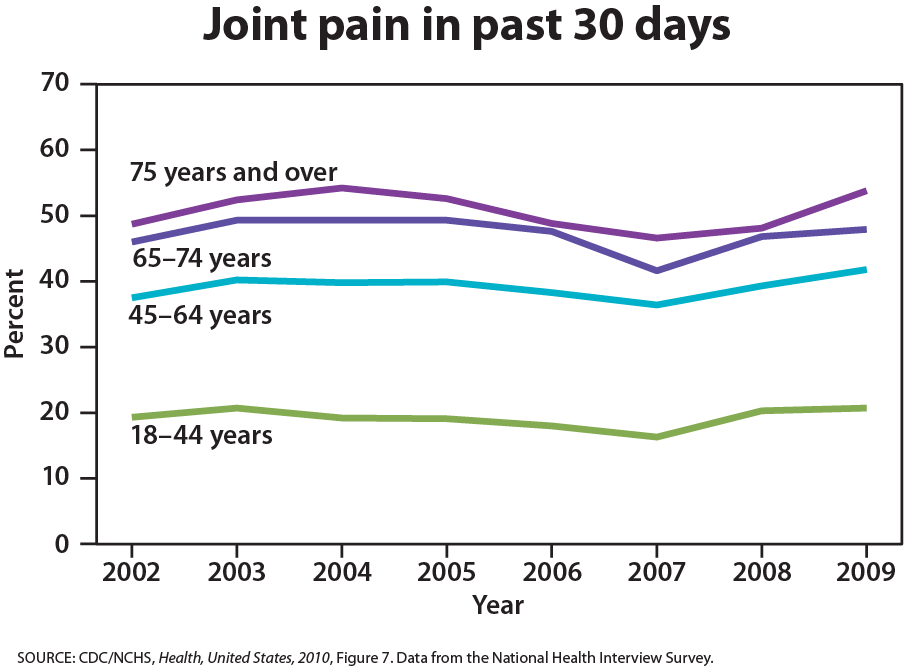
Hearing loss is more prevalent in men than women. And it is experienced by more white, non-Hispanics than by Black men and women. Smoking, middle ear infections, and exposure to loud noises increase hearing loss.

In summary, primary aging can be compensated for through exercise, corrective lenses, nutrition, and hearing aids.  And, more importantly, by reducing stereotypes about aging, people of age can maintain self-respect, recognize their own strengths, and count on receiving the respect and social inclusion they deserve.

**Secondary Aging (Ob8)**

**Secondary aging** refers to changes that are caused by illness or disease. These illnesses reduce independence, impact quality of life, affect family members and other caregivers, and bring financial burden. Some of the most prevalent illnesses that cause impairment are discussed below.

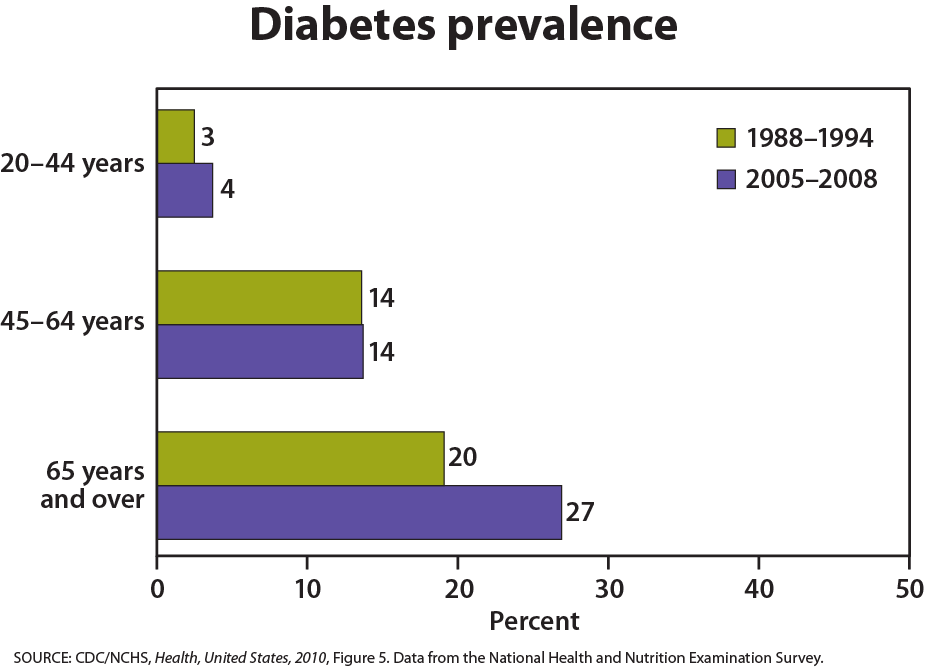
**Arthritis:**This is the leading cause of disability in older adults. Arthritis results in swelling of the joints and connective tissue that limits mobility. Arthritis is more common among women than men and increases with age. About 19.3 percent of people over 75 are disabled with arthritis; 11.4 percent of people between 65 and 74 experience this disability.



