CONTENT ATTRIBUTION

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Achieving the Dream Edition

Except where expressly noted otherwise, the contents are based on the Lumen Learning edition of *Developmental Psychology* which uses materials published in the Open Course Library written by Linda Overstreet.

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The content of the Overstreet text has been left intact, but the instructional design of the accompanying course documents is mine. 20 years of online teaching experience has gone into the design of the learning activities presented in this course. The foundation of my methodology is best described as technoheutagogy – technology enhanced learner determined learning. To the extent possible, the learner selects the focus, depth, and pace of learning by creating her/his personalized learning path through the content. I encourage you to explore the material in the Course Information section which follows the final textbook chapter, and if you have an interest in going further into this approach please visit my website: http://www.technoheutagogy.com.

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ECE Developmental Psychology

ECE DEVELOPMENTAL PSYCHOLOGY

Created for ECE GDEV 2028

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NSCC

Nova Scotia

CONTENTS

INSTRUCTOR RESOURCES

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PART I.

CHAPTER 1: EARLY ADULTHOOD

CHAPTER 1.

INTRODUCTION TO EARLY ADULTHOOD

Learning Objectives

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

1. Discuss the developmental tasks of early adulthood.
2. Describe physical development in early adulthood.
3. Explain how early adulthood is a healthy, yet risky time of life.
4. Summarize Levinson's theory of adult transitions.
5. Distinguish between formal and postformal thought.
6. Explain dialectical thought.
7. Describe Erikson's stage of intimacy vs. isolation.
8. Question Erikson's assertion about the focus on intimacy in early adulthood.
9. Identify trends in mate selection, age at first marriage, and cohabitation in the United States.
10. Discuss fertility issues in early adulthood.
11. Explain social exchange theory of mate selection.
12. Define the principle of least interest.
13. Apply Sternberg's theory of love to specific examples of relationships.
14. Apply Lee's love styles to specific examples of relationships.
15. Compare frames of relationships.
16. Explain the wheel theory of love.
17. Explain the process of disaffection.
18. Describe some current concerns in education in today's colleges.

DEVELOPMENTAL TASKS OF EARLY ADULTHOOD

Early adulthood can be a very busy time of life. Havighurst (1972) describes some of the developmental tasks of young adults. These include:

Photo Courtesy of Joshua Gray

- Achieving autonomy: trying to establish oneself as an independent person with a life of one's own
- Establishing identity: more firmly establishing likes, dislikes, preferences, and philosophies
- Developing emotional stability: becoming more stable emotionally which is considered a sign of maturing
- Establishing a career: deciding on and pursuing a career or at least an initial career direction and pursuing an education
- Finding intimacy: forming first close, long-term relationships
- Becoming part of a group or community: young adults may, for the first time, become involved with various groups in the community. They may begin voting or volunteering to be part of civic organizations (scouts, church groups, etc.). This is especially true for those who participate in organizations as parents.
- Establishing a residence and learning how to manage a household: learning how to budget and keep a home maintained.
- Becoming a parent and rearing children: learning how to manage a household with children. Making marital adjustments and learning to parent.

Exercise

To what extent do you think these have changed in the last several years? How might these tasks be different across cultures?

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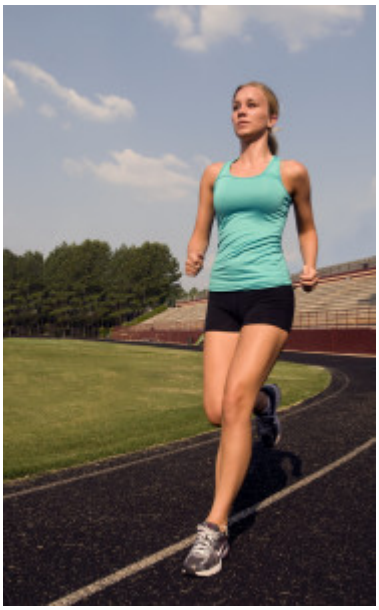
CHAPTER 2.

PHYSICAL DEVELOPMENT



The Physiological Peak: People in their twenties and thirties are considered young adults. If you are in your early twenties, good news- you are probably at the peak of your physiological development. Your reproductive system, motor ability, strength, and lung capacity are operating at their best. Now here is the bad news. These systems will now start a slow, gradual decline so that by the time you reach your mid to late 30s, you will begin to notice signs of aging. This includes a decline in your immune system, your response time, and in your ability to recover quickly from physical exertion. For example, you may have noticed that it takes you quite some time to stop panting after running to class or taking the stairs. But, here is more good news. Getting out of shape is not an inevitable part of aging; it is probably due to the fact that you have become less physically active and have experienced greater stress. How is that good news, you ask? It's good news because it means that there are thing you can do to combat many of these changes. So keep in mind, as we continue to discuss the life span that many of the changes we associate with aging can be turned around if we adopt healthier lifestyles.

A Healthy, but Risky Time: Doctor's visits are less frequent in early adulthood than for those in midlife and late adulthood and are necessitated primarily by injury and pregnancy (Berger, 2005). However, among the top five causes of death in young adulthood are non-intentional injury (including motor vehicle accidents), homicide, and suicide (Heron, M. P. & B. L. Smith, 2007). Cancer and heart disease complete the list. Rates of violent death (homicide, suicide, and accidents) are highest among young adult males, and vary among by race and ethnicity. Rates of violent death are higher in the United States than in Canada, Mexico, Japan, and other selected countries. Males are 3 times more likely to die in auto accidents than are females (Frieden, 2011).

Substance Abuse: Rates of violent death are influenced by substance abuse which peaks during early adulthood. Illicit drug use peaks between the ages of 19 and 22 and then begins to decline (Berk, 2007). And twenty-five percent of those who smoke cigarettes, a third of those who smoke marijuana, and 70 percent of those who abuse cocaine began using after age 17 (Volkow, 2004). Some young adults use as a way of coping with stressors from family, personal relationships, or concerns over being on one's own. Others use because they have friends who use and in the early 20s, there is still a good deal of pressure to conform. Half of all alcohol consumed in the United States is in the form of binge drinking (Frieden, 2011).

Drugs impair judgment, reduce inhibitions, and alter mood, all of which can lead to dangerous behavior. Reckless driving, violent altercations, and forced sexual encounters are some examples. Binge drinking on college campuses has received considerable media and public attention. The role alcohol plays in predicting acquaintance rape on college campuses is of particular

concern. In the majority of cases of rape, the victim knows the rapist. Being intoxicated increases a female's risk of being the victim of date or acquaintance rape (Fisher et als. in Carroll, 2007). And, she is more likely to blame herself and to be blamed by others if she was intoxicated when raped. Males increase their risk of being accused of rape if they are drunk when an incidence occurred (Carroll, 2007).

Drug and alcohol use increase the risk of sexually transmitted infections because people are more likely to engage in risky sexual behavior when under the influence. This includes having sex with someone who has had multiple partners, having anal sex without the use of a condom, having multiple partners, or having sex with someone whose history is unknown. And, as we previously discussed in our lesson on Beginnings, drugs and alcohol ingested during pregnancy have a teratogenic effect.

SEXUAL RESPONSIVENESS AND REPRODUCTION IN EARLY ADULTHOOD

Sexual Responsiveness: Men and women tend to reach their peak of sexual responsiveness at different ages. For men, sexual responsiveness tends to peak in the late teens and early twenties. Sexual arousal can easily occur in response to physical stimulation or fantasizing. Sexual responsiveness begins a slow decline in the late twenties and into the thirties although a man may continue to be sexually active. Through time, a man may require more intense stimulation in order to become aroused. Women often find that they become more sexually responsive throughout their 20s and 30s and may peak in the late 30s or early 40s. This is likely due to greater self-confidence and reduced inhibitions about sexuality.

Reproduction: For many couples, early adulthood is the time for having children. However, delaying childbearing until the late 20s or early 30s has become more common in the United States.

Couples delay childbearing for a number of reasons. Women are more likely to attend college and begin careers before starting families. And both men and women are delaying marriage until they are in their late 20s and early 30s.

Infertility: Infertility affects about 6.1 million women or 10 percent of the reproductive age population (American Society of Reproductive Medicine [ASRM], 2000-2007). Male factors create infertility in about a third of the cases. For men, the most common cause is a lack of sperm production or low sperm production. Female factors cause infertility in another third of cases. For women, one of the most common causes of infertility is the failure to ovulate. Another cause of infertility is pelvic inflammatory disease, an infection of the female genital tract (Carroll, 2007). Pelvic inflammatory disease is experienced by 1 out of 7 women in the United States and leads to infertility about 20 percent of the time. One of the major causes of pelvic inflammatory disease is Chlamydia trachomatis, the most commonly diagnosed sexually transmitted infection in young women. Another cause of pelvic inflammatory disease is gonorrhea. Both male and female factors contribute to the remainder of cases of infertility.

Fertility treatment: The majority of infertility cases (85-90 percent) are treated using fertility drugs to increase ovulation or with surgical procedures to repair the reproductive organs or remove scar tissue from the reproductive tract. In vitro fertilization is used to treat infertility in less than 5 percent of cases. IVF is used when a woman has blocked or deformed fallopian tubes or sometimes when a man has a very low sperm count. This procedure involves removing eggs from the female and fertilizing the eggs outside the woman's body. The fertilized egg is then reinserted in the woman's uterus. The average cost of IVF is over $12,000 and the success rate is between 5 to 30 percent. IVF makes up about 99 percent of artificial reproductive procedures.

Less common procedures include gamete intra-fallopian tube transfer (GIFT) which involves implanting both sperm and ova into the fallopian tube and fertilization is allowed to occur naturally. The success rate of implantation is higher for GIFT than for IVF (Carroll, 2007). Zygote intra-fallopian tube transfer (ZIFT) is another procedure in which sperm and ova are fertilized outside of the woman's body and the fertilized egg or zygote is then implanted in the fallopian tube. This allows the zygote to travel down the fallopian tube and embed in the lining of the uterus naturally. This procedure also has a higher success rate than IVF.

Insurance coverage for infertility is required in fourteen states, but the amount and type of coverage available varies greatly (ASRM, 2000-2007). The majority of couples seeking treatment for infertility pay much of the cost. Consequently, infertility treatment is much more accessible to couples with higher incomes. However, grants and funding sources are available for lower income couples seeking infertility treatment as well.

Image Credit

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CHAPTER 3.

COGNITIVE DEVELOPMENT

BEYOND FORMAL OPERATIONAL THOUGHT: POST-FORMAL THOUGHT

In our last lesson, we discussed formal operational thought. The hallmark of this type of thinking is the ability to think abstractly or to consider possibilities and ideas about circumstances never directly experienced. Thinking abstractly is only one characteristic of adult thought, however. If you compare a 15-year-old with someone in their late 30s, you would probably find that the latter considers not only what is possible, but also what is likely. Why the change? The adult has gained experience and understands why possibilities do not always become realities. This difference in adult and adolescent thought can spark arguments between the generations. Here is an example. A student in her late 30s relayed such an argument she was having with her 14-year-old son. The son had saved a considerable amount of money and wanted to buy an old car and store it in the garage until he was old enough to drive. He could sit in it; pretend he was driving, clean it up, and show it to his friends. It sounded like a perfect opportunity. The mother, however, had practical objections. The car could just sit for several years without deteriorating. The son would certainly change his mind about the type of car he wanted before he was old enough to drive and they would be stuck with a car that would not run. Having a car nearby would be too much temptation and the son might decide to sneak it out for a quick run around the block, etc.

Postformal thought is practical, realistic and more individualistic. As a person approaches the late 30s, chances are they make decisions out of necessity or because of prior experience and are less influenced by what others think. Of course, this is particularly true in individualistic cultures such as the United States.

DIALECTICAL THOUGHT

In addition to moving toward more practical considerations, thinking in early adulthood may also become more flexible and balanced. Abstract ideas that the adolescent believes in firmly may become standards by which the adult evaluates reality. Adolescents tend to think in dichotomies; ideas are true or false; good or bad; right or wrong and there is no middle ground. However, with experience, the adult comes to recognize that there is some right and some wrong in each position, some good or some bad in a policy or approach, some truth and some falsity in a particular idea. This ability to bring together salient aspects of two opposing viewpoints or positions is referred to as dialectical thought and is considered one of the most advanced aspects of postformal thinking (Basseches, 1984). Such thinking is more realistic because very few positions, ideas, situations, or people are completely right or wrong. So, for example, parents who were considered angels or devils by the adolescent eventually become just people with strengths and weaknesses, endearing qualities and faults to the adult.

EDUCATIONAL CONCERNS

In 2005, 37 percent of people in the United States between 18 and 24 had some college or an associate degree; about 30 percent of people between 25 and 34 had completed an education at the bachelor's level or higher (U. S. Bureau of the Census, 2005). Of current concern is the relationship between higher education and the workplace. Bok (2005), American educator and Harvard University President, calls for a closer alignment between the goals of educators and the demands of the economy. Companies outsource much of their work, not only to save costs, but to find workers with the skills they need. What is required to do well in today's economy? Colleges and universities, he argues, need to promote global awareness, critical thinking skills, the ability to communicate, moral reasoning, and responsibility in their students (Bok, 2006). Regional accrediting agencies and state organizations provide similar guidelines for educators. Workers need skills in listening, reading, writing, speaking, global awareness, critical thinking, civility, and computer literacy-all skills that enhance success in the workplace. The U. S. Secretary of Education, Margaret Spellings challenges colleges and universities to demonstrate their effectiveness in providing these skills to students and to work toward increasing America's competitiveness in the global economy (U. S. Department of Education, 2006).

A quality education is more than a credential. Being able to communicate and work well with others is crucial for success. There is some evidence to suggest that most workers who lose their jobs do so because of an inability to work with others, not because they do not know how to do their jobs (Cascio, in Berger 2005). Writing, reading, being able to work with a diverse work team, and having the social skills required to be successful in a career and in society are qualities that go beyond merely earning a credential to compete for a job. Employers must select employees who are not only degreed, but who will be successful in the work environment. Hopefully, students gain these skills as they pursue their degrees. Listen to this story about the lack of rigor in higher education and the problems students face as a result: A Lack Of Rigor Leaves Students 'Adrift' In College.

Image Credit

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CHAPTER 4.

PSYCHOSOCIAL DEVELOPMENT

GAINING ADULT STATUS

Many of the developmental tasks of early adulthood involve becoming part of the adult world and gaining independence. Young adults sometimes complain that they are not treated with respect-especially if they are put in positions of authority over older workers. Consequently, young adults may emphasize their age to gain credibility from those who are even slightly younger. "You're only 23? I'm 27!" a young adult might exclaim. (Note: This kind of statement is much less likely to come from someone in their 40s!).

The focus of early adulthood is often on the future. Many aspects of life are on hold while people go to school, go to work, and prepare for a brighter future. There may be a belief that the hurried life now lived will improve 'as soon as I finish school' or 'as soon as I get promoted' or 'as soon as the children get a little older.' As a result, time may seem to pass rather quickly. The day consists of meeting many demands that these tasks bring. The incentive for working so hard is that it will all result in better future.

LEVINSON'S THEORY

In 1978, Daniel Levinson published a book entitled *The Seasons of a Man's Life* in which he presented a theory of development in adulthood. Levinson's work was based on in-depth interviews with 40 men between the ages of 35-45. He later conducted interviews with women as well (1996). According to Levinson, these adults have an image of the future that motivates them. This image is called "the dream" and for the men interviewed, it was a dream of how their career paths would progress and where they would be at midlife. Women held a "split dream"; an image of the future in both work and family life and a concern with the timing and coordination of the two. Dreams are very motivating. Dreams of a home bring excitement to couples as they look, save, and fantasize about how life will be. Dreams of careers motivate students to continue in school as they fantasize about how much their hard work will pay off. Dreams of playgrounds on a summer day inspire would be parents. A dream is perfect and retains that perfection as long as it remains in the future. But as the realization of it moves closer, it may or may not measure up to its image. If it does, all is well. But if it does not, the image must be replaced or modified. And so, in adulthood, plans are made, efforts follow, and plans are reevaluated. This creating and recreating characterizes Levinson's theory.

Levinson's stages are presented below (Levinson, 1978). He suggests that period of transition last about 5 years and periods of "settling down" last about 7 years. The ages presented below are based on life in the middle class about 30 years ago. Think about how these ages and transitions might be different today.

- Early adult transition (17-22): Leaving home, leaving family; making first choices about career and education

- Entering the adult world (22-28): Committing to an occupation, defining goals, finding intimate relationships
- Age 30 transition (28-33): Reevaluating those choices and perhaps making modifications or changing one's attitude toward love and work
- Settling down (33 to 40): Reinvesting in work and family commitments; becoming involved in the community
- Midlife transition (40-45): Reevaluating previous commitments; making dramatic changes if necessary; giving expression to previously ignored talents or aspirations; feeling more of a sense of urgency about life and its meaning
- Entering middle adulthood (45-50): Committing to new choices made and placing one's energies into these commitments

Adulthood, then, is a period of building and rebuilding one's life. Many of the decisions that are made in early adulthood are made before a person has had enough experience to really understand the consequences of such decisions. And, perhaps, many of these initial decisions are made with one goal in mind-to be seen as an adult. As a result, early decisions may be driven more by the expectations of others. For example, imagine someone who chose a career path based on other's advice but now find that the job is not what was expected. The age 30 transition may involve recommitting to the same job, not because it's stimulating, but because it pays well. Settling down may involve settling down with a new set of expectations for that job. As the adult gains status, he or she may be freer to make more independent choices. And sometimes these are very different from those previously made. The midlife transition differs from the age 30 transition in that the person is more aware of how much time has gone by and how much time is left. This brings a sense of urgency and impatience about making changes. The future focus of early adulthood gives way to an emphasis on the present in midlife. (We will explore this in our next lesson.) Overall, Levinson calls our attention to the dynamic nature of adulthood.

Exercise

How well do you think Levinson's theory translates culturally?

Do you think that personal desire and a concern with reconciling dreams with the realities of work and family is equally important in all cultures?

Do you think these considerations are equally important in all social classes, races and ethnic groups? Why or why not?

How might this model be modified in today's economy?

ERIKSON'S THEORY

Intimacy vs. Isolation

Erikson believed that the main task of early adulthood was to establish intimate relationships. Intimate relationships are more difficult if one is still struggling with

identity. Achieving a sense of identity is a life-long process, but there are periods of identity crisis and stability. And having some sense of identify is essential for intimate relationships. In early adulthood, intimacy (or emotional or psychological closeness) comes from friendships and mates.

Friendships as a source of intimacy

In our twenties, intimacy needs may be met in friendships rather than with partners. This is especially true in the United States today as many young adults postpone making long-term commitments to partners either in marriage or in cohabitation. The kinds of friendships shared by women tend to differ from those shared by men (Tannen, 1990). Friendships between men are more likely to involve sharing information, providing solutions, or focusing on activities rather than discussion problems or emotions. Men tend to discuss opinions or factual information or spend time together in an activity of mutual interest. Friendships between women are more likely to focus on sharing weaknesses, emotions, or problems. Women talk about difficulties they are having in other relationships and express their sadness, frustrations, and joys. These differences in approaches lead to problems when men and women come together. She may want to vent about a problem she is having; he may want to provide a solution and move on to some activity. But when he offers a solution, she thinks he does not care!