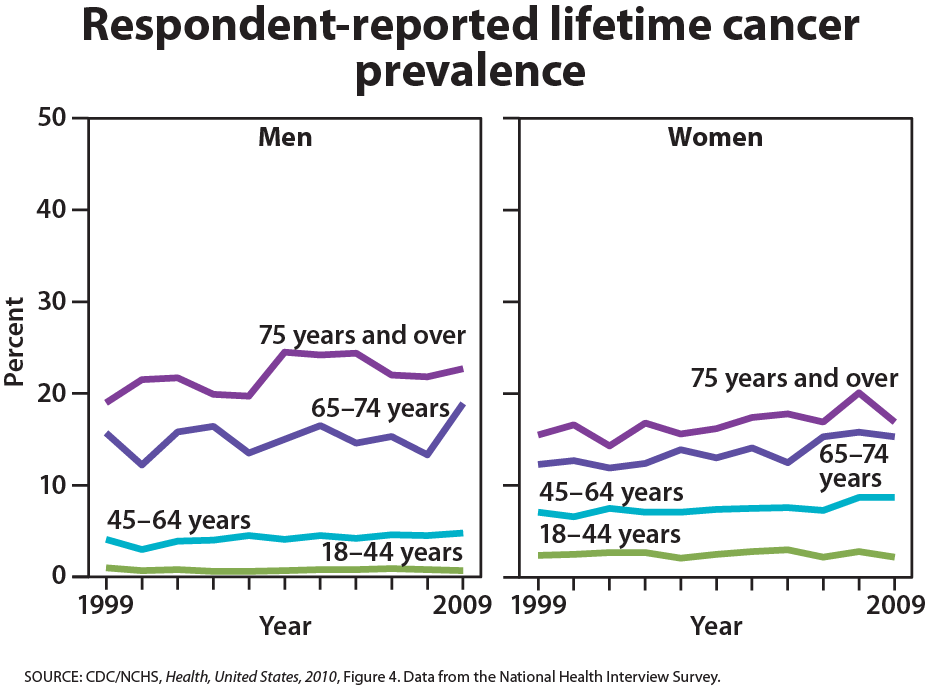
**Hypertension:**  Hypertension or high blood pressure and associated heart disease and circulatory conditions increase with age. Hypertension disables 11.1 percent of 65 to 74 year olds and 17.1 percent of people over 75. Rates are higher among women and Blacks. Rates are highest for women over 75.

**Heart Disease and Stroke:**Coronary disease and stroke are higher among older men than women. The incidence of stroke is lower than that of coronary disease.

**Diabetes:**In 2008, 27 percent of those 65 and older had diabetes.  Rates are higher among Mexican origin individuals and Blacks than non-Hispanic whites.  The treatment for diabetes includes dietary changes, increasing physical activity, weight loss for those who are overweight, and medication (National Institute on Aging, 2011).