Friendships between men and women become more difficult because of the unspoken question about whether the friendships will lead to a romantic involvement. It may be acceptable to have opposite-sex friends as an adolescent, but once a person begins dating or marries; such friendships can be considered threatening. Consequently, friendships may diminish once a person has a partner or single friends may be replaced with couple friends.

PARTNERS AS A SOURCE OF INTIMACY: DATING, COHABITATION, AND MATE SELECTION

Dating

In general, traditional dating among teens and those in their early twenties has been replaced with more varied and flexible ways of getting together. The Friday night date with dinner and a movie that may still be enjoyed by those in their 30s gives way to less formal, more spontaneous meetings that may include several couples or a group of friends. Two people may get to know each other and go somewhere alone. How would you describe a "typical" date? Who calls? Who pays? Who decides where to go? What is the purpose of the date? In general, greater planning is required for people who have additional family and work responsibilities. Teens may simply have to negotiate getting out of the house and carving out time to be with friends.

Cohabitation or Living Together

How prevalent is cohabitation? There are over 5 million heterosexual cohabiting couples in the United States and, an additional 594,000 same-sex couples share households (U. S. Census Bureau, 2006). In 2000, 9 percent of women and 12 percent of men were in cohabiting relationships (Bumpass in Casper & Bianchi, 2002). This number reflects only those couples who were together when census data were collected, however. The number of cohabiting couples in the United States today is over 10 times higher than it was in 1960.

Similar increases have also occurred in other industrialized countries. For example, rates are high

in Great Britain, Australia, Sweden, Denmark, and Finland. In fact, more children in Sweden are born to cohabiting couples than to married couples. The lowest rates of cohabitation are in Ireland, Italy, and Japan (Benokraitis, 2005).

How long do cohabiting relationships last?

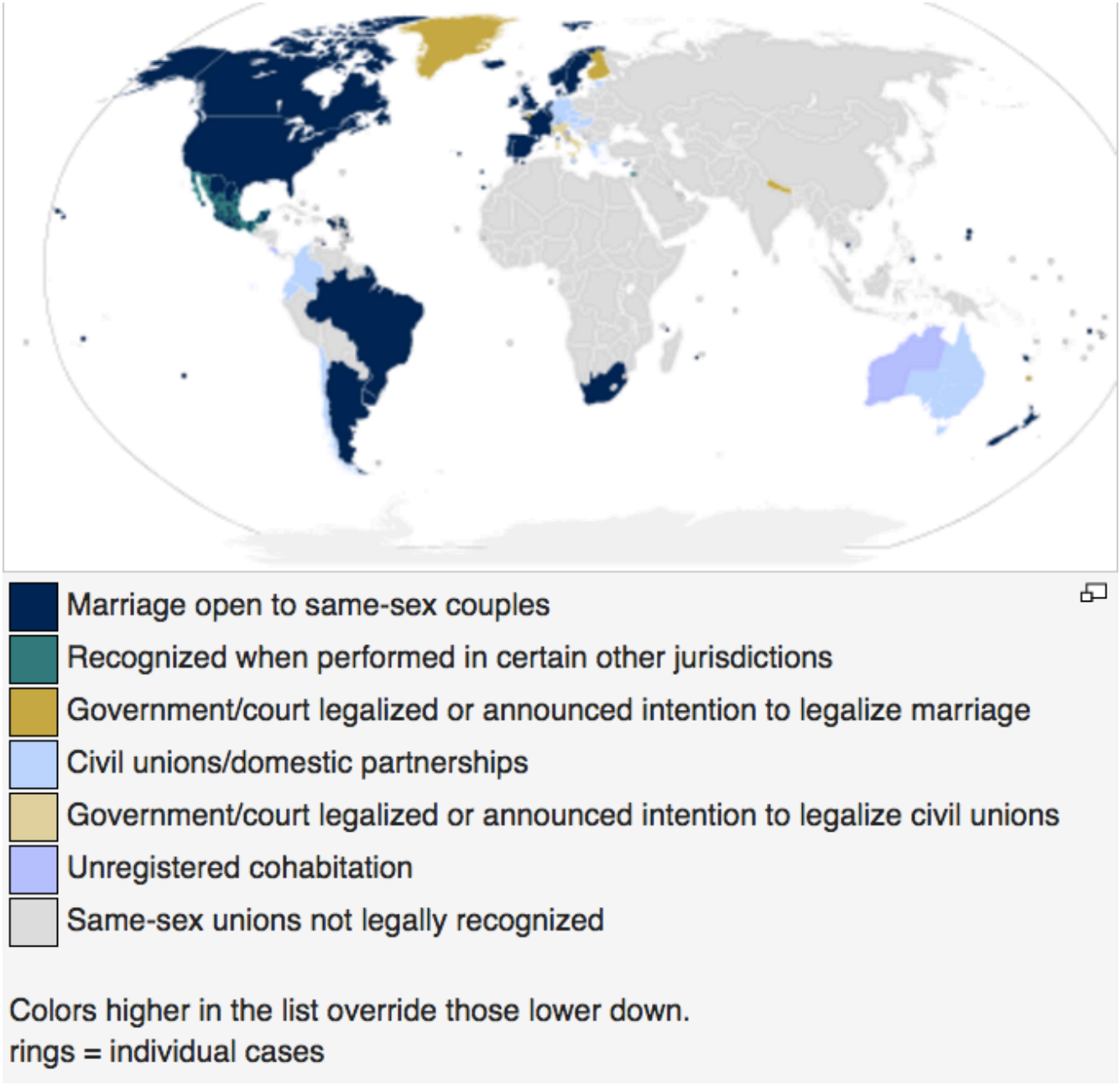
Cohabitation tends to last longer in European countries than in the United States. Half of cohabiting relationships in the U. S. end within a year; only 10 percent last more than 5 years. These short-term cohabiting relationships are more characteristics of people in their early 20s. Many of these couples eventually marry. Those who cohabit more than five years tend to be older and more committed to the relationship. Cohabitation may be preferable to marriage for a number of reasons. For partners over 65, cohabitation is preferable to marriage for practical reasons. For many of them, marriage would result in a loss of Social Security benefits and consequently is not an option. Others may believe that their relationship is more satisfying because they are not bound by marriage. Consider this explanation from a 62-year old woman who was previously in a long-term, dissatisfying marriage. She and her partner live in New York but spend winters in South Texas at a travel park near the beach. "There are about 20 other couples in this park and we are the only ones who aren't married. They look at us and say, 'I wish we were so in love'. I don't want to be like them." (Author's files.) Or another couple who have been happily cohabiting for over 12 years. Both had previously been in bad marriages that began as long-term, friendly, and satisfying relationships. But after marriage, these relationships became troubled marriages. These happily cohabiting partners stated that they believe that there is something about marriage that "ruins a friendship".

The majority of people who cohabit are between the ages of 25-44. Only about 20 percent of those who cohabit are under age 24. Cohabitation among younger adults tends to be short-lived. Relationships between older adults tend to last longer.

Why do people cohabit?

People cohabit for a variety of reasons. The largest number of couples in the United States engages in premarital cohabitation. These couples are testing the relationship before deciding to marry. About half of these couples eventually get married. The second most common type of cohabitation is dating cohabitation. These partnerships are entered into for fun or convenience and involve less commitment than premarital cohabitation. About half of these partners break up and about one-third eventually marry. Trial marriage is a type of cohabitation in which partners are trying to see what it might be like to be married. They are not testing the other person as a potential mate, necessarily; rather, they are trying to find out how being married might feel and what kinds of adjustments they might have to make. Over half of these couples split up. In the substitute marriage, partners are committed to one another and are not necessarily seeking marriage. Forty percent of these couples continue to cohabit after 5 to 7 years (Bianchi & Casper, 2000). Certainly, there are other reasons people cohabit. Some cohabit out of a feeling of insecurity or to gain freedom from someone else (Ridley, C. Peterman, D. & Avery, A., 1978). And many cohabit because they cannot legally marry.

Same-Sex Couples



Same sex marriage is legal in 21 countries, including the United States. Many other countries either recognize same-sex couples for the purpose of immigration, grant rights for domestic partnerships, or grant common law marriage status to same-sex couples.

Same sex couples struggle with concerns such as the division of household tasks, finances, sex, and friendships as do heterosexual couples. One difference between same sex and heterosexual couples, however, is that same sex couples have to live with the added stress that comes from social disapproval and discrimination. And continued contact with an ex-partner may be more likely among homosexuals and bisexuals because of closeness of the circle of friends and acquaintances.

Photo Courtesy Salvor Gissurardottir

MATE-SELECTION

Contemporary young adults in the United States are waiting longer than before to marry. The median age of first marriage is 25 for women and 27 for men. This reflects a dramatic increase in age of first marriage for women, but the age for men is similar to that found in the late 1800s. Marriage is being postponed for college and starting a family often takes place after a woman has completed her education and begun a career. However, the majority of women will eventually marry (Bianchi & Casper, 2000).

Social exchange theory suggests that people try to maximize rewards and minimize costs in social relationships. Each person entering the marriage market comes equipped with assets and liabilities or a certain amount of social currency with which to attract a prospective mate. For men, assets might include earning potential and status while for women, assets might include physical attractiveness and youth.

A fair exchange

Customers in the market do not look for a 'good deal', however. Rather, most look for a relationship that is mutually beneficial or equitable. One of the reasons for this is because most a relationship in which one partner has far more assets than the other will result if power disparities and a difference in the level of commitment from each partner. According to Waller's principle of least interest, the partner who has the most to lose without the relationship (or is the most dependent on the relationship) will have the least amount of power and is in danger of being exploited. A greater balance of power, then, may add stability to the relationship.

Homogamy and the filter theory of mate selection: Societies specify through both formal and informal rules who is an appropriate mate. Consequently, mate selection is not completely left to the individual. Rules of endogamy indicate within which groups we should marry. For example, many cultures specify that people marry within their own race, social class, age group, or religion. These rules encourage homogamy or marriage between people who share social characteristics. The majority of marriages in the U. S. are homogamous with respect to race, social class, age and to a lesser extent, religion. Rules of exogamy specify the groups into which one is prohibited from marrying. For example, in most of the United States, people are not allowed to marry someone of the same sex.

According to the filter theory of mate selection (Kerckhoff & Davis, 1962), the pool of eligible partners becomes narrower as it passes through filters used to eliminate members of the pool. One such filter is propinquity or geographic proximity. Mate selection in the United States typically involves meeting eligible partners face to face. Those with whom one does not come into contact

are simply not contenders. Race and ethnicity is another filter used to eliminate partners. Although interracial dating has increased in recent years and interracial marriage rates are higher than before, interracial marriage still represents only 5.4 percent of all marriages in the United States. Physical appearance is another feature considered when selecting a mate. Age, social class, and religion are also criteria used to narrow the field of eligibles. Thus, the field of eligibles becomes significantly smaller before those things we are most conscious of such as preferences, values, goals, and interests, are even considered.

Online Relationships

What impact does the internet have on the pool of eligibles? There are hundreds of websites designed to help people meet. Some of these are geared toward helping people find suitable marriage partners and others focus on less committed involvements. Websites focus on specific populations-big beautiful women, Christian motorcyclists, parents without partners, and people over 50, etc. Theoretically, the pool of eligibles is much larger as a result. However, many who visit sites are not interested in marriage; many are already married. And so if a person is looking for a partner online, the pool must be filtered again to eliminate those who are not seeking long-term relationships. While this is true in the traditional marriage market as well, knowing a person's intentions and determining the sincerity of their responses becomes problematic online.

Photo Courtesy Vikram Kharvi

This young man offers his picture and a description of his professional status and stability. While he's looking for employment, his ad might also help him find an eligible partner online.

Online communication differs from face-to-face interaction in a number of ways. In face-to-face meetings, people have many cues upon which to base their first impressions. A person's looks, voice, mannerisms, dress, scent, and surroundings all provide information in face-to-face meetings. But in computer- mediated meetings, written messages are the only cues provided. Fantasy is used to conjure up images of voice, physical appearance, mannerisms, and so forth. The anonymity of online involvement makes it easier to become intimate without fear of interdependence. It is easier to tell one's secrets because there is little fear of loss. One can find a virtual partner who is warm, accepting,

and undemanding (Gwinnell, 1998). And exchanges can be focused more on emotional attraction than physical appearance.

When online, people tend to disclose more intimate details about themselves more quickly. A shy person can open up without worrying about whether or not the partner is frowning or looking away. And someone who has been abused may feel safer in virtual relationships. None of the worries of home or work get in the way of the exchange. The partner can be given one's undivided attention, unlike trying to have a conversation on the phone with a houseful of others or at work between duties. Online exchanges take the place of the corner café as a place to relax, have fun, and be you (Brooks, 1997). However, breaking up or disappearing is also easier. A person can simply not respond, or block e-mail.

But what happens if the partners meet face to face? People often complain that pictures they have been provided of the partner are misleading. And once couples begin to think more seriously about the relationship, the reality of family situations, work demands, goals, timing, values, and money all add new dimensions to the mix. Next we will turn our attention to theories of love.

Image Credit

- Map of where same-sex marriage is legal. **Provided by**: Wikipedia. **Located at**: https://en.wikipedia.org/wiki/Same-sex_marriage#/media/File:World_marriage-equality_laws.svg. **License**: *CC BY-SA: Attribution-ShareAlike*

CHAPTER 5.

TYPES OF LOVE

STERNBERG'S TRIANGLE OF LOVE: THREE COMPONENTS

Sternberg (1988) suggests that there are three main components of love: passion, intimacy, and commitment. Love relationships vary depending on the presence or absence of each of these components. Passion refers to the intense, physical attraction partners feel toward one another. Intimacy involves the ability the share feelings, personal thoughts and psychological closeness with the other. Commitment is the conscious decision to stay together. Passion can be found in the early stages of a relationship, but intimacy takes time to develop because it is based on knowledge of the partner. Once intimacy has been established, partners may resolve to stay in the relationship. Although many would agree that all three components are important to a relationship, many love relationships do not consist of all three. Let's look at other possibilities.

Liking: In this relationship, intimacy or knowledge of the other and a sense of closeness is present. Passion and commitment, however, are not. Partners feel free to be themselves and disclose personal information. They may feel that the other person knows them well and can be honest with them and let them know if they think the person is wrong. These partners are friends. However, being told that your partner 'thinks of you as a friend' can be a devastating blow if you are attracted to them and seek a romantic involvement.

Infatuation: Perhaps, this is Sternberg's version of "love at first sight". Infatuation consists of an immediate, intense physical attraction to someone. A person who is infatuated finds it hard to think of anything but the other person. Brief encounters are played over and over in one's head; it may be difficult to eat and there may be a rather constant state of arousal. Infatuation is rather short-lived, however, lasting perhaps only a matter of months or as long as a year or so. It tends to be based on chemical attraction and an image of what one thinks the other is all about.

Fatuous Love: However, some people who have a strong physical attraction push for commitment early in the relationship. Passion and commitment are aspects of fatuous love. There is no intimacy and the commitment is premature. Partners rarely talk seriously or share their ideas. They focus on their intense physical attraction and yet one, or both, is also talking of making a lasting commitment. Sometimes this is out of a sense of insecurity and a desire to make sure the partner is locked into the relationship.

Empty Love: This type of love may be found later in a relationship or in a relationship that was formed to meet needs other than intimacy or passion (money, childrearing, status). Here the partners

are committed to staying in the relationship (for the children, because of a religious conviction, or because there are no alternatives perhaps), but do not share ideas or feelings with each other and have no physical attraction for one another.

Romantic Love: Intimacy and passion are components of romantic love, but there is no commitment. The partners spend much time with one another and enjoy their closeness but have not made plans to continue 'no matter what'. This may be true because they are not in a position to make such commitments or because they are looking for passion and closeness and are afraid it will die out if they commit to one another and start to focus on other kinds of obligations.

Companionate Love: Intimacy and commitment are the hallmarks of companionate love. Partners love and respect one another and they are committed to staying together. But their physical attraction may have never been strong or may have just died out. This may be interpreted as 'just the way things are' after so much time together or there may be a sense of regret and loss. Nevertheless, partners are good friends committed to one another.

Consummate Love: Intimacy, passion, and commitment are present in consummate love. This is often the ideal type of love. The couple shares passion; the spark has not died, and the closeness is there. They feel like best friends as well as lovers and they are committed to staying together.

TYPES OF LOVERS

Lee (1973) offers a theory of love styles or types of lovers derived from an analysis of writings about love through the centuries. As you read these, think about how these styles might become part of the types of love described above.

Pragma is a style of love that emphasizes the practical aspects of love. The pragmatic lover considers compatibility and the sensibility of their choice of partners. This lover will be concerned with goals in life, status, family reputation, attitudes about parenting, career issues and other practical concerns.

Mania is a style of love characterized by volatility, insecurity, and possessiveness. This lover gets highly upset during arguments or breakups, may have trouble sleeping when in love, and feels emotions very intensely.

Agape is an altruistic, selfless love. These partners give of themselves without expecting anything in return. Such a lover places the partner's happiness above their own and is self-sacrificing to benefit the partner.

Eros is an erotic style of loving in which the person feels consumed. Physical chemistry and emotional involvement are important to this type of lover.

Ludus refers to a style of loving that emphasizes the game of seduction and fun. Such a lover stays away from commitment and often has several love interests at the same time. This lover does not self-disclose and in fact may prefer to keep the other guessing. This lover can end a relationship easily.

Storge is a style of love that develops slowly over time. It often begins as a friendship and becomes sexual much later. These partners are likely to remain friends even after the breakup.

FRAMES OF RELATIONSHIPS

A H M

Another useful way to consider relationships is to consider the amount of dependency in the relationship. Davidson (1991) suggests three models. The **A-frame** relationship is one in which the

partners lean on one another and are highly dependent on the other for survival. If one partner changes, the other is at risk of 'falling over'. This type of relationship cannot easily accommodate change and the partners are vulnerable should change occur. A breakup could be devastating.

The **H-frame** relationship is one in which the partners live parallel lives. They rarely spend time with one another and tend to have separate lives. What time they do share is usually spent meeting obligations rather than sharing intimacies. This independent type of relationship can end without suffering emotionally.

The **M-frame** relationship is interdependent. Partners have a strong sense of connection but also are able to stand alone without suffering devastation. If this relationship ends, partners will be hurt and saddened, but will still be able to stand alone. This ability comes from a strong sense of self-love. Partners can love each other without losing a sense of self. And each individual has self-respect and confidence that enriches the relationship as well as strengthens the self.

We have been looking at love in the context of many kinds of relationships. In our next lesson, we will focus more specifically on marital relationships. But before we do, we examine the dynamics of falling in and out of love.