**Cancer:** Men over 75 have the highest rates of cancer at 28 percent. Women 65 and older have rates of 17 percent. Rates for older non-Hispanic Whites are twice as high as for Hispanics and non-Hispanic Blacks. The most common types of cancer found in men are prostate and lung cancer. Breast and lung cancer are the most common forms in women.



**Osteoporosis:**Osteoporosis increases with age as bones become brittle and lose minerals. Bone loss is four times more likely in women than in men and becomes even more prevalent in women 85 and older. Whites suffer osteoporosis more than do non-Hispanic Blacks.

**Alzheimer's disease:**Between 2.4 and 5.1 million people in the United States suffer with Alzheimer's disease (AD) (National Institute on Aging, 2011). This disease is not becomes more prevalent with age, but is not inevitable.  This typically appears after age 60 but develops slowly for years before it's appearance.  Social support, and aerobic exercise can reduce the risk of Alzheimer's disease. As the large cohort of Baby Boomers begins turning 65 in 2011, the number of cases of Alzheimer's disease is expected to increase dramatically.  Where will these people receive care?  Seventy percent of AD patients are cared for in the home. Such care can be emotionally, financially, and physically stressful. Most AD patients live 8 to 10 years with the disease and long-term care costs an average of $174,000 per patient (He et al., 2005).

**Normal Aging**

The Baltimore Longitudinal Study on Aging (2006) began in 1958 and has traced the aging process in 1,400 people from age 20 to 90. Researchers from the BLSA have found that the aging process varies significantly from individual to individual and from one organ system to another. Kidney function may deteriorate earlier in some individuals. Bone strength declines more rapidly in others. Much of this is determined by genetics, lifestyle, and disease. However, some generalizations about the aging process have been found:

* Heart muscles thicken with age
* Arteries become less flexible
* Lung capacity diminishes
* Brain cells lose some functioning but new neurons can also be produced
* Kidneys become less efficient in removing waste from the blood
* The bladder loses its ability to store urine
* Body fat stabilizes and then declines
* Muscle mass is lost without exercise
* Bone mineral is lost. Weight bearing exercise slows this down.

**Theories of Aging (Ob11, Ob12)**

**Why do we age?**

There are a number of attempts to explain why we age and many factors that contribute to aging. Genetics, diet, lifestyle, activity, and exposure to pollutants all play a role in the aging process.

**Cell Life**

Cells divide a limited number of times and then stop. This phenomenon, known as the **Hayflick limit,** is evidenced in cells studied in test tubes which divide about 50 times before becoming senescent. Senescent cells do not die. They simply stop replicating. Senescent cells can help limit the growth of other cells which may reduce risk of developing tumors when younger, but can alter genes later in life and result in promoting the growth of tumors as we age (Dollemore, 2006). Limited cell growth is attributed to **telomeres** which are the tips of the protective coating around chromosomes. Each time cells replicate, the telomere is shortened. Eventually, loss of telomere length is thought to create damage to chromosomes and produce cell senescence.

**Biochemistry and Aging**

**Free Radical Theory:** As we metabolize oxygen, mitochondria in the cells convert oxygen to adenosine triphosphate (ATP) which provides energy to the cell. Unpaired electrons are a by product of this process and these unstable electrons cause cellular damage as they find other electrons with which to bond. These free radicals have some benefits and are used by the immune system to destroy bacteria. However, cellular damage accumulates and eventually reduces functioning of organs and systems. Many food products and vitamin supplements are promoted as age-reducing. Antioxidant drugs have been shown to increase the longevity in nematodes (small worms), but the ability to slow the aging process by introducing antioxidants in the diet is still controversial.

**Protein Crosslinking:** This theory focuses on the role blood sugar, or glucose, plays in the aging of cells. Glucose molecules attach themselves to proteins and form chains or crosslinks. These crosslinks reduce the flexibility of tissue and tissue become stiff and loses functioning. The circulatory system becomes less efficient as the tissue of the heart, arteries and lungs lose flexibility. And joints grow stiff as glucose combines with collegen. (To conduct your own demonstration of this process, take a piece of meat and place it in a hot skillet. The outer surface of the meat will caramelize and the tissue will become stiff and hard.)

**DNA Damage:**As we live, DNA is damaged by environmental factors such as toxic agents, pollutants, and sun exposure (Dollemore, 2006). This results in deletions of genetic material, and mutations in the DNA that is duplicated in new cells. The accumulation of these errors results in reduced functioning in cells and tissues.

**Decline in the Immune System:**As we age, B-lymphocytes and T-lymphocytes become less active. These cells are crucial to our immune system as they secrete antibodies and directly attack infected cells. The thymus, where T-cells are manufactured, shrinks as we age. This reduces our body's ability to fight infection Berger, 2005).

**Cognitive Development in Late Adulthood (Ob13)**

**How does aging affect memory? (Ob10)**

**The Sensory Register**

Aging may create small decrements in the sensitivity of the sensory register. And, to the extent that a person has a more difficult time hearing or seeing, that information will not be stored in memory. This is an important point, because many older people assume that if they cannot remember something, it is because their memory is poor. In fact, it may be that the information was never seen or heard.

**The Working Memory**

Older people have more difficulty using memory strategies to recall details (Berk, 2007). As we age, the working memory loses some of its capacity. This makes it more difficult to concentrate on more than one thing at a time or to keep remember details of an event.  However, people compensate for this by writing down information and avoiding situations where there is too much going on at once to focus on a particular cognitive task.

**The Long-Term Memory**

This type of memory involves the storage of information for long periods of time. Retrieving such information depends on how well it was learned in the first place rather than how long it has been stored. If information is stored effectively, an older person may remember facts, events, names and other types of information stored in long-term memory throughout life.  The memory of adults of all ages seems to be similar when they are asked to recall names of teachers or classmates. And older adults remember more about their early adulthood and adolescence than about middle adulthood (Berk, 2007). Older adults retain **semantic memory** or the ability to remember vocabulary.

Younger adults rely more on mental rehearsal strategies to store and retrieve information. Older adults focus rely more on external cues such as familiarity and context to recall information (Berk, 2007). And they are more likely to report the main idea of a story rather than all of the details (Jepson & Labouvie-Vief, in Berk, 2007).

A positive attitude about being able to learn and remember plays an important role in memory. When people are under stress (perhaps feeling stressed about memory loss), they have a more difficult time taking in information because they are preoccupied with anxieties.  Many of the laboratory memory tests require compare the performance of older and younger adults on timed memory tests in which older adults do not perform as well. However, few real life situations require speedy responses to memory tasks. Older adults rely on more meaningful cues to remember facts and events without any impairment to everyday living.

**New Research on Aging and Cognition**

Can the brain be trained in order to build cognitive reserve to reduce the effects of normal aging? ACTIVE (Advanced Cognitive Training for Independent and Vital Elderly), a study conducted between 1999 and 2001 in which 2,802 individuals age 65 to 94, suggests that the answer is "yes". These participants (26 percent who were African-American) received 10 group training sessions and 4 follow up sessions to work on tasks of memory, reasoning, and speed of processing. These mental workouts improved cognitive functioning even 5 years later. Many of the participants believed that this improvement could be seen in everyday tasks as well (Tennstedt, Morris, et al, 2006). Learning new things, engaging in activities that are considered challenging, and being physically active at any age may build a reserve to minimize the effects of primary aging of the brain.

**Wisdom**

Wisdom is the ability to use common sense and good judgment in making decisions. A wise person is insightful and has knowledge that can be used to overcome obstacles in living. Does aging bring wisdom? While living longer brings experience, it does not always bring wisdom. Those who have had experience helping others resolve problems in living and those who have served in leadership positions seem to have more wisdom. So it is age combined with a certain type of experience that brings wisdom.  However, older adults do have greater emotional wisdom or the ability to empathize with and understand others.