THE PROCESS OF LOVE AND BREAKING UP

Reiss (1960) provides a theory of love as process. Based on the wheel theory of love, love relationships begin with the establishment of rapport.

Rapport involves sharing likes, preferences, establishing some common interests. The next step is to begin to disclose more personal information through self-revelation. When one person begins to open up, the social expectation is that the other will follow and also share more personal information so that each has made some risk and trust is built. Sexual intimacy may also become part of the relationship. Gradually, partners begin to disclose even more about themselves and are met with support and acceptance as they build mutual dependency. With time, partners come to rely on each other for need fulfillment. The wheel must continue in order for love to last. It becomes important for partners to continue to establish rapport by discussing the day's events, communicating about their goals and desires, and showing signs of trust. Partners must continue to rely on one another to have certain needs fulfilled. If the wheel turns backward, partners talk less and less, rely less on one another and are less likely to disclose.

PROCESS OF DISAFFECTION: BREAKING UP

When relationships are new, partners tend to give one another the benefit of the doubt and focus on what they like about one another. Flaws and imperfections do not go unnoticed; rather, they are described as endearing qualities. So, for example, the partner who has a very large nose is described as 'distinguished' or as having a 'striking feature.' This is very exhilarating because features that someone may have previously felt self-conscious about are now accepted or even appreciated. However, once partners begin the process of breaking up, these views are abandoned and questionable qualities are once again flaws and imperfections.

Kersten (1990) provides a look at the dynamics of breaking up. Although this work is primarily about divorce, the dynamics of dissolving any long-term relationship are similar. The beginning phase of breaking up involves seeing imperfections in the relationship but remaining hopeful that things will improve. This improvement will require the partner's cooperation because they are primarily at fault. So, as long as the offending partner makes the necessary changes, and of course

the offended partner will provide the advice, support, and guidance required, the relationship will continue. (If you are thinking that this is not going to work-you are right. Attempts to change one's partner are usually doomed to failure. Would you want your partner to try to change you?)

Once it becomes clear that efforts to change are futile, the middle phase is entered. This phase is marked by disappointment. Partners talk less and less, make little eye contact, and grow further apart. One may still try to make contact, but the other is clearly disengaged and is considering the benefits and costs of leaving the relationship.

In the end phase, the decision to leave has been made. The specific details are being worked out. Turning a relationship around is very difficult at this point. Trust has diminished, and thoughts have turned elsewhere. This stage is one of hopelessness.

We will explore marriage, divorce, and cohabitation more fully in our next lesson.

Image Credit

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CHAPTER 6.

ACTIVITY: LOVE ATTITUDE SCALE

INTRODUCTION

So what is your love style? Your authors discussed several types of love in the text, including John Lee's six love types. The Love Attitude Scale, created by Clyde Hendrick and Susan Hendrick, measures your attitudes about each of the styles.

DIRECTIONS

For each of the following statements, write the number (1-5) that most nearly describes your attitude or belief. Some of the items refer to a specific love relationship, while others refer to general attitudes and beliefs about love. Whenever possible, answer the questions with your current partner in mind. If you are not currently dating anyone, answer the questions with your most recent partner in mind. If you have never been in love, answer in terms of what you think your responses would most likely be.

For even more insight, make a copy of the questions and have your current partner complete them also. Answer the questions independently of each other and then compare your scores.

After looking at your style, type a paragraph in which you answer the following questions:

- Does these scores surprise you? Why or why not?
- What would you consider the advantages and disadvantages of these styles to be?
- What styles do you think would be most common in adolescence? Early adulthood? Adulthood? Why?

The code for the rating to be used for each statement is as follows:

SD = STRONGLY disagree; D = Disagree; N = Neutral; A = Agree; SA = STRONGLY agree

SD	D	N	A	SA
1	2	3	4	5

1. My lover and I were attracted to each other immediately after we first met
2. I try to keep my lover a little uncertain about my commitment to him/her.
3. It is hard to say exactly where friendship ends and love begins.
4. I consider what a person is going to become in life before I commit myself to him/her.
5. When things aren't right with my lover and me, my stomach gets upset.
6. I try to always help my lover through difficult times.
7. My lover and I have the right physical "chemistry" between us.
8. I believe that what my lover doesn't know about me won't hurt him/her.

9. Genuine love first requires caring for a while.
10. I try to plan my life carefully before choosing a lover.
11. When my love affairs break up, I get so depressed.
12. I would rather suffer myself than let my lover suffer.
13. Our lovemaking is very intense and satisfying.
14. I have sometimes had to keep two of my lovers from finding out about each other.
15. I expect to always be friends with the one I love.
16. It is best to love someone with a similar background.
17. Sometimes I get so excited about being in love that I can't sleep.
18. I cannot be happy unless I place my lover's happiness before my own.
19. I feel that my lover and I were meant for each other.
20. I can get over love affairs pretty easily and quickly.
21. The best kind of love grows out of a long friendship.
22. A main consideration in choosing a lover is how he/she reflects on my family.
23. When my lover doesn't pay attention to me, I feel sick all over.
24. I am usually willing to sacrifice my own wishes to let my lover achieve his/hers.
25. My lover and I became emotionally involved rather quickly.
26. My lover would get upset if he/she knew of some of the things I've done with other people.
27. Our friendship merged gradually into love over time.
28. An important factor in choosing a partner is whether or not he/she will be a good parent.
29. When I am in love, I have trouble concentrating.
30. Whatever I own is my lover's to use as he/she chooses.
31. My lover and I really understand each other.
32. When my lover gets too dependent on me, I want to back off a little.
33. Love is really a deep friendship, not a mysterious, mystical emotion.
34. One consideration in choosing a partner is how he/she will reflect on my career.
35. I cannot relax if I suspect that my lover is with someone else.
36. When my lover gets angry with me, I still love Him/her fully and unconditionally.
37. My lover fits my ideal standards of physical beauty/handsomeness.
38. I enjoy playing the "game of love" with a number is different partners.
39. My most satisfying love relationships have developed from good friendships.
40. Before getting very involved with anyone, I try to figure out how compatible his/her hereditary background is with mine in case we ever have children.

41. If my lover ignores me for a while, I do stupid things to get his/her attention back.
42. I would endure all things for the sake of my lover.

Source: Hendrick, C and Hendrick, S. (1986). "A theory and method of love." Journal of Personality and Social Psychology, 50, 2, 392-402. Reprinted with permission of the American Psychological Association.

LOVE ATTITUDE SCALE — SCORING INSTRUCTIONS

The higher the score, the stronger you are on this love style

Scoring:

Eros: Add up all the numbers you circled for items 1, 7, 13, 19, 25, 31, and 37.
Eros Score: _____

Ludus: Add up all the numbers you circled for items 2, 8, 14, 20, 26, 32, and 38.
Ludus Score: _____

Storge: Add up all the numbers you circled for items 3, 9, 15, 21, 27, 33, and 39.
Storge Score: _____

Pragma: Add up all the numbers you circled for items 4, 10, 16, 22, 28, 34, and 40.
Pragma Score: _____

Mania: Add up all the numbers you circled for items 5, 11, 17, 23, 29, 35, and 41.
Mania Score: _____

Agape: Add up all the numbers you circled for items 6, 12, 18, 24, 30, 36, and 42.
Agape Score: _____

CHAPTER 7.

ASSIGNMENT: LOVE STYLES

After studying Lee's Love Styles, answer the Love Styles questionnaire you see in this week's lessons. Compute your scores and then answer the following questions. (Post your answers and respond to at least one other person for full credit.)

- Do these scores surprise you? Why or why not?
- What would you consider the advantages and disadvantages of these styles to be?
- What styles do you think would be most common in adolescence? Early adulthood? Adulthood? Why?

CHAPTER 8.

STUDY GUIDE: ADOLESCENCE AND EARLY ADULTHOOD

ADOLESCENCE AND EMERGING ADULTHOOD

1. Define puberty. What kinds of changes occur during puberty?
2. What impacts the timing of puberty?
3. Describe the growth spurt.
4. Discuss changes in the teenage brain (review your notes over the film.)
5. Distinguish between primary and secondary sex characteristics and give examples of each.
6. What is spermarche? Menarche?
7. How do cultural ideals and timing impact adolescent body image?
8. Describe some nutritional concerns during adolescence.
9. What is anorexia? Bulimia?
10. What is the myth of mutuality? Who is most likely to suffer from sexual abuse?
11. Characterize teen drug use.
12. What is formal operational intelligence?
13. Define and give examples of adolescent egocentrism, the imaginary audience, the personal fable, and the invincibility fable.
14. How does Erikson characterize adolescence?
15. What is a psychosocial moratorium? What is foreclosure? Identity diffusion?
16. Contrast teens as offenders and as victims of crime.
17. Discuss teen suicide.
18. What do teens want from parents?
19. List the developmental tasks of early adulthood.
20. Explain how emerging adulthood is a health but risky time.
21. Explain Levinson's theory of adulthood.
22. What is postformal thought? What is dialectical thought? What factors promote this?
23. Characterize cohabitation and types of cohabitation.
24. What is the median age of first marriage?
25. Explain social exchange theory of mate selection.

26. What is the principle of least interest?
27. Explain Sternberg's dimensions of love.
28. List and describe Lee's love styles.
29. Characterize frames of relationships.
30. Explain the wheel theory of love.
31. What is the "process of disaffection"? What happens in each stage?

CHAPTER 9.

PRACTICE TEST: ADOLESCENCE AND EARLY ADULTHOOD

Exercises

1. Fourteen-year-old Monica is very idealistic and often develops crushes on people she doesn't even know. This reflects her newly developed cognitive ability to:
A) imagine possible worlds and people.
B) take another person's viewpoint.
C) deal simultaneously with two sides of an issue.
D) see herself as others see her.

2. The term menarche refers to:
A) first ovulation.
B) the growth of the uterus.
C) a girl's first menstrual period.
D) the start of estrogen production.

3. New research indicates changes in the teenage brain. What occurs?
A) There is a growth spurt in the prefrontal lobes of the brain.
B) The hippocampus shrinks substantially.
C) The circadian rhythm shifts making teens more alert in the morning.
D) The motor cortex doubles in size.

4. Which of the following is TRUE about puberty?
A) Only males experience lowered voices during puberty.
B) Both males and females may experience breast growth during puberty.
C) Teens typically gain about 20 pounds in weight during puberty.
D) Males have greater body image problems than do females.

5. Most teens in the United States have which problem with nutrition?
A) They have too much calcium in the diet.
B) They consume too many calories and inadequate nutrition.
C) They typically do not consume enough protein.
D) They have low sodium levels.

6. The substance that is most commonly used by youth in America today is:
A) Alcohol.
B) Vicodin.
C) Tobacco.
D) Marijuana.

7. Which of the following is TRUE of youth in the United States today?
A) Teen pregnancy rates are down.
B) Teen crime rates have increased sharply in the last 5 years.

C) Teen drop out rates are at an all time high.
D) Teens suicide rates have increased steadily since the 1970s.

8. Changes in secondary sex characteristics include ALL BUT WHICH ONE?
A) growth of the testes.
B) The development of pubic hair.
C) Breast development.
D) An accumulation of fat on the thighs and hips.

9. Which of the following is TRUE about puberty?
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13. Changes in secondary sex characteristics include ALL BUT WHICH ONE?
A) growth of the testes.
B) The development of pubic hair.
C) Breast development.
D) An accumulation of fat on the thighs and hips.

14. The invincibility fable refers to a teenager's
A) belief that the body is indestructible.
B) feeling that everyone is watching their behavior.
C) belief that they are destined to be famous.
D) feeling that others do not understand how the teen feels.

15. Which of the following is TRUE concerning teens?
A) Teens are often the victims of violence.
B) Most types of teen crime are higher today than ever before.
C) There are more runaway teens than thrownaway teens.
D) Teen pregnancy rates are at an all-time high in the United States.

16. Bob helped his sports team win the state championship and now he thinks he may someday be famous. This reflects:

A) the invincibility fable.
B) egocentrism.
C) the personal fable.
D) the imaginary audience.

17. This type of love is self-centered and manipulative.
A) agape.
B) storge.
C) ludus.
D) companionate.

18. If you believe the principle of least interest, you can maximize your power:
A) by showing your partner how much you need him or her.
B) by having plenty of other options for other relationships.
C) by doing things to gain your partner's interest in the relationship.
D) by being kind and loving.

19. Early adulthood is a time of:
A) peak physiological development.
B) thinking that you are destined to be famous.
C) worrying about what others think.
D) concrete operational thought.

20. This type of thought is associated with adulthood and education.
A) concrete operational thought.
B) dialectical thought.
C) preoperational thought.
D) existential thought.

Solutions to Exercises

1. A
2. C
3. A
4. B
5. B
6. D
7. A
8. A
9. B
10. B
11. D
12. A
13. A
14. A
15. A
16. C

17. C
18. B
19. A
20. B

PART II.

CHAPTER 2: MIDDLE ADULTHOOD

CHAPTER 10.

INTRODUCTION TO MIDDLE ADULTHOOD

Learning Objectives

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

1. Explain trends in life expectancy and healthy life expectancy.
2. List developmental tasks of midlife.
3. Summarize physical changes that occur in midlife.
4. Explain physical changes that occur during menopause.
5. Describe variations in cultural responses to menopause.
6. Contrast menopause and andropause.
7. Explain the relationships between the climacteric and sexual expression.
8. Discuss the impact of exercise on health in midlife.
9. Describe the ideal diet for middle aged adults.
10. Describe cognitive development in midlife.
11. Compare midlife students with younger students and their approach to learning.
12. Contrast the expert and the novice.
13. Evaluate the notion of the midlife crisis.
14. Define kinkeeping and the impact of caregiving.
15. Describe Erikson's stage of generativity vs. stagnation.
16. Compare types of singles.
17. Contrast intrinsic and utilitarian marriages.
18. Classify types of marriages based on Cuber and Harroff's model.
19. Discuss communication in marriage.
20. Describe the stations of divorce.
21. Discuss issues related to re-coupling including remarriage and cohabitation.
22. Describe personality changes in midlife.
23. Discuss work related issues in midlife.

INTRODUCTION

Middle adulthood (or midlife) refers to the period of the lifespan between young adulthood and old age. This period lasts from 20 to 40 years depending on how these stages, ages, and tasks are culturally defined. The most common age definition is from 40 to 65, but there can be a range of up to 10 years (ages 30-75) on either side of these numbers. The mid-thiries or the forties through the late 60s can be our guide. Research on this period of life is relatively new and many aspects of midlife are still being explored. This may be the least studied period of the lifespan. And this is a varied group. We can see considerable differences in individuals within this developmental stage. There is much to learn about this group. In the United States, the large Baby Boom cohort (those born between 1946 and 1964) are now midlife adults and this has led to increased interest in this developmental stage.

This is a relatively new period of life. One hundred years ago, life expectancy in the United States was about 47 years. Life-expectancy has increased globally by about 6 years since 1990 and now stands at 68 years and ranges from 57 years in low-income countries to 80 in high-income countries (World Health Organization, 2011). This number reflects an increase in life expectancy in Africa due to availability of antiretroviral medications to reduce HIV/AIDS, and a decrease in Europe and in countries in the former Soviet Union. Life expectancy in the United States for those born in 2007 is now at 75.9 for white males, 80.8 for white females, 70.0 for black males, and 76.8 for black females (U.S. National Center for Health Statistics, 2010). The U. S. ranks 42nd in the world and has been declining in rank. Children born in the U. S. today may be the first generation to have a shorter life span than their parents. Much of this decline has been attributed to the increase in sedentary lifestyle and obesity. See the Washington Post article, U.S. Deaths Rise by 50,000 in 2005, for more details.

Of course, longevity is not the only consideration. How long can we expect to lead health lives? Healthy life expectancy, or the years one can expect to live in good health, is 67 for males and 71 for females in the United States. It is higher in Japan with a healthy life expectancy of 72 for males and 78 for females. Certainly, living healthier lives is the goal. In the United States, Canada, and other countries where people live well in midlife, there are new concerns are about the aging process, the impact of lifestyle on health, productivity at work, and how to best spend the second half of life.

DEVELOPMENTAL TASKS

Lachman (2004) provides a comprehensive overview of the challenges facing midlife adults. These include:

1. Losing parents and experiencing associated grief.
2. Launching children into their own lives.
3. Adjusting to home life without children (often referred to as the empty nest).
4. Dealing with adult children who return to live at home (known as boomerang children in the United States).
5. Becoming grandparents.
6. Preparing for late adulthood.
7. Acting as caregivers for aging parents or spouses.

Let's explore these tasks and this stage of life.

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CHAPTER 11.

PHYSICAL DEVELOPMENT

There are few biologically based physical changes in midlife other than changes in vision, more joint pain, and weight gain (Lachman, 2004). Vision is affected by age. As we age, the lens of the eye gets larger but the eye loses some of the flexibility required to adjust to visual stimuli. Middle aged adults often have trouble seeing up close as a result. Night vision is also affected as the pupil loses some of its ability to open and close to accommodate drastic changes in light. Autoimmune disease such as rheumatoid arthritis often starts in the 50s. Weight gain, sometimes referred to as the middle-aged spread, or the accumulation of fat in the abdomen is one of the common complaints of midlife adults. Men tend to gain fat on their upper abdomen and back while women tend to gain more fat on their waist and upper arms. Many adults are surprised at this weight gain because their diets have not changed. However, the metabolism slows during midlife by about one-third (Berger, 2005). Consequently, midlife adults have to increase their level of exercise, eat less, and watch their nutrition to maintain their earlier physique.

Hearing loss is experienced by about 14 percent of midlife adults (Gratton & Vasquez in Berk, 2007) as a result of being exposed to high levels of noise. Men may experience some hearing loss by 30 and women by 50. High frequency sounds are the first affected by such hearing loss. This loss accumulates after years of being exposed to intense noise levels. Men are more likely to work in noisy occupations. Hearing loss is also exacerbated by cigarette smoking, high blood pressure, and stroke. Most hearing loss could be prevented by guarding against being exposed to extremely noisy environments. (There is new concern over hearing loss in early adulthood with the widespread use of headphones for IPods and other similar devices.)

Most of the changes that occur in midlife can be easily compensated for (by buying glasses, exercising, and watching what one eats, for example.) And most midlife adults experience general good health. However, the percentage of adults who have a disability increases through midlife; while 7 percent of people in their early 40s have a disability, the rate jumps to 30 percent by the early 60s. This increase is highest among those of lower socioeconomic status (Bumpass and Aquilino, 1995).

What can we conclude from this information? Again, lifestyle has a strong impact on the health status of midlife adults. Smoking tobacco, drinking alcohol, poor diet, stress, physical inactivity, and chronic disease such as diabetes or arthritis reduce overall health. It becomes important for midlife adults to take preventative measures to enhance physical well-being. Those midlife adults who have a strong sense of mastery and control over their lives, who engage in challenging physical and mental

activity, who engage in weight bearing exercise, monitor their nutrition, and make use of social resources are most likely to enjoy a plateau of good health through these years (Lachman, 2004).