**Problem Solving**

Problem solving tasks that require processing non-meaningful information quickly (a kind of task that might be part of a laboratory experiment on mental processes) declines with age. However, real life challenges facing older adults do not rely on speed of processing or making choices on one’s own. Older adults are able to make resolve everyday problems by relying on input from others such as family and friends. And they are less likely than younger adults to delay making decisions on important matters such as medical care (Strough et al., 2003; Meegan & Berg, 2002).

**Abnormal Loss of Cognitive Functioning During Late Adulthood (Ob14, Ob15)**

Dementia refers to severely impaired judgment, memory or problem-solving ability. It can occur before old age and is not an inevitable development even among the very old. Dementia can be caused by numerous diseases and circumstances, all of which result in similar general symptoms of impaired judgment, etc.  Alzheimer’s disease is the most common form of dementia and is incurable. But there are also nonorganic causes of dementia that can be prevented. Malnutrition, alcoholism, depression, and mixing medications can result in symptoms of dementia. If these causes are properly identified, they can be treated. Cerebral vascular disease can also reduce cognitive functioning.

Delirium is a sudden experience of confusion experienced by some older adults. Read the article and listen to the story found at <http://www.npr.org/templates/story/story.php?storyId=111623212> for more information on treating delirium and the possible links between delirium and Alzheimer's Disease.

**Psychosocial Development in Late Adulthood**

**Integrity vs. Despair (Ob16)**

How do people cope with old age? Erikson (1980) believed that late adulthood is a time for making sense out of one's life, finding meaning to one's existence, and adjusting to inevitable death. He called this stage **integrity vs. despair**. Imagine being able to look back on life with the sense that if you had a chance to do it over again; you would probably make many of the same choices. Of course, life does not typically involve perfect choices. But a sense of contentment and acceptance, understanding and tolerance of others are important features of integrity. Bitterness and resentments in relationships and life events can bring a sense of despair at the end of life.

**Disengagement vs. Activity (Ob17)**

**Disengagement theory** (Cummings & Henry, 1961) suggests that during late adulthood, the individual and society mutually withdraw. Older people become more isolated from others and less concerned or involved with life in general. This once popular theory is now criticized as being ageist and used in order to justify treating older adults as second class citizens. **Activity theory** suggests that people are barred form meaningful experiences as they age. But older adults continue to want to remain active and work toward replacing opportunities lost with new ones. **Continuity theory** suggests that as people age, they continue to view the self in much the same way as they did when they were younger. Their approach to problems, goals, and situations is much the same as it was before. They are the same individuals, but simply in older bodies. Consequently, older adults continue to maintain their identity even as they give up previous roles. For example, a retired Coast Guard commander attends reunions with shipmates, stays interested in new technology for home use, is meticulous in the jobs he does for friends or at church, and displays mementos of life on the ship. He is able to maintain a sense of self as a result. We do not give up who we are as we age. Hopefully, we are able to share these aspects of our identity with others throughout life. Focusing on what a person can do and pursuing those interests and activities is one way to optimize and maintain self-identity.

**Generativity in Late Adulthood (Ob18)**

People in late adulthood continue to be productive in many ways. These include work, education, volunteering, family life, and intimate relationships.

**Productivity in Work**

Some continue to be productive in work. Mandatory retirement is now illegal in the United States. However, we find that many do choose retirement by age 65 and most leave work by choice. Those who do leave by choice adjust to retirement more easily. Chances are, they have prepared for a smoother transition by gradually giving more attention to an avocation or interest as they approach retirement. And they are more likely to be financially ready to retire. Those who must leave abruptly for health reasons or because of layoffs or downsizing have a more difficult time adjusting to their new circumstances. Men, especially, can find unexpected retirement difficult. Women may feel less of an identify loss after retirement because much of their identity may have come from family roles as well. But women tend to have poorer retirement funds accumulated from work and if they take their retirement funds in a lump sum (be that from their own or from a deceased husband’s funds), are more at risk of outliving those funds. Women need better financial retirement planning.