THE CLIMACTERIC

One biologically based change that occurs during midlife is the climacteric. During midlife, men may experience a reduction in their ability to reproduce. Women, however, lose their ability to reproduce once they reach menopause.

Menopause for women: Menopause refers to a period of transition in which a woman's ovaries stop releasing eggs and the level of estrogen and progesterone production decreases. After menopause, a woman's menstruation ceases (U. S. National Library of Medicine and National Institute of Health [NLM/NIH], 2007).

Changes typically occur between the mid 40s and mid 50s. The median age range for a women to have her last menstrual period is 50-52, but ages vary. A woman may first begin to notice that her periods are more or less frequent than before. These changes in menstruation may last from 1 to 3 years. After a year without menstruation, a woman is considered menopausal and no longer capable of reproduction. (Keep in mind that some women, however, may experience another period even after going for a year without one.) The loss of estrogen also affects vaginal lubrication which diminishes and becomes more watery. The vaginal wall also becomes thinner, and less elastic.

Menopause is not seen as universally distressing (Lachman, 2004). Changes in hormone levels are associated with hot flashes and sweats in some women, but women vary in the extent to which these are experienced. Depression, irritability, and weight gain are not menopausal (Avis, 1999; Rossi, 2004). Depression and mood swings are more common during menopause in women who have prior histories of these conditions rather than those who have not. And the incidence of depression and mood swings is not greater among menopausal women than non-menopausal women.

Cultural influences seem to also play a role in the way menopause is experienced. Numerous international students enrolled in my class have expressed their disbelief when we discuss menopause. For example, after listing the symptoms of menopause, a woman from Kenya or Nigeria might respond, "We do not have this in my country or if we do, it is not a big deal" to which some U. S. students reply, "I want to go there!" Indeed, there are cultural variations in the experience of menopausal symptoms. Hot flashes are experienced by 75 percent of women in Western cultures, but by less than 20 percent of women in Japan (Obermeyer in Berk, 2007).

Women in the United States respond differently to menopause depending upon the expectations they have for themselves and their lives. White, career-oriented women, African-American, and Mexican-American women overall tend to think of menopause as a liberating experience. Nevertheless, there has been a popular tendency to erroneously attribute frustrations and irritations expressed by women of menopausal age to menopause and thereby not take her concerns seriously. Fortunately, many practitioners in the United States today are normalizing rather than pathologizing menopause.

Concerns about the effects of hormone replacement has changed the frequency with which estrogen replacement and hormone replacement therapies have been prescribed for menopausal women. Estrogen replacement therapy was once commonly used to treat menopausal symptoms. But more recently, hormone replacement therapy has been associated with breast cancer, stroke, and the development of blood clots (NLM/NIH, 2007). Most women do not have symptoms severe enough to warrant estrogen or hormone replacement therapy. But if so, they can be treated with lower doses

of estrogen and monitored with more frequent breast and pelvic exams. There are also some other ways to reduce symptoms. These include avoiding caffeine and alcohol, eating soy, remaining sexually active, practicing relaxation techniques, and using water-based lubricants during intercourse.

Andropause for men: Do males experience a climacteric? They do not lose their ability to reproduce as they age, although they do tend to produce lower levels of testosterone and fewer sperm. However, men are capable of reproduction throughout life. It is natural for sex drive to diminish slightly as men age, but a lack of sex drive may be a result of extremely low levels of testosterone. About 5 million men experience low levels of testosterone that results in symptoms such as: a loss of interest in sex, loss of body hair, difficulty achieving or maintaining erection, loss of muscle mass, and breast enlargement. Low testosterone levels may be due to glandular disease such as testicular cancer. Testosterone levels can be tested and if they are low, men can be treated with testosterone replacement therapy. This can increase sex drive, muscle mass, and beard growth. However, long term HRT for men can increase the risk of prostate cancer (The Patient Education Institute, 2005).

THE CLIMACTERIC AND SEXUALITY

Sexuality is an important part of people's lives at any age. Midlife adults tend to have sex lives that are very similar to that of younger adulthood. And many women feel freer and less inhibited sexually as they age. However, a woman may notice less vaginal lubrication during arousal and men may experience changes in their erections from time to time. This is particularly true for men after age 65. As discussed in the previous paragraph, men who experience consistent problems are likely to have medical conditions (such as diabetes or heart disease) that impact sexual functioning (National Institute on Aging, 2005).

Couples continue to enjoy physical intimacy and may engage in more foreplay, oral sex, and other forms of sexual expression rather than focusing as much on sexual intercourse. Risk of pregnancy continues until a woman has been without menstruation for at least 12 months, however, and couples should continue to use contraception. People continue to be at risk of contracting sexually transmitted infections such as genital herpes, chlamydia, and genital warts. And 10 percent of new cases of AIDS in the United States are of people 50 and older. Practicing safe sex is important at any age. Hopefully, when partners understand how aging affects sexual expression, they will be less likely to misinterpret these changes as a lack of sexual interest or displeasure in the partner and more able to continue to have satisfying and safe sexual relationships.

EXERCISE, NUTRITION, AND HEALTH

The impact of exercise: Exercise is a powerful way to combat the changes we associate with aging. Exercise builds muscle, increases metabolism, helps control blood sugar, increases bone density, and relieves stress. Unfortunately, fewer than half of midlife adults exercise and only about 20 percent exercise frequently and strenuously enough to achieve health benefits. Many stop exercising soon after they begin an exercise program-particularly those who are very overweight. The best exercise programs are those that are engaged in regularly-regardless of the activity. But a well-rounded program that is easy to follow includes walking and weight training. Having a safe, enjoyable place to walk can make the difference in whether or not someone walks regularly. Weight lifting and stretching exercises at home can also be part of an effective program. Exercise is particularly helpful in reducing stress in midlife. Walking, jogging, cycling, or swimming can release the tension caused

by stressors. And learning relaxation techniques can have healthful benefits. Exercise can be thought of as preventative health care; promoting exercise for the 78 million "baby boomers" may be one of the best ways to reduce health care costs and improve quality of life (Shure & Cahan, 1998).

Nutritional concerns: Aging brings about a reduction in the number of calories a person requires. Many Americans respond to weight gain by dieting. However, eating less does not typically mean eating right and people often suffer vitamin and mineral deficiencies as a result. Very often, physicians will recommend vitamin supplements to their middle aged patients.

The new food pyramid: The ideal diet is one low in fat, sugar, high in fiber, low in sodium, and cholesterol. In 2005, the Food Pyramid, a set of nutritional guidelines established by the U. S. Government was updated to accommodate new information on nutrition and to provide people with guidelines based on age, sex, and activity levels.

The ideal diet is also one low in sodium (less than 2300 mg per day). Sodium causes fluid retention which may in turn exacerbate high blood pressure. The ideal diet is also low in cholesterol (less than 300 mg per day). The ideal diet is also one high in fiber. Fiber is thought to reduce the risk of certain cancers and heart disease. Finally, an ideal diet is low in sugar. Sugar is not only a problem for diabetics; it is also a problem for most people. Sugar satisfies the appetite but provides no protein, vitamins or minerals. It provides empty calories. High starch diets are also a problem because starch is converted to sugar in the body. A 1-2 ounce serving of red wine (or grape juice) can have beneficial effects as well. Red wine can increase "good cholesterol" or HDLs (high density lipoproteins) in the blood and provides antioxidants important to combating aging.

Image Credit

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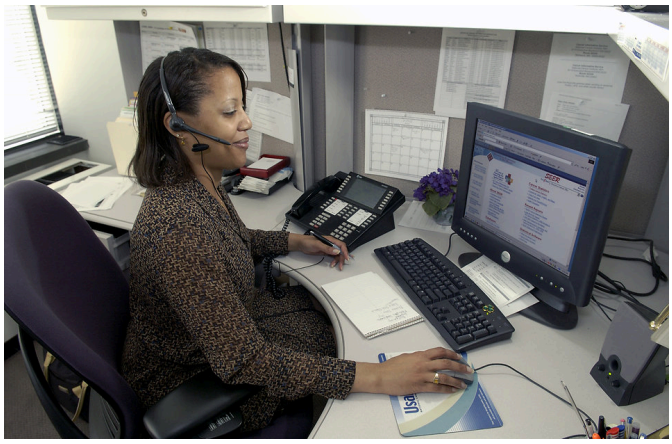
CHAPTER 12.

COGNITIVE DEVELOPMENT

PLASTICITY OF INTELLIGENCE



Prior research on cognition and aging has been focused on comparing young and old adults and assuming that midlife adults fall somewhere in between. But some abilities may decrease while others improve during midlife. The concept of plasticity means that intelligence can be shaped by experience. Intelligence is influenced by culture, social contexts, and personal choices as much as by heredity and age. In fact, there is new evidence that mental exercise or training can have lasting benefits (National Institutes of Health, 2007). We explore aspects of midlife intelligence below.

FORMAL OPERATIONAL AND POST-FORMAL INTELLIGENCE

Remember formal operational thought? Formal operational thought involves being able to think abstractly; however, this ability does not apply to all situations or subjects. Formal operational thought is influenced by experience and education. Some adults lead patterned, orderly, lives in which they are not challenged to think abstractly about their world. Many adults do not receive any formal education and are not taught to think abstractly about situations they have never experienced. Nor are they exposed to conceptual tools used to formally analyze hypothetical situations. Those who do think abstractly, in fact, may be able to do so more easily in some subjects than others. For example, English majors may be able to think abstractly about literature, but be unable to use abstract reasoning in physics or chemistry. Abstract reasoning in a particular field requires a knowledge base that we might not have in all areas. So our ability to think abstractly depends to a large extent on our experiences.

Post-formal thought continues: As discussed previously, adults tend to think in more practical terms than do adolescents. Although they may be able to use abstract reasoning when they approach a situation and consider possibilities, they are more likely to think practically about what is likely to occur.

INCREASES AND DECREASES

Tacit knowledge (Hedlund, Antonakis, and Sternberg, 2001) increases with age. Tacit knowledge is pragmatic or practical and learned through experience rather than explicitly taught. It might be

thought of as "know-how" or "professional instinct." It is referred to as tacit because it cannot be codified or written down. It does not involve academic knowledge, rather it involves being able to use skills and to problem-solve in practical ways. Tacit knowledge can be understood in the workplace and by blue collar workers such as carpenters, chefs, and hair dressers. These occupations and cognitive skills are the subject of the book, *The Mind at Work, by Mike Rose*. Read an interview with Rose HERE.

Verbal memory, spatial skills, inductive reasoning (generalizing from particular examples), and vocabulary increase with age as well (Willis and Shaie, 1999). You may have heard that wisdom comes with age. However, wisdom may be more of a function of personality than cognition. Those who exhibit wisdom in midlife, may have made wiser choices at younger ages as well.

The mechanics of cognition such as working memory and speed of processing gradually decline with age but can be easily compensated for through the use of higher order cognitive skills such as forming strategies to enhance memory or summarizing and comparing ideas rather than relying on rote memorization (Lachman, 2004). Further, the declines mentioned above may diminish as new generations, equipped with higher levels of education, begin to enter midlife.

LEARNING IN OLDER ADULTS

Midlife adults in the United States often find themselves in classrooms. Whether they enroll in school to sharpen particular skills, to retool and reenter the workplace, or to pursue interests that have previously been neglected, these students tend to approach learning differently than do younger college students (Knowles, Horton, & Swanson, 1998).

An 18 year-old college student may focus more on rote memorization in studying for tests. They may be able to memorize information more quickly than an older student, but not have as thorough a grasp on the meaning of that information. Older students may take a bit longer to learn material, but are less likely to forget it quickly. Adult learners tend to look for relevance and meaning when learning information. Older adults have the hardest time learning material that is meaningless or unfamiliar. They are more likely to ask themselves, "What does this mean?" or "Why is this important?" when being introduced to information or when trying to concepts or facts. Older adults are more task-oriented learners and want to organize their activity around problem-solving. They see the instructor as a resource person rather than the "expert" and appreciate having their life experience recognized and incorporated into the material being covered.

This type of learning is more easily accomplished if adequate time is allowed for mastering the material. Keeping distractions at a minimum and studying when rested and energetic enhances adult learning. **Androgogy** is a type of teaching that considers the needs of adults (versus pedagogy which was originally geared toward teaching children).

GAINING EXPERTISE: THE NOVICE AND THE EXPERT

When we work extensively in an area, we may gain expertise. Some areas of expertise develop after about 10 years of working in a field. Some gain expertise after a shorter period of time. Consider the study skills of a seasoned student versus a new student or a new nurse versus an experienced nurse. One of the major differences is that the new one operates as a novice while the seasoned student or nurse performs more like an expert. An expert has a different approach to learning and problem-solving than does a novice or someone new to a field. While a novice tends to rely on formal procedures or guidelines, the expert relies more on intuition and is more flexible in solving

problems. a novice's performance tends to be more conscious and methodical than an experts. An expert tends to perform actions in a more automatic fashion. An expert cook, for example, may be able to prepare a difficult recipe but not really describe how they did it. The novice cook might rigidly adhere to the recipe, hanging on every word and measurement. The expert also has better strategies for tackling problems than does a novice.

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CHAPTER 13.

PSYCHOSOCIAL DEVELOPMENT

MIDLIFE CRISIS?

Remember Levinson's theory from our last lesson? Levinson found that the men he interviewed sometimes had difficulty reconciling the "dream" they held about the future with the reality they now experience. "What do I really get from and give to my wife, children, friends, work, community-and self?" a man might ask (Levinson, 1978, p. 192). Tasks of the midlife transition include **1) ending early adulthood; 2) reassessing life in the present and making modifications if needed; and 3) reconciling "polarities" or contradictions in ones sense of self**. Perhaps, early adulthood ends when a person no longer seeks adult status-but feels like a full adult in the eyes of others. This 'permission' may lead to different choices in life; choices that are made for self-fulfillment instead of social acceptance. While people in their early 20s may emphasize how old they are (to gain respect, to be viewed as experienced), by the time people reach their 40s, they tend to emphasize how young they are. (Few 40 year olds cut each other down for being so young: "You're only 43? I'm 48!!")

This new perspective on time brings about a new sense of urgency to life. The person becomes focused more on the present than the future or the past. The person grows impatient at being in the "waiting room of life" postponing doing the things they have always wanted to do. Now is the time. If it's ever going to happen, it better happen now. A previous focus on the future gives way to an emphasis on the present. Neugarten (1968) notes that in midlife, people no longer think of their lives in terms of how long they have lived. Rather, life is thought of in terms of how many years are left. If an adult is not satisfied at midlife, there is a new sense of urgency to start to make changes now.

Changes may involve ending a relationship or modifying one's expectations of a partner. These modifications are easier than changing the self (Levinson, 1978). Midlife is a period of transition in which one holds earlier images of the self while forming new ideas about the self of the future. A greater awareness of aging accompanies feelings of youth. And harm that may have been done previously in relationships haunts new dreams of contributing to the well-being of others. These polarities are the quieter struggles that continue after outward signs of "crisis" have gone away.

Levinson characterized midlife as a time of developmental crisis. However, research suggests that most people in the United States today do not experience a midlife crisis and that, in fact, many women find midlife a freeing, satisfying period. Results of a 10 year study conducted by the MacArthur Foundation Research Network on Successful Midlife Development, based on telephone interviews with over 3,000 midlife adults suggest that the years between 40 and 60 are ones marked by a sense of well-being. Only 23 percent of their participants reported experiencing a midlife crisis. The crisis tended to occur among the highly educated and was triggered by a major life event rather than out of a fear of aging (Research Network on Successful Midlife Development, accessed 2007). Maybe only the more affluent and educated have the luxury (or burden) of such self-examination. Nevertheless, sales of products designed to make one feel younger and "over the hill" birthday parties with black balloons and banners abound.

GOAL-FREE LIVING

One of the reasons the men in Levinson's study became concerned about their life was because it had not followed the course they had envisioned. Shapiro (2006) offers an alternative to linear thinking about the future and career paths. Many plan their futures by using a map. They have a sense of where they are and where they want to be and form strategies to get from point A to point B. While this seems perfectly logical, Shapiro suggests that following a map closes one to opportunities for the future and provides a standard by which all actual events may fall short. Life, then, is evaluated by how closely actual life events have followed the map. If so, all is well. If not, a feeling of frustration and failure creeps in. Shapiro suggests using a compass rather than a map as one's guide. A compass indicates a direction, but does not provide a destination. So, a person who lives "goal free" has direction and areas of interest that guide decision-making, but does not know the outcome. (Many of us do not know the outcome-even when we follow a map!) This approach opens a person up to possibilities that often occur by chance and frees one from being stressed or devastated if a preset destination is not reached by a certain time. And more importantly, goal-free (or compass-guided living) focuses a person's attention on the process of the journey and helps them appreciate all of their experiences along the way. What do you think? How many of your plans were mapped out previously? Could you be happy knowing that you do not know where you will be 5 years from now?

A clear sense of self, identity, and control can be important for meeting the challenges of midlife (Lachman and Firth, 2004). Consider this story of overcoming gender identity at midlife.

Finding Identity at Midlife: The Story of Erika

The late 40s brought about dramatic change in Erika's life. Erika is a transsexual who began the process of transitioning from male to female at about age 48. Since about age 8, Erika (then Richard) felt that he was more feminine than masculine. An impromptu game of "dress up" with a girl who lived in the neighborhood left Richard feeling a sense of connection and 'rightness' he had not before experienced. Through the years, dressing up and wearing make-up provided comfort and relief as well as the anxiety of possibly being discovered. Richard married and pursued a career in the military and later as a geologist, two very masculine careers, but all the while felt out of place in a masculine world.

Through the years, discomfort gave rise to depression and thoughts of suicide. "I felt like some sick, weird person." Not knowing what was wrong and not having anyone to talk to was very difficult. Erika finally found out what was wrong after searching the internet. First, she looked up "transvestite". "Is that what I am?" she wondered. But these descriptions did not apply. Finally, she learned about gender identity disorder, marked by a feeling of discomfort and disconnection between one's sense of self and biological gender. Eventually, Richard got the courage to tell his wife. Her response was, "you're killing my husband", to which he replied, "He would have died anyway." The couple separated after 24 years of marriage. After several months, however, the couple got back together. "We were just too good of friends to break up." But her wife did not want to see it, initially. "I would get dressed in the garage or dress like a man from the waist up and then stop behind a grocery store and finish changing before I got to my destination."

Erika found a psychologist in the phone book and began treatment under the Harry Benjamin standard of care. This care requires that an individual be identified as transsexual by two psychologists, and lives completely as a member of the other sex for one year before beginning surgical and hormonal treatments. Erika's surgery cost about $30,000. Hormone therapy and electrolysis cost far more.

Now in their 30th year together, Erika and wife they live under the same roof, but no longer share a

bedroom. Erika now has full status through the state and government as a female. And her wife, is a warm, accepting, roommate. "The day that she yelled from her bedroom, 'do you have any pantyhose' was an important one." And seeing her lipstick on the rim of a wine glass created a feeling of congruence for Erika. Erika could now be Erika.

ERIKSON'S THEORY

According to Erikson, midlife adults face the crisis of generativity vs. stagnation. This involves looking at one's life while asking the question, "Am I doing anything worthwhile? Is anyone going to know that I was here? What am I contributing to others?" If not, a feeling of being stuck or stagnated may result. This discomfort can motivate a person to redirect energies into more meaningful activities. It is important to make revisions here so that in later life, one may feel a sense of pride and accomplishment and feel content with the choices that have been made.

PRODUCTIVITY AT HOME

Family relationships

Younger and older adults tend to experience more spouse-related stress than do midlife adults. Midlife adults often have overload stressors such as having too many demands placed on them by children or due to financial concerns. Parents adjust to launching their children into lives of their own during this time. Some parents who feel uncomfortable about their children leaving home may actually precipitate a crisis to keep it from happening or push their child out too soon (Anderson and Sabatelli, 2007). But even welcomed and anticipated departure can still require adjustment on the part of the parents as they get used to their empty nest.

Adult children typically maintain frequent contact with their parents if for no other reason, for money and advice. Attitudes toward one's parents may become more accepting and forgiving as parents are seen in a more objective way-as people with good points and bad. And, as adults, children can continue to be subjected to criticism, ridicule, and abuse at the hand of parents. How long are we "adult children"? For as long as our parents are living, we continue in the role of son or daughter. (I had a neighbor in her nineties who would tell me her "boys" were coming to see her this weekend. Her boys were in their 70s-but they were still her boys!) But after ones parents are gone, the adult is no longer a child; as one 40 year old man explained after the death of his father, "I'll never be a kid again." And adult children, known as boomerang kids, may return home to live temporarily after divorces or if they lose employment.

Being a midlife child sometimes involves **kinkeeping**; organizing events and communication in order to maintain family ties. Kinkeepers are often midlife daughters (they are the person who tells you what food to bring to a gathering or makes arrangement for a family reunion), but kinkeepers can be midlife sons as well.

Caregiving of a disabled child, spouse, or other family member is part of the lives of some midlife adults. Overall, one major source of stress is that of trying to balance caregiving with meeting the demands of work away from home. Caregiving can have both positive and negative consequences that depend in part on the gender of the caregiver and the person receiving the care. Men and women

express greater distress when caring for a spouse than when caring for other family members. Men who care are providing care for a spouse are more likely to experience greater hostility but also more personal growth than non-caregiving males. Men who are caring for disabled children express having more positive relationships with others. Women experience more positive relationships with others and greater purpose in life when caring for parents either in or outside of their home. But women who are caring for disabled children may experience poorer health and greater distress as a result (Marks, 1998).

CHAPTER 14.

RELATIONSHIPS

INTIMATE RELATIONSHIPS

Single or Spouse-free? The number of adults who remain single has increased dramatically in the last 30 years. We have more people who never marry, more widows and more divorcees driving up the number of singles. Singles represent about 25 percent of American households. Singlehood has become a more acceptable lifestyle than it was in the past and many singles are very happy with their status. Whether or not a single person is happy depends on the circumstances of their remaining single.

STEIN'S TYPOLOGY OF SINGLES

Many of the research findings about singles reveal that they are not all alike. Happiness with one's status depends on whether the person is single by choice and whether the situation is permanent. Let's look at Stein's (1981) four categories of singles for a better understanding of this.

Voluntary temporary singles: These are younger people who have never been married and divorced people who are postponing marriage and remarriage. They may be more involved in careers or getting an education or just wanting to have fun without making a commitment to any one person. They are not quite ready for that kind of relationship. These people tend to report being very happy with their single status.

Voluntary permanent singles: These individuals do not want to marry and aren't intending to marry. This might include cohabiting couples who don't want to marry, priests, nuns, or others who are not considering marriage. Again, this group is typically single by choice and understandably more contented with this decision.

Involuntary temporary: These are people who are actively seeking mates. They hope to marry or remarry and may be involved in going on blind dates, seeking a partner on the internet or placing "getting personal" aids in search of a mate. They tend to be more anxious about being single.

Involuntary permanent: These are older divorced, widowed, or never-married people who wanted to marry but have not found a mate and are coming to accept singlehood as a probable permanent situation. Some are bitter about not having married while others are more accepting of how their life has developed.

Marriage: It has been said that marriage can be the greatest source of happiness or pain in one's life,

depending on the relationship. Those who are in marriages can experience deeper happiness and pain than those who are unattached. All marriages are not alike and the same marriage between two people may change through the years. Below we will look at how satisfaction with marriage is affected by the life cycle and two ways to characterizing marriages.

Marital satisfaction & the life cycle: Marital satisfaction has peaks and valleys during the course of the life cycle. Rates of happiness are highest in the years prior to the birth of the first child. It hits a low point with the coming of children. Relationships become more traditional and there are more financial hardships and stress in living. Then it begins to improve when children leave home. Children bring new expectations to the marital relationship. Two people, who are comfortable with their roles as partners, may find the added parental duties and expectations more challenging to meet. Some couples elect not to have children in order to have more time and resources for the marriage. These child-free couples are happy keeping their time and attention on their partners, careers, and interests.

TYPES OF MARRIAGES

Intrinsic and Utilitarian Marriages: One way marriages vary is with regard to the reason the partners are married. Some marriages have intrinsic value: the partners are together because they enjoy, love and value one another. Marriage is not thought of as a means to another end-is an end in itself. These partners look for someone they are drawn to and with whom they feel a close and intense relationship. These partners find the relationship personally rewarding. Other marriages called utilitarian marriages are unions entered primarily for practical reasons. The partners see one another as a means to an end. The marriage brings financial security, children, social approval, housekeeping, political favor, a good car, a great house, and so on. These partners do not focus on intimacy. These marriages may be chosen more out of default. ("She was there when it was time to get married so here we are.") Marriages entered for practical reasons are more common throughout history and throughout the world.

Intrinsic marriages are a relatively recent phenomenon arising out of the 20th century focus on romantic love as a basis for marriage and increased independence of the partners. Marriage today is viewed as less necessary for economic survival. In general, utilitarian marriages tend to be more stable than intrinsic ones. In an intrinsic marriage, if the love or passion cools, there is nothing else to keep the partners together. In utilitarian marriages, there may be numerous ties to one another (children, property, and status). However, intrinsic marriages may be more romantically satisfying. Are most marriages intrinsic or utilitarian?

In reality, marriages fall somewhere in between these two extremes. Now let's look at another typology of marriage. As you read these types, think of whether these are more utilitarian or more intrinsic.

CUBER AND HARROFF

This classic typology of marriages is based on interviews with 437 highly educated, upper-middle class people, and ages 35 to 55 (Cuber & Haroff, 1965). All were financially successful and emotionally adjusted. From their interviews, the researchers found five major types of marriages. Some of these are more intrinsic and some more utilitarian. (One of the merits of this model is that it calls attention to the variation we find in marriages.)

1) **Conflict-habituated marriages**: In these marriages, there is considerable tension and

unresolved conflict. Spouses habitually quarrel, nag, and bring up the past. As a rule, both spouses acknowledge their incompatibility and recognize the atmosphere of tension as normal. The subject of the argument hardly seems important, and partners do not resolve or expect to resolve their differences. 'Of course we don't settle any of the issues. It's sort of a matter of principle not to. Because somebody would have to give in and lose face for the next encounter', explained a member of a 25 year long conflict-habituated marriage. The conflict between them is "controlled" meaning it doesn't escalate. And it may be main way the partners interact with one another.

2) **Devitalized relationships**: These marriages are characterized as being empty, apathetic relationships which once had something more. Usually couples have been married several years, and over the course of time, the relationship has lost it's zest, intimacy, and meaning. Once deeply in love, they recall spending a great deal of time enjoying sex, and having a close emotional relationship in the past. But now they spend little time together, enjoy sex together less, and no longer share many interests and activities. Most of their time is "duty time" together spent entertaining, planning and sharing activities with their children, and participating in community responsibilities and functions. Once their marriage was intrinsic, but now has become utilitarian.

Cuber and Haroff found these to be common among their respondents. Couples accepted this and tried to be "mature" about it. Some attributed it to being in middle-age; as a normal part of growing older. Others were resentful, bitter about it and others were ambivalent. Many felt it was appropriate for spouses who have been married for several years and these marriages were stable.

3) **Passive-congenial**: These utilitarian marriages emphasize qualities in the partners rather than emotional closeness. These upper-middle class couples tended to emphasize civic and professional responsibilities and the importance of property, children, and reputation. Among working class people the focus might be on the need for security or hopes for children. Unlike devitalized marriages, passive-congenial partners never expected the marriage to be emotionally intense. Instead, they stress the "sensibility" of their decision to marry. There is little conflict, but that does not mean there are no unspoken frustrations. There is little intimacy but the partner's fail each other's need for casual companionship. Passive-congenial marriages are less likely to end in divorce than unions in which partners have high expectations for emotional intensity. But if the marriage fails to fill practical needs, such as economic support or professional advancement, the partners may decide to divorce. Or, if one partner discovers they want more intimacy, they may leave.

4) **Vital**: These intrinsic marriages are created out of a desire for being together for the sake of enjoying one another. Vital partners retain their separate identities, but really enjoy sharing activities. They do have conflict, but it is likely to center on real issues rather than on "who said what first" or old grievances. They try to settle disagreements quickly so they can resume the relationship that means so much to them. There are few long-term areas of tension. Sex is important and pleasurable. Cuber and Haroff found these marriages to be in the minority.

5) **Total marriage**: These are also intrinsic. They are like vital marriages but the marriage encompasses even more areas of the partner's lives. Spouses may share work life, friends and leisure activities, as well as home life. They may organize their lives to make it possible to be alone together for long periods. These relationships are emotionally intense. Total marriages were also rare. They may also be at risk for rapid disintegration if the marital quality changes. These partners tend to want such intensity and be dissatisfied with anything less. These marriages also

foster a mutual dependency that makes it hard for the remaining partner to adjust in case of death or divorce.

MARITAL COMMUNICATION

Advice on how to improve one's marriage is centuries old. One of today's experts on marital communication is John Gottman. Gottman (1999) differs from many marriage counselors in his belief that having a good marriage does not depend on compatibility. Rather, the way that partners communicate to one another is crucial. At the University of Washington in Seattle, Gottman has measures the physiological responses of thousands of couples as they discuss issues of disagreement. Fidgeting in one's chair, leaning closer to or further away from the partner while speaking, increases in respiration and heart rate are all recorded and analyzed along with videotaped recordings of the partners' exchanges. Gottman believes he can accurately predict whether or not a couple will stay together by analyzing their communication. In marriages destined to fail, partners engage in the "marriage killers": contempt, criticism, defensiveness, and stonewalling. Each of these undermines the politeness and respect that healthy marriages require. And stonewalling, or shutting someone out, is the strongest sign that a relationship is destined to fail. Listen to *Act One: What Really Happens in Marriage* to hear Gottman talk about his work.

DIVORCE

We have examined divorce from the standpoint of its impact on children. And, in our last lesson, we looked at the "process of disaffection." One way to understand divorce is to look at the types of divorces people experience when a relationship ends. Bohannon (1971) describes six "stations of divorce". The first is the emotional divorce. This involves a lot of mini-divorces in which partners make alienating remarks to one another. Partners become disengaged from one another and emotionally withdrawn. Some couples divorce emotionally, but never legally.

The **economic divorce** involves the division of property and debt, determining whether alimony will be paid, and determining if a spouse who provided support while their partner was in school or other lengthy training that increased their earning potential will be entitled to future earnings. Sometimes custody battles are motivated by economic concerns.

The **legal divorce** involves court proceedings and negotiations that legally dissolve the partners' marital ties to one another. This is when society views a couple as divorced and may be a process that is somewhat anticlimactic. The actual time spent in the courtroom may be brief and the final culmination of much of what has occurred in the other stations of divorce.

The **coparental divorce** is experienced by those couples who have children together. Determining custody and visitation are part of this station of divorce. This can be the most difficult station of divorce.

The **community divorce** is perhaps given the least attention when thinking of divorce. This involves severing ties with neighbors, coworkers, friends, and relatives following divorce. When family and friends choose sides in a break-up, relationships are lost. Divorced adults may find that they are no longer included in events and ties are no longer maintained. A person begins to get used to their single status. This may initially involve a sense of anxiety about the future.

The **psychic divorce** takes the longest to complete. This involves grieving, becoming more objective about one's role in the break up, and feeling whole again as a single person. This transition

may take 5 years or more. Many people never complete this because they remarry before getting to this point.

REMARRIAGE

Rates of remarriage: Half of all marriages are remarriages for at least one partner. But remarriage rates have declined slightly in the past few years. Cohabitation is the main way couples prepare for remarriage, but even when living together, many important issues are still not discussed. Issues concerning money, ex-spouses, children, visitation, future plans, previous difficulties in marriage, etc. can all pose problems later in the relationship. And few couples engage in premarital counseling or other structured efforts to cover this ground before entering marriage again.

Happiness in remarriage: Reviews are mixed as to how happy remarriages are. Some say that they have found the right partner and have learned from mistakes. But the divorce rates for remarriages are higher than for first marriages. This is especially true in stepfamilies for reasons which we have already discussed. People who have remarried tend to divorce more quickly than do first marriages. This may be due to the fact that they have fewer constraints on staying married (are more financially or psychologically independent).

Factors effecting remarriage: The chances of remarrying depend on a number of things. First, it depends on the availability of partners. As time goes by, there are more available women than men in the marriage pool. Consequently, men are more likely than women to remarry. This lack of available partners is experienced by all women, but especially by African-American women where the ratio of women to men is quite high. Women are more likely to have children living with them, and this diminishes the chance of remarriage as well. And marriage is more attractive for males than females (Seccombe & Warner, 2004). Men tend to remarry sooner (3 years after divorce on average vs. 5 years on average for women).

Many women do not remarry because they do not want to remarry. Traditionally, marriage has provided more benefits to men than to women. Women typically have to make more adjustments in work (accommodating work life to meet family demands or the approval of the husband) and at home (taking more responsibility for household duties). Further, men's physical desirability is not as influenced by aging as is women's. The cultural emphasis on youth and physical beauty for women does not apply for men.

Education increases men's likelihood of remarrying but may reduce the likelihood for women. Part of this is due to the expectation (almost an unspoken rule) referred to as the "marriage gradient". This rule suggests among couples, the man is supposed to have more education than the woman. Today, there are more women with higher levels of education than before and women with higher levels are less likely to find partners matching this expectation. Being happily single requires being economically self-sufficient and being psychologically independent. Women in this situation may find remarriage much less attractive.

HOW DO CHILDREN INFLUENCE RECOUPLING/REPARTNERING?

Children lower the probability of remarriage, especially for women. One of the reasons for this is because women with children have less time and fewer resources for dating. Dating is difficult for a woman who has to find a babysitter, pay for a babysitter, and 'come home on time' if she is concerned about what her children think about her relationships. There is more guilt experienced about going out and finding the time and location for sexual intimacy can be problematic. Men may shy away

from the responsibility of children or may find it difficult to get along with a girlfriend's children. And parents may find it difficult to date someone who wants to change the relationship they have with their children. Sometimes, she may feel pulled in two directions as the children and the man in her life all seek attention and engage in power struggles to get it. Some women decide that it is easier to be single than to experience such divisions. (This can also be true for men whose dates try to establish their importance over the importance of the children.) Children usually remain central to a single parent's life.

COURTSHIP IN REMARRIAGE

Courtships are shorter in remarriage than in first marriages. When couples are "dating", there is less going out and more time spent in activities at home or with the children. So the couple gets less time together to focus on their relationship. Anxiety or memories of past relationships can get in the way. As one Talmudic scholar suggests "when a divorced man marries a divorced woman, four go to bed." (Secombe & Warner, 2004).

Remarried couples tend to have more realistic expectations for marriage, but also tend to be less willing to stay in unhappy situations. And re-divorce is more likely, especially when children are involved.

Image Credit

- smiling couple. **Authored by**: Bill Branson. **Located at**: http://www.freestockphotos.biz/stockphoto/17066. **License**: *Public Domain: No Known Copyright*

CHAPTER 15.

WORK AND PERSONALITY

PRODUCTIVITY AT WORK

Work and midlife includes many scenarios. Some experience stable careers while others experience lay-offs and find themselves back in school to gain new skills for reemployment. Others experience discrimination due to age or find it difficult to gain employment because of the higher salary demands compared with younger, less experienced workers (Barnett, 1997). Many people over 50 seek meaning as well as income in careers entered into in midlife known as "encore careers" www.encore.org/). Some midlife adults anticipate retirement, while others may be postponing it for financial reasons. Listen to this story of *Encore Careers in the lives of Baby Boomers*.

One or more interactive elements has been excluded from this version of the text. You can view them online here: https://pressbooks.nscc.ca/ece-dev-psych/?p=67#oembed-1

The workplace today is one in which many people from various walks of life come together. Work schedules are more flexible and varied, and more work independently from home or anywhere there is an internet connection. The midlife worker must be flexible, stay current with technology, and be capable of working within a global community. And the midlife mind seeks meaningful work.

PERSONALITY IN MIDLIFE

Does the personality change in midlife? Think about your parents or other adults you've known for some time. Did their personalities change when they reached midlife? Or were they pretty much the same? Some theorists maintain that personality becomes more stable as we reach middle adulthood. Other suggest that with age comes the addition of new personality traits-one's we may not have felt comfortable showing when we were younger.

Midlife is viewed as a time of increased stability especially if compared with early adulthood or adolescence. A person's tendency toward extraversion, agreeableness, neuroticism, conscientiousness, and openness, the Big Five personality traits, is more consistent (McCrae & Costa, 2003). Midlife adults become more agreeable, but decline in openness and neuroticism.

However, midlife is also viewed as a time of change. Carl Jung believed that our personality actually matures as we get older. A healthy personality is one that is balanced. People suffer tension and anxiety when they fail to express all of their qualities. Jung believed that each of us possess a "shadow side". For example, those who are typically introverted also have an extroverted side that rarely finds expression unless we are relaxed and uninhibited. Each of us has both a masculine and feminine side but in younger years, we feel societal pressure to give expression only to one. As we get older, we

may become freer to express all of our traits as the situation arises. We find gender convergence in older adults. Men become more interested in intimacy and family ties. Women may become more assertive. This gender convergence is also affected by changes in society's expectations for males and females. With each new generation we find that the roles of men and women are less stereotypic and this allows for change as well.

Again, a sense of mastery and control over one's life can help midlife adults meet the challenges of this time of life (Lachman and Firth, 2004).

CONCLUSION

Midlife is a period of transition. It is also a time of productivity and expertise; a time of putting things together. Midlife is perhaps the least studied period of life. The story of midlife will continue to unfold as more attention is given to it as a part of the lifespan.