Sixteen percent of adults over 65 were in the labor force in 2008 (U. S. Census Bureau 2011).  Globally, 6.2 percent are in the labor force and this number is expected to reach 10.1 million by 2016.  Many adults 65 and older continue to work either full-time or part-time either for income or pleasure or both.  In 2003, 39 percent of full-time workers over 55 were women over the age of 70; 53 percent were men over 70. This increase in numbers of older adults is likely to mean that more will continue to part of the workforce in years to come. (He et al., article, U. S. Census, 2005).

**Education**

Twenty percent of people over 65 have a bachelors or higher degree.  And over 7 million people over 65 take adult education courses (U. S. Census Bureau, 2011).  Lifelong learning through continuing education programs on college campuses or programs known as “Elderhostels” which allow older adults to travel abroad, live on campus and study provide enriching experiences. Academic courses as well as practical skills such as computer classes, foreign languages, budgeting, and holistic medicines are among the courses offered. Older adults who have higher levels of education are more likely to take continuing education. But offering more educational experiences to a diverse group of older adults, including those who are institutionalized in nursing homes can bring enhance the quality of life.

**Volunteering: Face-to-face and Virtually**

About 40 percent of older adults are involved in some type of structured, face-to-face, volunteer work.  But many older adults, about 60 percent, engage in a sort of informal type of volunteerism helping out neighbors or friends rather than working in an organization (Berger, 2005). They may help a friend by taking them somewhere or shopping for them, etc. Some do participate in organized volunteer programs but interestingly enough, those who do tend to work part-time as well. Those who retire and do not work are less likely to feel that they have a contribution to make. (It's as if when one gets used to staying at home, their confidence to go out into the world diminishes.) And those who have recently retired are more likely to volunteer than those over 75 years of age.

New opportunities exist for older adults to serve as **virtual volunteers** by dialoguing online with others from around their world and sharing their support, interests, and expertise. According to an article from **AARP** (American Association of Retired Persons), virtual volunteerism has increased from 3,000 in 1998 to over 40,000 participants in 2005. These volunteer opportunities range from helping teens with their writing to communicating with ‘neighbors’ in villages of developing countries. Virtual volunteering is available to those who cannot engage in face-to-face interactions and opens up a new world of possibilities and ways to connect, maintain identity, and be productive (Uscher, 2006).

**Religious Activities**

People tend to become more involved in prayer and religious activities as they age as well.  This provides a social network as well as a belief system that combats the fear of death.  It provides a focus for volunteerism and other activities as well.  For example, one elderly woman prides herself on knitting prayer shawls that are given to those who are sick.  Another serves on the alter guild and is responsible for keeping robes and linens clean and ready for communion.

**Political Activism**

The elderly are very politically active. They have high rates of voting and engage in letter writing to congress on issues that not only affect them, but on a wide range of domestic and foreign concerns. In the 2008 election, 70 percent of people 65 and older voted.  This group tied with 45-65 year olds as having the highest voter turnout (U. S. Census Bureau, 2011).

**Relationships during Late Adulthood (Ob19, Ob20)**

**Grandparenting:**Grandparenting typically begins in midlife rather than late adulthood, but because people are living longer, they can anticipate being grandparents for longer periods of time. Cherlin and Furstenberg (1986) describe three styles of grandparents:

1. Remote: These grandparents rarely see their grandchildren. Usually they live far away from the grandchildren, but may also have a distant relationship. Contact is typically made on special occasions such as holidays or birthdays. Thirty percent of the grandparents studied by Cherlin and Furstenberg were remote.

2. Companionate Grandparents:  Fifty-five percent of grandparents studied were described as "companionate". These grandparents do things with the grandchild but have little authority or control over them. They prefer to spend time with them without interfering in parenting. They are more like friends to their grandchildren.

3. Involved Grandparents: Fifteen percent of grandparents were described as "involved". These grandparents take a very active role in their grandchild's life. They children might even live with the grandparent. The involved grandparent is one who has frequent contact with and authority over the grandchild.

An increasing number of grandparents are raising grandchildren today. Issues such as custody, visitation, and continued contact between grandparents and grandchildren after parental divorce are contemporary concerns.