PART III.

CHAPTER 3: LATE ADULTHOOD

CHAPTER 16.

INTRODUCTION TO LATE ADULTHOOD

Learning Objectives

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 socio-emotional selectivity theory.
24. Classify types of elder abuse.

DEFINING LATE ADULTHOOD: AGE OR QUALITY OF LIFE?

Photo Courtesy Overstreet

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

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:

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.

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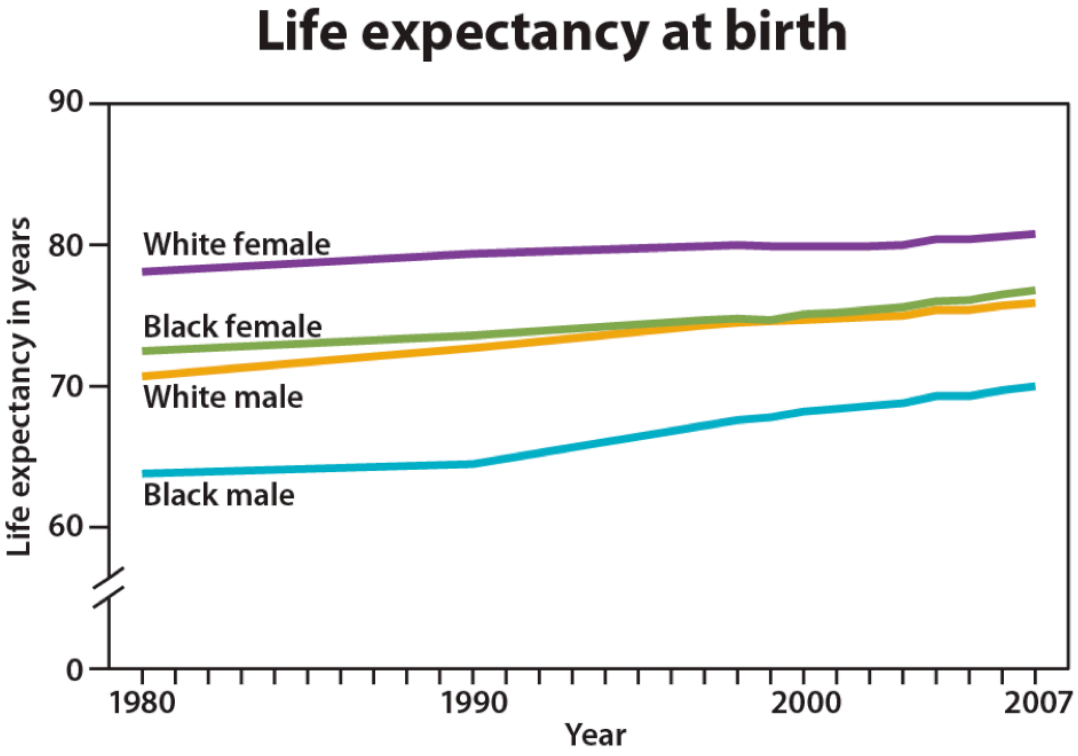
CHAPTER 17.

PHYSICAL DEVELOPMENT

LIFE EXPECTANCY AND QUALITY OF LIFE

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).



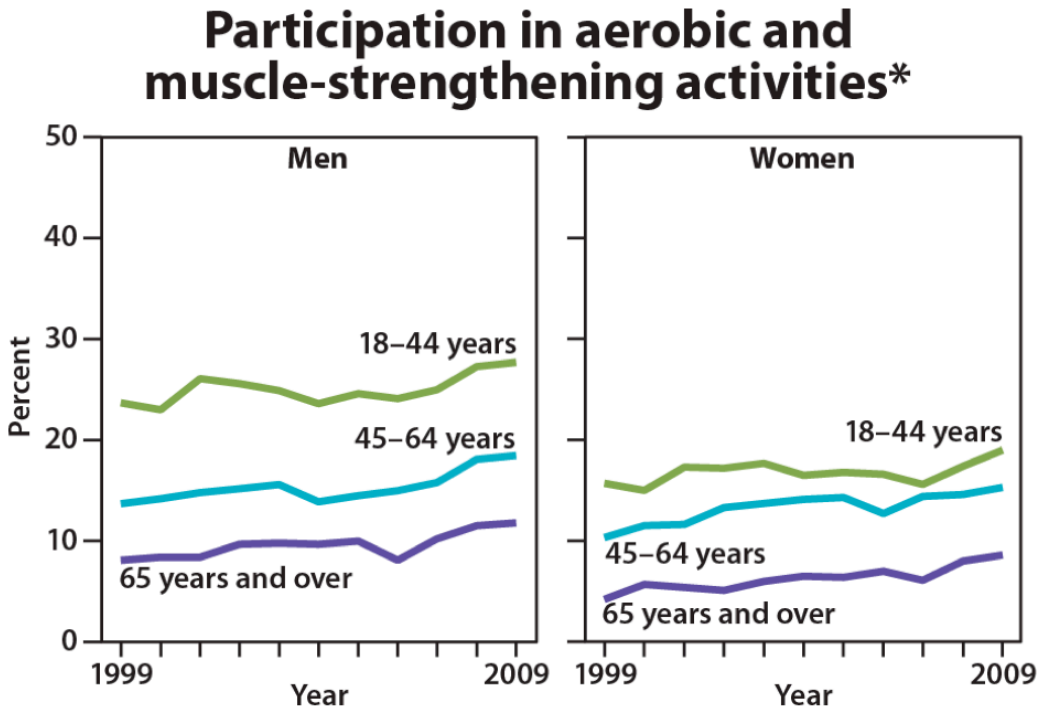
SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 1. Data from the National Vital Statistics System.

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.



NOTE: *Activities that meet the 2008 federal guidelines available at: http://www.health.gov/paguidelines/default.aspx.
SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 12. Data from the National Health Interview Survey.

ATTITUDES ABOUT AGING

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

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.

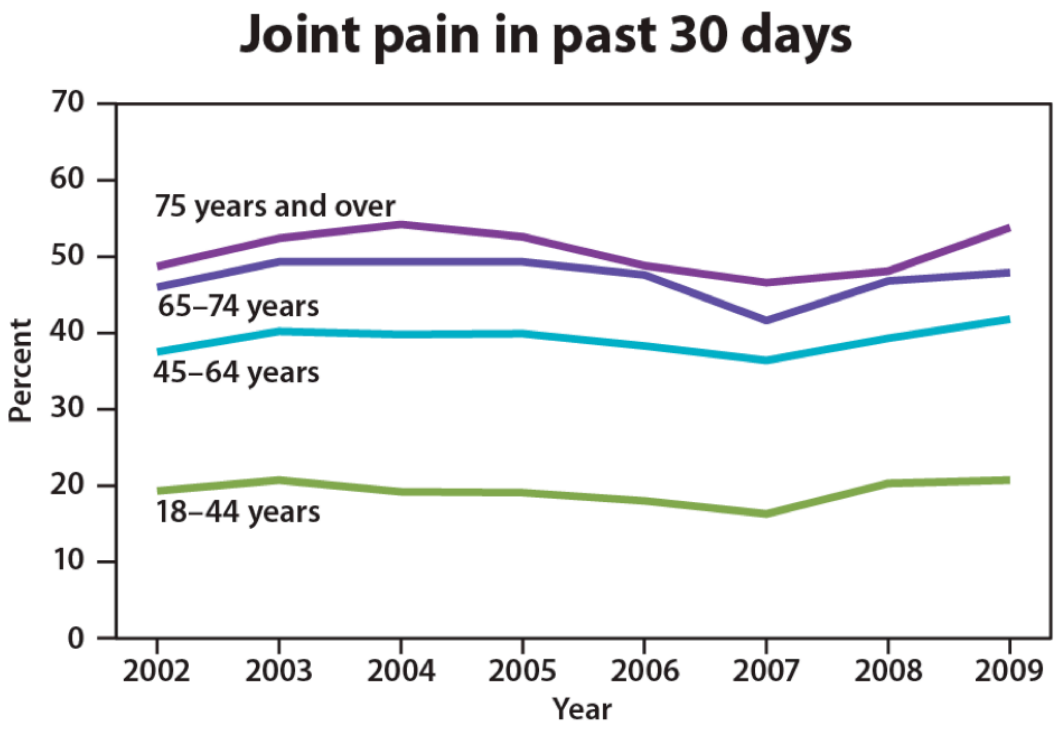
Hearing loss is more prevalent in men than women. And it is experienced by more white, non-Hispanics than by Black men and women. Smoking, middle ear infections, and exposure to loud noises increase hearing loss.

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

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.

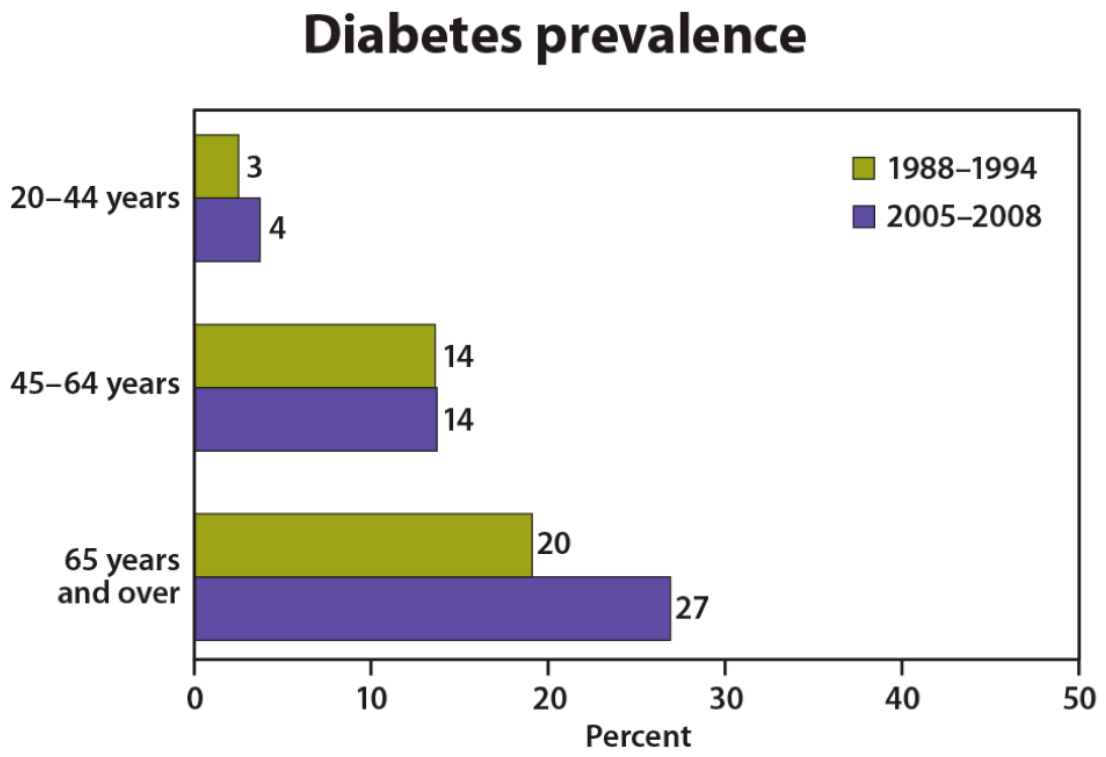


SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 7. Data from the National Health Interview Survey.

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.

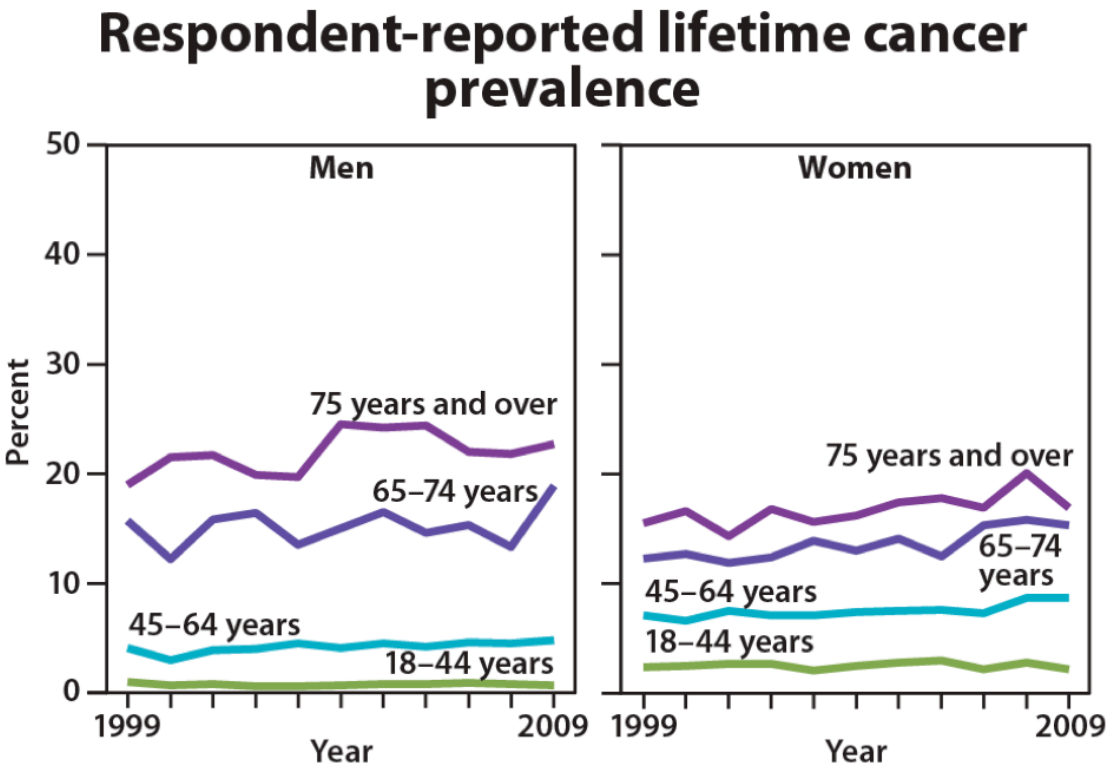
Heart Disease and Stroke: Coronary disease and stroke are higher among older men than women. The incidence of stroke is lower than that of coronary disease.

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).



SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 5. Data from the National Health and Nutrition Examination Survey.

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.



SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 4. Data from the National Health Interview Survey.

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

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.)

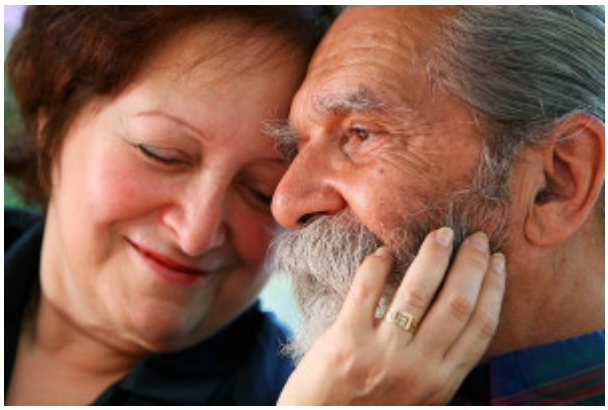
DNA Damage: As we live, DNA is damaged by environmental factors such as toxic agents, pollutants, and sun exposure (Dollemore, 2006). This results in deletions of genetic material, and mutations in the DNA that is duplicated in new cells. The accumulation of these errors results in reduced functioning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

CHAPTER 18.

COGNITIVE DEVELOPMENT

HOW DOES AGING AFFECT MEMORY?



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

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, Treating Delirium: An Often Missed Diagnosis, for more information on treating delirium and the possible links between delirium and Alzheimer's Disease.

Image Credit

- Image of old couple. **Authored by**: Ian MacKenzie. **Provided by**: Flickr. **Located at**: https://en.wikipedia.org/wiki/Remarriage#/media/File:Old_couple_in_love.jpg. **License**: *CC BY: Attribution*

CHAPTER 19.

PSYCHOSOCIAL DEVELOPMENT

INTEGRITY VS. DESPAIR

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

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

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).

CHAPTER 20.

RELATIONSHIPS

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

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

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

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.

Image Credit

- image of elderly couple. **Authored by**: Candida Performa. **Located at**: https://en.wikipedia.org/wiki/Remarriage#/media/File:It%27s_all_about_love.jpg. **License**: *CC BY: Attribution*

CHAPTER 21.

LISTEN: TREATING DELIRIUM

Delirium, a sudden onset of confusion, is a relatively common problem among elderly people while hospitalized (affecting more than 2 million seniors a year), but doctors often dismiss the symptoms as dementia. Listen to this NPR link to learn about the importance of diagnosing and treating for delirium in elderly patients.

- Treating Delirium: An Often Missed Diagnosis

Image Credit

- Authored by: geralt. Located at: https://pixabay.com/en/icons-symbols-wave-send-listen-842890/. License: Public Domain: No Known Copyright

CHAPTER 22.

ADDITIONAL LINKS

Should people give up their careers in late adulthood?

Click on the links below to learn about musicians who didn't let their age stop them:

- John Mayall
- Les Paul

PART IV.

CHAPTER 4: DEATH AND DYING

CHAPTER 23.

INTRODUCTION TO DEATH AND DYING

Learning Objectives

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

1. Compare the leading causes of death in the United States with those of developing countries.
2. Compare physiological, social, and psychic death.
3. List and describe the stages of loss based on various models including that of Kubler-Ross.
4. Explain the philosophy and practice of palliative care.
5. Describe hospice care.
6. Differentiate attitudes toward hospice care based on race and ethnicity.
7. Summarize Dame Cicely Saunders' writings about total pain of the dying.
8. Compare euthanasia, passive-euthanasia, and physician-assisted suicide.
9. Characterize bereavement and grief.
10. Express your own ideas about death and dying.

"Everything has to die," he told her during a telephone conversation.

"I want you to know how much I have enjoyed being with you, having you as my friend, and confidant and what a good father you have been to me. Thank you so much." she told him.

"You are entirely welcome." he replied.

He had known for years that smoking will eventually kill him. But he never expected that lung cancer would take his life so quickly or be so painful. A diagnosis in late summer was followed with radiation and chemotherapy during which time there were moments of hope interspersed with discussions about where his wife might want to live after his death and whether or not he would have a blood count adequate to let him precede with his next treatment. Hope and despair exist side by side. After a few months, depression and quiet sadness preoccupied him although he was always willing to relieve others by reporting that he 'felt a little better' if they asked. He returned home in January after one of his many hospital stays and soon grew worse. Back in the hospital, he was told of possible treatment options to delay his death. He asked his family members what they wanted him to do and then announced that he wanted to go home. He was ready to die. He returned home. Sitting in his favorite chair and being fed his favorite food gave way to lying in the hospital bed in his room and rejecting all food. Eyes closed and no longer talking, he surprised everyone by joining in and singing "Happy birthday" to his wife, son, and daughter-in-law who all had birthdays close together. A pearl necklace he had purchased 2 months earlier in case he died before his wife's birthday was

retrieved and she told him how proud she would be as she wore it. He kissed her once and then again as she said goodbye. He died a few days later (Author's notes).

Photo Courtesy Robert Paul Young

A dying process that allows an individual to make choices about treatment, to say goodbyes and to take care of final arrangements is what many people hope for. Such a death might be considered a "good death." But of course, many deaths do not occur in this way. Not all deaths include such a dialogue with family members or being able to die in familiar surroundings. People die suddenly and alone. People leave home and never return. Children precede parents in death; wives precede husbands, and the homeless are bereaved by strangers.

In this lesson, we look at death and dying, grief and bereavement. We explore palliative care and hospice. And we explore funeral rites and the right to die.

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CHAPTER 24.

MOST COMMON CAUSES OF DEATH

THE UNITED STATES

In 1900, the most common causes of death were infectious diseases which brought death quickly. Today, the most common causes of death are chronic diseases in which a slow and steady decline in health ultimately results in death. How might this impact the way we think of death, how we grieve, and the amount of control a person has over his or her own dying process?

The leading causes of death and number of deaths per category in 2004 in the United States are listed below. (National Vital Statistics Reports, Center for Disease Control, 2006).

- Heart Disease (654,092)
- Malignant neoplasms (cancer) (550,270)
- Cerebrovascular disease (stroke) (150,147)
- Chronic lower respiratory disease (123,884)
- Accidents (123,884)
- Diabetes Mellitus (106.694)
- Alzheimer's Disease (72,815)
- Influenza and Pneumonia (65,829)
- Nephritis (61,472)
- Septicemia (42,762)
- Suicide (33,464)
- Chronic Liver Disease (31,647)
- Hypertension and hypertensive renal disease (26,549)
- Parkinson's disease (22,953)
- Pneumonitis (18,018)

These numbers reflect a change in Alzheimer's disease which moved up from the 8th leading cause of death to the 7th and influenza and pneumonia moved down in rank from 7th to 8th.

DEADLIEST DISEASES WORLDWIDE

The top 12 deadliest diseases in the world are listed below along with the estimated number of deaths per cause. These figures are for 2002 and do not reflect deaths due to violence or suicide (World Health Organization, World Health Report, 2004). Notice the higher rates of death due to HIV/AIDS,

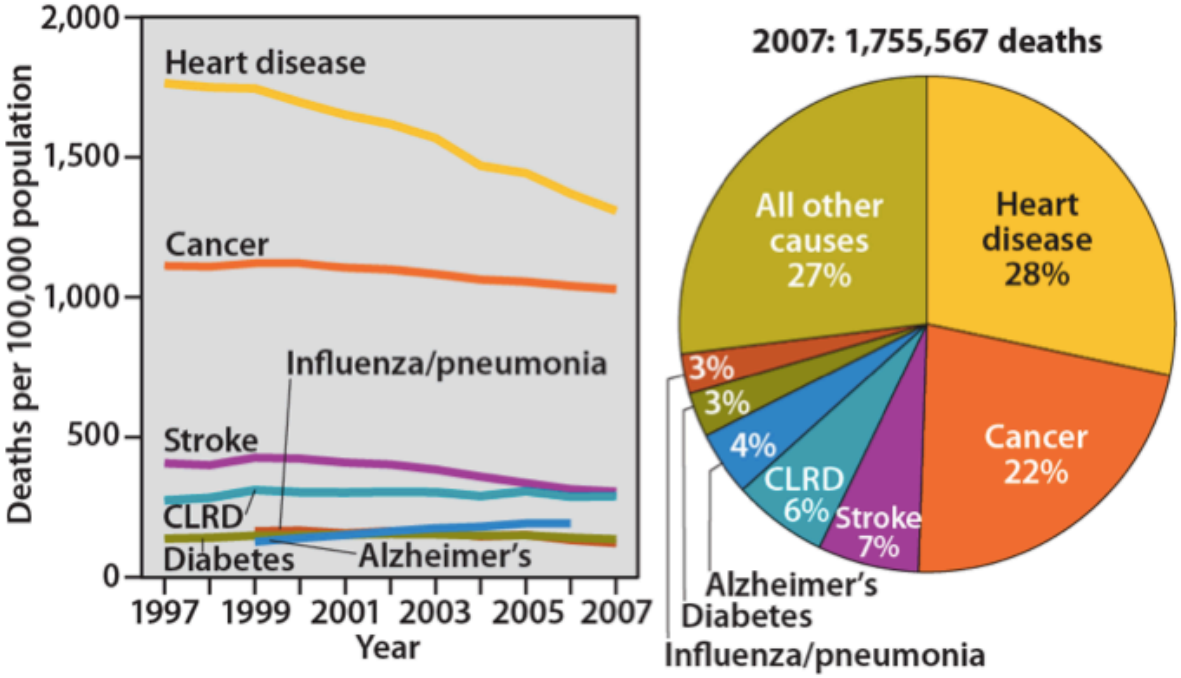
perinatal conditions and diarrheal conditions than is found in the United States. Deaths of infants, young children, young mothers, and men and women in adolescence, young adulthood and midlife are more common. Many of these deaths are due to preventable causes. Ideas about the swiftness and unpredictable nature of death are certainly greater when living under such circumstances.

1. Heart disease (7.2 million)
2. Cerebrovascular disease (5.5 million)
3. Lower respiratory infections (3.9 million)
4. HIV/AIDS (2.8 million)
5. Chronic obstructive pulmonary (2.7 million)
6. Perinatal conditions (2.5 million)
7. Diarrheal diseases (1.8 million)
8. Tuberculosis (1.6 million)
9. Malaria (1.3 million)
10. Trachea, bronchus, lung cancers (1.2 million)
11. Road traffic accidents (1.2 million)
12. Diabetes mellitus (1 million)

A COMPARISON OF DEATH BY AGE IN THE UNITED STATES:

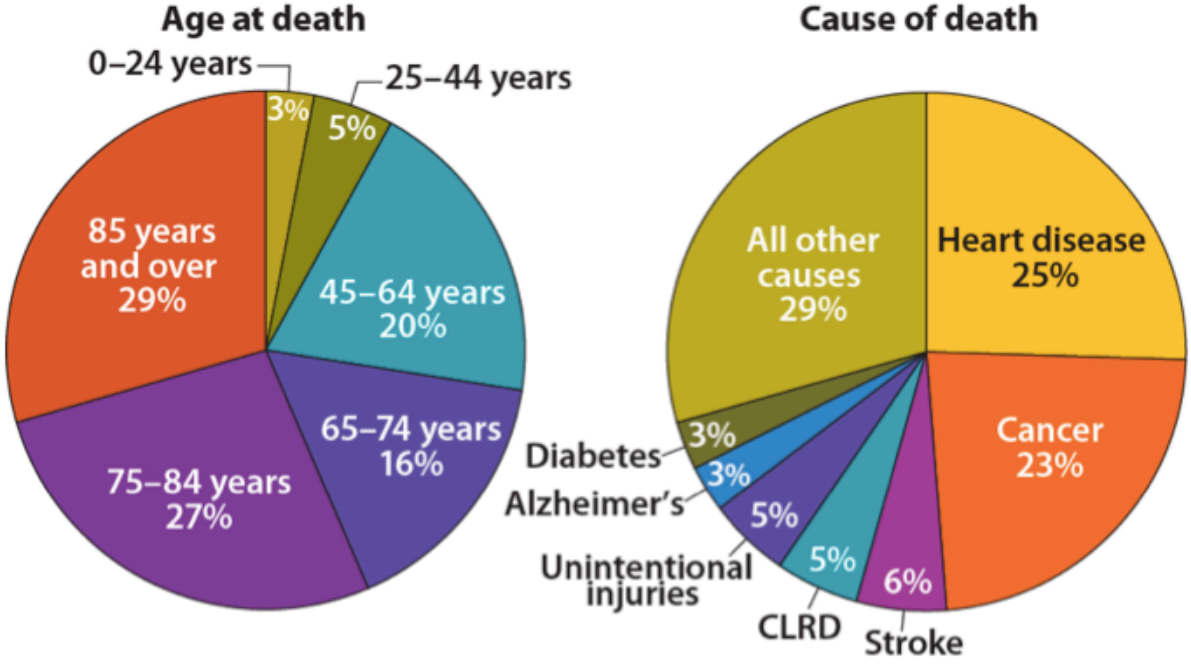
A comparison of the causes of death in the United States in the year 2007 for people in late adulthood and among all ages is given below. Notice that 29 percent of all deaths were of people ages 85 and older and that rates of death due to heart disease had declined since 1997, although heart disease is still the leading cause of death.

Death rates among persons 65 years of age and over



NOTE: CLRD is chronic lower respiratory diseases.
SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 31. Data from the National Vital Statistics System.

Deaths for all ages, 2007



NOTE: CLRD is chronic lower respiratory diseases.
SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 24. Data from the National Vital Statistics System.

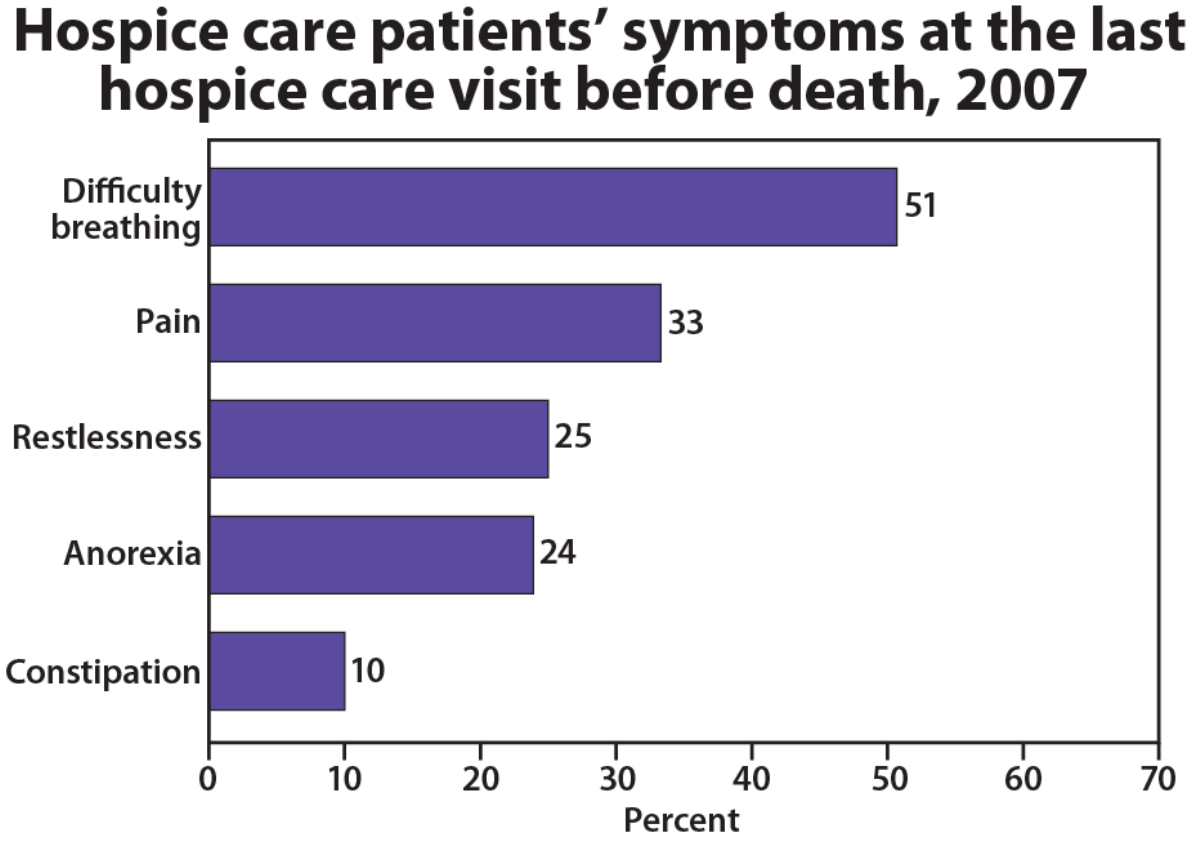
CHAPTER 25.

THE PROCESS OF DYING

ASPECTS OF DEATH

One way to understand death and dying is to look more closely at physical death, psychological death, and social death. These deaths do not occur simultaneously. Rather, a person's physiological, social, and psychic death can occur at different times (Pattison, 1977).

Physiological death occurs when the vital organs no longer function. The digestive and respiratory systems begin to shut down during the gradual process of dying. A dying person no longer wants to eat as digestion slows and the digestive track loses moisture and chewing, swallowing, and elimination become painful processes. Circulation slows and mottling or the pooling of blood may be noticeable on the underside of the body appearing much like bruising. Breathing becomes more sporadic and shallow and may make a rattling sound as air travels through mucus filled passageways. The person often sleeps more and more and may talk less although continues to hear. The kinds of symptoms noted prior to death in patients under hospice care (care focused on helping patients die as comfortably as possible) is noted below.



SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 40. Data from the National Home and Hospice Care Survey.

When a person no longer has brain activity, they are clinically dead. Physiological death may take 72 or fewer hours.

Social death begins much earlier than physiological death. Social death occurs when others begin to withdraw from someone who is terminally ill or has been diagnosed with a terminal illness. Those diagnosed with conditions such as AIDS or cancer may find that friends, family members, and even health care professionals begin to say less and visit less frequently. Meaningful discussions may be replaced with comments about the weather or other topics of light conversation. Doctors may spend less time with patients after their prognosis becomes poor. Why do others begin to withdraw? Friends and family members may feel that they do not know what to say or that they can offer no solutions to relieve suffering. They withdraw to protect themselves against feeling inadequate or from having to face the reality of death. Health professionals, trained to heal, may also feel inadequate and uncomfortable facing decline and death. A patient who is dying may be referred to as "circling the drain" meaning that they are approaching death. People in nursing homes may live as socially dead for years with no one visiting or calling. Social support is important for quality of life and those who experience social death are deprived from the benefits that come from loving interaction with others.

Psychic death occurs when the dying person begins to accept death and to withdraw from others and regress into the self. This can take place long before physiological death (or even social death if others are still supporting and visiting the dying person) and can even bring physiological death closer. People have some control over the timing of their death and can hold on until after important occasions or die quickly after having lost someone important to them. They can give up their will to live.

CHAPTER 26.

FIVE STAGES OF LOSS

Kubler-Ross (1969, 1975) describes five stages of loss experienced by someone who faces the news of their impending death. These "stages" are not really stages that a person goes through in order or only once; nor are they stages that occur with the same intensity. Indeed, the process of death is influenced by a person's life experiences, the timing of their death in relation to life events, the predictability of their death based on health or illness, their belief system, and their assessment of the quality of their own life. Nevertheless, these stages help us to understand and recognize some of what a dying person experiences psychologically. And by understanding, we are more equipped to support that person as they die.

Denial is often the first reaction to overwhelming, unimaginable news. Denial, or disbelief or shock, protects us by allowing such news to enter slowly and to give us time to come to grips with what is taking place. The person who receives positive test results for life-threatening conditions may question the results, seek second opinions, or may simply feel a sense of disbelief psychologically even though they know that the results are true.

Anger also provides us with protection in that being angry energizes us to fight against something and gives structure to a situation that may be thrusting us into the unknown. It is much easier to be angry than to be sad or in pain or depressed. It helps us to temporarily believe that we have a sense of control over our future and to feel that we have at least expressed our rage about how unfair life can be. Anger can be focused on a person, a health care provider, at God, or at the world in general. And it can be expressed over issues that have nothing to do with our death; consequently, being in this stage of loss is not always obvious.

Bargaining involves trying to think of what could be done to turn the situation around. Living better, devoting self to a cause, being a better friend, parent, or spouse, are all agreements one might willingly commit to if doing so would lengthen life. Asking to just live long enough to witness a family event or finish a task are examples of bargaining.

Depression is sadness and sadness is appropriate for such an event. Feeling the full weight of loss, crying, and losing interest in the outside world is an important part of the process of dying. This depression makes others feel very uncomfortable and family members may try to console their loved one. Sometimes hospice care may include the use of antidepressants to reduce depression during this stage.

Acceptance involves learning how to carry on and to incorporate this aspect of the life span into daily existence. Reaching acceptance does not in any way imply that people who are dying are happy about it or content with it. It means that they are facing it and continuing to make arrangements and to say what they wish to say to others. Some terminally ill people find that they live life more fully than ever before after they come to this stage.

We no longer think that there is a "right way" to experience the loss. People move through a variety of stages with different frequency and in various ways.

CHAPTER 27.

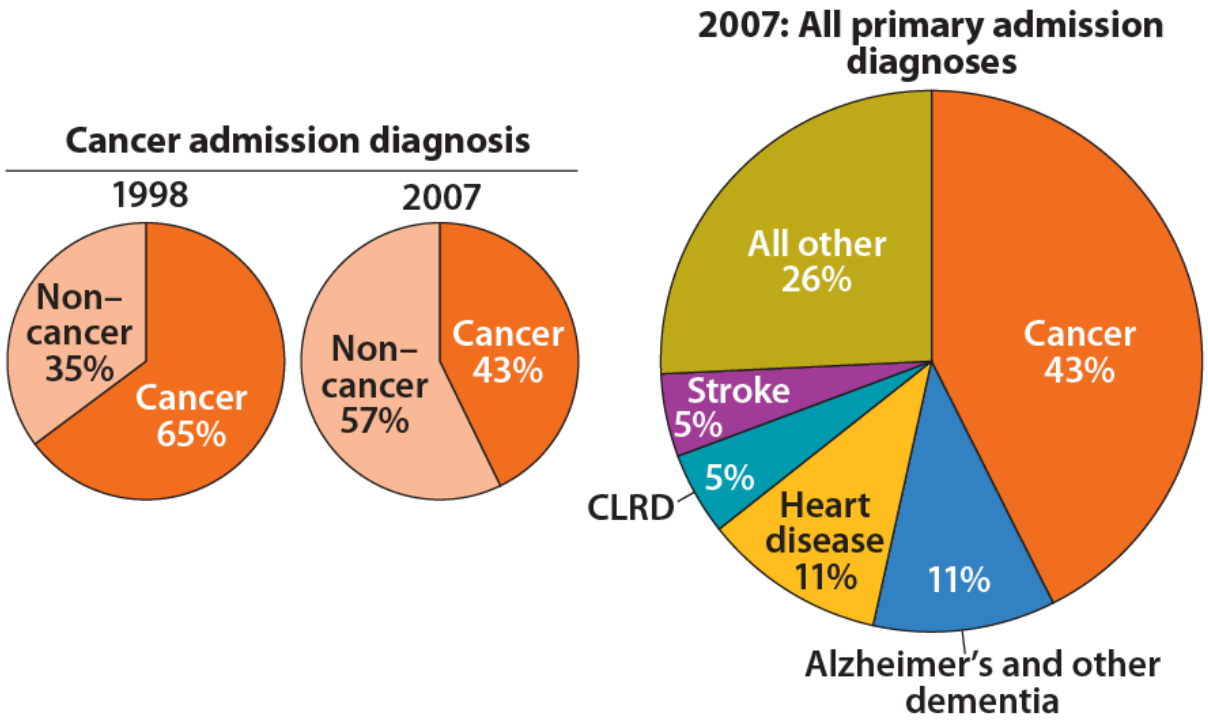
PALLIATIVE CARE AND HOSPICE

Kubler-Ross's work was introduced at a period in which the **hospice movement** began in the United States. This movement focused attention on caring for the dying. **Palliative care** focuses on providing comfort and relief from physical and emotional pain to patients throughout their illness even while being treated (NIH, 2007). Palliative care is part of hospice programs. Hospice involves caring for dying patients by helping them be as free from pain as possible, providing them with assistance to complete wills and other arrangements for their survivors, giving them social support through the psychological stages of loss, and helping family members cope with the dying process, grief, and bereavement. In order to enter hospice, a patient must be diagnosed as terminally ill with an anticipated death within 6 months. Most hospice care does not include medical treatment of disease or resuscitation although some programs administer curative care as well. The patient is allowed to go through the dying process without invasive treatments. Family members, who have agreed to put their loved one on hospice, may become anxious when the patient begins to experience the death. They may believe that feeding or breathing tubes will sustain life and want to change their decision. Hospice workers try to inform the family of what to expect and reassure them that much of what they see is a normal part of the dying process.