**Marriage and Divorce:**Fifty-six percent of people over 65 are married.  The majority of older men and just over 40 percent of older women are married (He et al., 2005). Seven percent of older men and 9 percent of older women are divorced and about 4 percent of older adults have never married. Many married couples feel their marriage has improved with time and the emotional intensity and level of conflict that might have been experienced earlier, has declined. This is not to say that bad marriages become good ones over the years, but that those marriages that were very conflict-ridden may no longer be together, and that many of the disagreement couples might have had earlier in their marriages may no longer be concerns. Children have grown and the division of labor in the home has probably been established. Men tend to report being satisfied with marriage more than do women. Women are more likely to complain about caring for a spouse who is ill or accommodating a retired husband and planning activities. Older couples continue to engage in sexual activity, but with less focus on intercourse and more on cuddling, caressing, and oral sex (Carroll, 2007).

Divorce after long-term marriage does occur, but is not very common. However, with the number of older adults on the rise, the divorce rate is likely to increase. A longer life expectancy and the expectation of happiness cause some older couples to begin a new life after divorce after 65. Consider Betty who divorced after 40 years of marriage. Her marriage had never been ideal but she stuck with it hoping things would improve and because she didn't want to hurt her husband's reputation (he was in a job in which divorce was frowned upon).  But she always hoped for more freedom and happiness in life and once her family obligations were no longer as great (the children and grandchildren were on their own), she and her husband divorced.  She characterized this as an act of love in that both she and her ex-husband were able to pursue their dreams in later life (Author’s notes).  Older adults who have been divorce since midlife tend to have settled into comfortable lives and, if they have raised children, to be proud of their accomplishments as single parents.

**Widowhood:** Twenty-nine percent of people over 65 are widowed (U. S. Census Bureau, 2011).  The death of a spouse is one of life's most disruptive experiences. It is especially hard on men who lose their wives. Often widowers do not have a network of friends or family members to fall back on and may have difficulty expressing their emotions to facilitate grief. Also, they may have been very dependent on their mates for routine tasks such as cooking, cleaning, etc. In addition, they typically expect to precede their wives in death and by losing a wife, have to adjust to something unexpected. However, if a man can adjust, he will find that he is in great demand, should he decide to remarry.

Widows may have less difficulty because they do have a social network and can take care of their own daily needs. They may have more difficulty financially if their husband's have handled all the finances in the past. They are much less likely to remarry because many do not wish to and because there are fewer men available.  At 65, there are 73 men to every 100 women.  The sex ratio becomes even further imbalanced at 85 with 48 men to every 100 women (U. S. Census Bureau, 2011).

**Loneliness or solitude?**Loneliness is a discrepancy between the social contact a person has and the contacts a person wants (Brehm et al., 2002). It can result from social or emotional isolation. Women tend to experience loneliness as a result of social isolation; men from emotional isolation. Loneliness can be accompanied by a lack of self-worth, impatience, desperation, and depression. This can lead to suicide, particularly in older, white, men who have the highest suicide rates of any age group, higher than Blacks, and higher than for females. Rates of suicide continue to climb and peaks in males after age 85 (National Center for Health Statistics, CDC, 2002).

Being alone does not always result in loneliness. For some, it means solitude. Solitude involves gaining self-awareness, taking care of the self, being comfortable alone, and pursuing one’s interests (Brehm et al., 2002).   Winnie, aged 80, describes her life alone as comfortable and meaningful. “I’m up early to take care of my 3 year old great-granddaughter who stays with me. We play and have lunch and later her mother comes after her. I love to sing and sing all the time. I sing in the choir. . . I enjoy my mornings at the kitchen table with my coffee. And me and Coco (her dog) enjoy sitting in the sun.” (Author’s notes).