The early hospices established were independently operated and dedicated to giving patients as much control over their own death process as possible. Today, there are more than 4,000 hospice programs and over 1,000 of them are offered through hospitals. Hospice care was given to over 1 million patients in 2004 (NIH, 2007; Senior Journal, 2007). Although hospice care has become more widespread, these new programs are subjected to more rigorous insurance guidelines that dictate the types and amounts of medications used, length of stay, and types of patients who are eligible to receive hospice care (Weitz, 2007). Thus, more patients are being served, but providers have less control over the services they provide, and lengths of stay are more limited. Patients receive palliative care in hospitals and in their homes.

The majority of patients on hospice are cancer patients and typically do not enter hospice until the last few weeks prior to death. The average length of stay is less than 30 days and many patients are on hospice for less than a week (National Center for Health Statistics, 2003). Medications are rubbed into the skin or given in drop form under the tongue to relieve the discomfort of swallowing pills or receiving injections. A hospice care team includes a chaplain as well as nurses and grief counselors to assist spiritual needs in addition to physical ones. When hospice is administered at home, family members may also be part, and sometimes the biggest part, of the care team. Certainly, being in familiar surroundings is preferable to dying in an unfamiliar place. But about 60 to 70 percent of people die in hospitals and another 16 percent die in institutions such as nursing homes (APA Online, 2001). Most hospice programs serve people over 65; few programs are available for terminally ill children (Wolfe et al., in Berger, 2005).

Primary admission diagnosis of discharged hospice care patients



NOTE: CLRD is chronic lower respiratory diseases.
SOURCE: CDC/NCHS, *Health, United States, 2010*, Figure 38. Data from the National Home and Hospice Care Survey.

Dame Cicely Saunders founded the hospice movement in Great Britain and described the kinds of pain experienced by those who are dying and their families. These 7 Pains include emotional include physical pain, spiritual pain, intellectual pain, emotional pain, interpersonal pain, financial pain and bureaucratic pain. Hospice care focuses on alleviating physical pain and providing spiritual guidance. Those suffering from Alzheimer's also experience intellectual pain and frustration as they lose their ability to remember and recognize others. Depression, anger, and frustration are elements of emotional pain, and family members can have tensions that a social worker or clergy member may be able to help resolve. Many patients are concerned with the financial burden their care will create for family members. And bureaucratic pain is also suffered while trying to submit bills and get information about health care benefits or to complete requirements for other legal matters. All of these concerns can be addressed by hospice care teams. Learn more about Saunders in the link provided at the end of this lesson.

The Hospice Foundation of America notes that not all racial and ethnic groups feel the same way about hospice care. African-American families may believe that medical treatment should be pursued on behalf of an ill relative as long as possible and that only God can decide when a person dies. Chinese-American families may feel very uncomfortable discussing issues of death or being near the deceased family member's body. The view that hospice care should always be used is not held by everyone and health care providers need to be sensitive to the wishes and beliefs of those they serve (Hospital Foundation of America, 2009).

CHAPTER 28.

EUTHANASIA

Euthanasia, or helping a person fulfill their wish to die, can happen in two ways: voluntary euthanasia and physician-assisted suicide. Voluntary euthanasia refers to helping someone fulfill their wish to die by acting in such a way to help that person's life end. This can be passive euthanasia such as no longer feeding someone or giving them food. Or it can be active euthanasia such as administering a lethal dose of medication to someone who wishes to die.

Physician-Assisted Suicide: Physician-assisted suicide occurs when a physician prescribes the means by which a person can end his or her own life. Physician-assisted suicide is legal in Oregon, the Netherlands, Switzerland, and Belgium. The Oregon Death with Dignity Act of 1997 grants physicians this right. Physician-assisted suicides, however, are rare.

A growing number of the population support physician-assisted suicide. In 2000, a ruling of the U. S. Supreme Court upheld the right of states to determine their laws on physician-assisted suicide despite efforts to limit physicians' ability to prescribe barbiturates and opiates for their patients requesting the means to end their lives. The position of the Supreme Court is that the debate concerning the morals and ethics surrounding the right to die is one that should be continued (Stein, 2000). As an increasing number of the population enters late adulthood, the emphasis on giving patients an active voice in determining certain aspects of their own death is likely.

CHAPTER 29.

BEREAVEMENT AND GRIEF

Bereavement refers to outward expressions of grief. Mourning and funeral rites are expressions of loss that reflect personal and cultural beliefs about the meaning of death and the afterlife. When asked what type of funeral they would like to have, students responded in a variety of ways; each expressing both their personal beliefs and values and those of their culture.

I would like the service to be at a Baptist church, preferably my Uncle Ike's small church. The service should be a celebration of life . . .I would like there to be hymns sung by my family members, including my favorite one, "It is Well With my Soul". . .At the end, I would like the message of salvation to be given to the attendees and an alter call for anyone who would like to give their life to Christ. . .

I want a very inexpensive funeral-the bare minimum, only one vase of flowers, no viewing of the remains and no long period of mourning from my remaining family . . . funeral expenses are extremely overpriced and out of hand. . .

When I die, I would want my family members, friends, and other relatives to dress my body as it is usually done in my country, Ghana. Lay my dressed body in an open space in my house at the night prior to the funeral ceremony for my loved ones to walk around my body and mourn for me. . .

I would like to be buried right away after I die because I don't want my family and friends to see my dead body and to be scared.

In my family we have always had the traditional ceremony-coffin, grave, tombstone, etc. But I have considered cremation and still ponder which method is more favorable. Unlike cremation, when you are 'buried' somewhere and family members have to make a special trip to visit, cremation is a little more personal because you can still be in the home with your loved ones . . .

I would like to have some of my favorite songs played . . .I will have a list made ahead of time. I want a peaceful and joyful ceremony and I want my family and close friends to gather to support one another. At the end of the celebration, I want everyone to go to the Thirsty Whale for a beer and Spang's for pizza!

When I die, I want to be cremated . . . I want it the way we do it in our culture. I want to have a three day funeral and on the 4th day, it would be my burial/cremation day . . .I want everyone to wear white instead of black, which means they already let go of me. I also want to have a mass on my cremation day.

When I die, I would like to have a befitting burial ceremony as it is done in my Igbo customs. I chose this kind of funeral ceremony because that is what every average person wishes to have.

I want to be cremated . . . I want all attendees wearing their favorite color and I would like the song "Riders on the Storm" to be played . . .I truly hope all the attendees will appreciate the bass. At the end of this simple, short service, attendees will be given multi-colored helium filled balloons . . . released to signify my release from this earth. . .They will be invited back to the house for ice cream cones, cheese popcorn and a wide variety of other treats and much, much, much rock music . . .

I want to be cremated when I die. To me, it's not just my culture to do so but it's more peaceful to put my remains or ashes to the world. Let it free and not stuck in a casket.

Ceremonies provide survivors a sense of closure after a loss. These rites and ceremonies send the message that the death is real and allow friends and loved ones to express their love and duty to those who die. Under circumstances in which a person has been lost and presumed dead or when family members were unable to attend a funeral, there can continue to be a lack of closure that makes it difficult to grieve and to learn to live with loss. And although many people are still in shock when they attend funerals, the ceremony still provides a marker of the beginning of a new period of one's life as a survivor.

Grief is the psychological, physical, and emotional experience of loss. The five stages of loss are experienced by those who are in grief (Kubler-Ross & Kessler, 2005). Grief reactions vary depending on whether a loss was anticipated or unexpected, (parents do not expect to lose their children, for example), and whether or not it occurred suddenly or after a long illness, and whether or not the survivor feels responsible for the death. Struggling with the question of responsibility is particularly felt by those who lose a loved one to suicide. There are numerous survivors for every suicide resulting in 4.5 million survivors of suicide in the United States (American Association of Suicidology, 2007). These survivors may torment themselves with endless "what ifs" in order to make sense of the loss and reduce feelings of guilt. And family members may also hold one another responsible for the loss. The same may be true for any sudden or unexpected death making conflict an added dimension to grief. Much of this laying of responsibility is an effort to think that we have some control over these losses; the assumption being that if we do not repeat the same mistakes, we can control what happens in our life.

Anticipatory grief occurs when a death is expected and survivors have time to prepare to some extent before the loss. Anticipatory grief can include the same denial, anger, bargaining, depression, and acceptance experienced in loss. This can make adjustment after a loss somewhat easier, although the stages of loss will be experienced again after the death (Kubler-Ross & Kessler, 2005). A death after a long-term, painful illness may bring family members a sense of relief that the suffering is over. The exhausting process of caring for someone who is ill is over. **Disenfranchised grief** may be experienced by those who have to hide the circumstances of their loss or whose grief goes unrecognized by others. Loss of an ex-spouse, lover, or pet may be examples of disenfranchised grief.

Yet grief continues as long as there is a loss. It has been said that intense grief lasts about two years or less, but grief is felt throughout life. One loss triggers the feelings that surround another. People grieve with varied intensity throughout the remainder of their lives. It does not end. But it eventually becomes something that a person has learned to live with. As long as we experience loss, we experience grief (Kubler-Ross & Kessler, 2005).

There are layers of grief. Initial denial, marked by shock and disbelief in the weeks following a loss may become an expectation that the loved one will walk in the door. And anger directed toward those who could not save our loved one's life, may become anger that life did not turn out as we expected. There is no right way to grieve. A bereavement counselor expressed it well by saying that grief touches us on the shoulder from time to time throughout life.

Grief and mixed emotions go hand in hand. A sense of relief is accompanied by regrets and periods of reminiscing about our loved ones are interspersed with feeling haunted by them in death. Our outward expressions of loss are also sometimes contradictory. We want to move on but

at the same time are saddened by going through a loved one's possessions and giving them away. We may no longer feel sexual arousal or we may want sex to feel connected and alive. We need others to befriend us but may get angry at their attempts to console us. These contradictions are normal and we need to allow ourselves and others to grieve in their own time and in their own ways.

The "death-denying, grief-dismissing world" is the modern world (Kubler-Ross & Kessler, 2005, p. 205). We are asked to grieve privately, quickly, and to medicate our suffering. Employers grant us 3 to 5 days for bereavement, if our loss is that of an immediate family member. And such leaves are sometimes limited to no more than one per year. Yet grief takes much longer and the bereaved are seldom ready to perform well on the job. Obviously life does have to continue. But Kubler-Ross and Kessler suggest that contemporary American society would do well to acknowledge and make more caring accommodations to those who are in grief. Listen to this story about Kubler-Ross and her life and work in the link below.

CONCLUSION

Death and grief are topics that are being given greater consideration. This trend should continue as the population "grays" and our awareness of natural disaster and war, both in the United States and throughout the world grows. Viewing death as an integral part of the lifespan will benefit those who are ill, those who are bereaved, and all of us as friends, caregivers, partners, family members and humans in a global society.

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CHAPTER 30.

ADDITIONAL LINKS

Additional Links

Learn more about some of the topics learned about in this module on late adulthood through the following links:

- Read and hear about the creation of the hospice movement from the obituary of Dame Cicely Saunders.
- Listen to the NPR report about Elizabeth Kubler-Ross: "On Death and Dying"
- See images about tthe top 10 causes of death
- Listen to the NPR report "Dying Alone, One Woman's Story": Home Alone
- Read about Ohio youth who volunteer their service as pallbearers for those who may not have any: Pallbearing as a Public Service
- Music Thanatology

CHAPTER 31.

STUDY GUIDE: MIDDLE AND LATE ADULTHOOD

ADULTHOOD, LATE ADULTHOOD, DEATH AND DYING

1. Summarize physical changes that occur in midlife.
2. Define menopause and explain menopausal changes.
3. What is andropause?
4. How does the climacteric impact sexuality?
5. How does exercise impact aging?
6. Describe the ideal diet for midlife adults.
7. Which cognitive skills increase and decrease in midlife?
8. How do midlife students differ from younger students?
9. Compare the expert and the novice.
10. Is there any such thing as a midlife crisis? Explain.
11. What is Erikson's stage for midlife adults?
12. What is kinkeeping?
13. Compare types of singles.
14. How does marital satisfaction vary during the life cycle?
15. Describe Cuber and Haroff's typology of marriages.
16. What does Gottman say about communication in marriage?
17. Describe the stations of divorce.
18. How common is remarriage?
19. What happens to personality in midlife?
20. Compare styles of grandparenting.
21. Compare optimal, usual, and impaired aging.
22. Discuss demographic changes in the age structure found in the United States from 1900 to the present.
23. America and the globe are "graying."What does this mean?
24. How has life expectancy changed since 1900? Compare life expectancies based on gender and race/ethnicity.

25. What is ageism? Define elderspeak.
26. Compare primary and secondary aging and give examples of each.
27. How common are problems of vision and hearing loss among people 65 and older?
28. Describe theories of aging. Why do we age? (Include definitions of Hayflick limit and telomeres).
29. How does age impact the sensory register, working (short-term), and long-term memory?
30. What is wisdom? Does it come with age?
31. Define abnormal losses of cognitive functioning including dementia and delirium. What are nonorganic causes?
32. Contrast disengagement, activity, and continuity theories of aging.
33. What is socio-emotional selectivity theory?
34. Who cares for older, dependent adults? How many are in nursing homes?
35. Discuss elderly abuse.
36. What are the most common causes of death in the United States?
37. What are the most deadly diseases worldwide?
38. Compare physiological, social, and psychic death.
39. List and describe the five stages of loss.
40. What is palliative care?
41. Describe hospice programs.
42. Who is Dame Cicely Saunders? What are the seven pains?
43. What is anticipatory grief? Disenfranchised grief?
44. Kubler-Ross and Kessler suggest that this is a "death-defying, grief-dismissing world". What does this mean?

CHAPTER 32.

PRACTICE TEST: MIDDLE AND LATE ADULTHOOD

Exercises

1. Which of the following is FALSE regarding the climacteric?
A) All cultures respond in the same way to the climacteric.
B) Men continue to be reproductive after midlife.
C) Most women complete menopause in their early 50s.
D) Couples continue to enjoy sex after the climacteric.

2. Encore careers:
A) are entered into in midlife.
B) emphasize meaning and purpose.
C) focus on making a societal contribution.
D) All of the above.

3. Erikson's stage for late adulthood is:
A) initiative verses guilt.
B) trust versus mistrust.
C) generativity versus stagnation.
D) integrity versus despair.

4. With age comes wisdom.
A) True
B) False

5. Tacit knowledge declines in midlife.
A) True
B) False

6. Rates of exercise among those 65 and older are higher for women than for men.
A) True
B) False

7. Adult students tend to do ALL BUT WHICH ONE of the following?
A) Focus on speed rather than accuracy.
B) Learn best with minimal distractions.
C) Focus on relevance of content.
D) Rely less on rote memorization.

8. Which category of the U. S. population has the shortest life expectancy?
A) Black males
B) Black females

C) White males
D) White females

9. The Hayflick limit is a concept that explains:
A) marital satisfaction.
B) cell age.
C) increases in intelligence historically.
D) depression in late adulthood.

10. This type of marriage is most likely to include empty love.
A) The vitalized marriage.
B) The passive-congenial marriage.
C) The total marriage.
D) Intrinsic marriage.

11. Which of the following is NOT one of Kubler-Ross's stages of grief/loss?
A) Recollection.
B) Denial.
C) Bargaining.
D) Anger.

12. A sudden experience of confusion and disorientation is known as:
A) Alzheimer's disease.
B) Dementia.
C) Delirium.
D) Parkinson's disease.

13. This station of divorce involves the loss of neighbors and friends.
A) The psychic divorce.
B) The "friendly" divorce.
C) The community divorce.
D) The emotional divorce.

14. A midlife adult is most likely to experience which of the following changes?
A) A loss of taste sensitivity.
B) Becoming nearsighted or farsighted.
C) Developing arthritis.
D) Weight loss.

15. Earl was diagnosed with ALS and given a life expectancy of 2 years. As his disease progressed, his family gradually adjusted to his inevitable death. This refers to which type of grief?
A) anticipatory grief.
B) incomplete grief.
C) preoccupied grief.
D) disenfranchised grief.

16. Secondary aging refers to:
A) Changes in the body that occur during midlife.
B) Changes in height and weight that are part of late adulthood.
C) Aging that occurs as a result of mental states or attitudes.
D) Changes associated with disease.

17. This theory suggests that people in late adulthood focus on friendships primarily because of the

enjoyment these relationships bring.
A) Pragmatic exchange theory.
B) Socioemotional selectivity theory.
C) The selection hypothesis.
D) The Hayflick Limit.

18. What percentage of people over 65 require institutional care?
A) 35 percent.
B) 54 percent.
C) 67 percent.
D) None of the above.

19. The expert is someone who:
A) knows a good deal about a particular subject or skill.
B) is exceptional in all areas.
C) has natural talent in an area.
D) focuses on solving-problems by relying on procedure manuals.

20. How common is remarriage?
A) About 10 percent of marriages are remarriages.
B) About 20 percent of marriages are remarriages.
C) About 50 percent of marriages are remarriages.
D) About 70 percent of marriages are remarriages.

Solutions to Exercises

1. A
2. D
3. D
4. False
5. False
6. False
7. A
8. A
9. B
10. B
11. A
12. C
13. C
14. B
15. A
16. D
17. B
18. D
19. A
20. C

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Textbook Remix Mapping	
NSCC Developmental Psychology	Developmental Psychology By Bill Pelz and Linda Overstreet
Chapter 1	Chapter 8
Chapter 2	Chapter 9
Chapter 3	Chapter 10
Chapter 4	Chapter 11