**Single, Cohabiting, and Remarried Older Adults (Ob23)**

About 4 percent of adults never marry. Many have long-term relationships, however. The never married tend to be very involved in family and care giving and do not appear to be particularly unhappy during late adulthood, especially if they have a healthy network of friends. Friendships tend to be an important influence in life satisfaction during late adulthood. Friends may be more influential than family members for many older adults. According to **socioemotional selectivity theory,** older adults become more selective in their friendships than when they were younger (Carstensen, Fung, & Charles, 2003). Friendships are not formed in order to enhance status or careers, and may be based purely on a sense of connection or the enjoyment of being together. Most elderly people have at least one close friend. These friends may provide emotional as well as physical support. Being able to talk with friends and rely on others is very important during this stage of life.

About 4 percent of older couples chose cohabitation over marriage (Chevan, 1996). As discussed in our lesson on early adulthood, these couples may prefer cohabitation for financial reasons, may be same-sex couples who cannot legally marry, or couples who do not want to marry because of previous dissatisfaction with marital relationships. There are between 1 and 3 million gay and lesbian older adults in America today and numbers will continue to increase (Cahill et al., 2000). These older adults have concerns over health insurance, being able to share living quarters in nursing homes and assisted living residences where staff members tend not to be accepting of homosexuality and bisexuality. SAGE (Senior Action in a Gay Environment) is an advocacy group working on remedying these concerns. Same-sex couples who have endured prejudice and discrimination through the years and can rely upon one another continue to have support through late adulthood. Those who are institutionalized, however, may find it harder to live together.

Couples, who remarry after midlife, tend to be happier in their marriages than in first marriage.  These partners are likely to be more financially independent, have children who are grown, and enjoy a greater emotional wisdom that comes with experience.

**Residence**

Older adults do not typically relocate far from their previous places of residence during late adulthood. A minority lives in planned retirement communities that require residents to be of a certain age. However, many older adults live in age-segregated neighborhoods that have become segregated as original inhabitants have aged and children have moved on. A major concern in future city planning and development will be whether older adults wish to live in age integrated or age segregated communities.

**Older Adults, Caregiving, and Long-Term Care (Ob21, Ob22)**

We previously noted the number of older adults who require long-term care and noted that the number increases with age. Most (70 percent) of older adults who require care receive that care in the home. Most are cared for by their spouse, or by a daughter or daughter-in-law. However, those who are not cared for at home are institutionalized. In 2008, 1.6 million out of the total 38.9 million Americans age 65 and older were nursing home residents (U. S. Census Bureau, 2011). Among 65-74, 11 per 1,000 adults aged 65 and older were in nursing homes. That number increases to 182 per 1,000 after age 85. More residents are women than men, and more are Black than white. As the population of those over 85 continues to increase, more will require nursing home care. Meeting the psychological and social as well as physical needs of nursing home residents is a growing concern. Rather than focusing primarily on food, hygiene, and medication, quality of life within these facilities is important. Residents of nursing homes are sometimes stripped of their identity as their personal possessions and reminders of their life are taken away. A rigid routine in which the residents have little voice can be alienating to an older adult. Routines that encourage passivity and dependence can be damaging to self-esteem and lead to further deterioration of health. Greater attention needs to be given to promoting successful aging within institutions.

**Elderly Abuse (Ob24)**

Nursing homes have been publicized as places where older adults are at risk of abuse. Abuse and neglect of nursing home residents is more often found in facilities that are run down and understaffed. However, older adults are more frequently abused by family members. The most commonly reported types of abuse are financial abuse and neglect. Victims are usually very frail and impaired and perpetrators are usually dependent on the victims for support. Prosecuting a family member who has financially abused a parent is very difficult. The victim may be reluctant to press charges and the court dockets are often very full resulting in long waits before a case is heard.   **Granny dumping** or the practice of family members abandoning older family members with severe disabilities in emergency rooms is a growing problem. An estimated 100,000 and 200,000 are dumped each year (Tanne in Berk, 2007).

**Conclusion**

Greater understanding of the needs of older adults and more resources with which to provide for these needs are necessary to promote healthy aging in our growing population of older adults. We are coming to recognize the strengths of late adulthood and to move beyond the stereotypes of aging. This new appreciation of the value of older adults promises to lay the groundwork for a new approach to this period of life.

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