Chapter 10

Aging Families

Title page image 10.1

Learning Objectives

After reading this chapter, you should be able to:

1 Examine your own views of “aging” and “being old.”

2 Describe Canada’s aging population today (statistical trends).

3 Identify the gains and losses that occur during later life.

4 Compare and contrast life course experiences in later life with respect to gender and culture.

5 Decide what decisions can be made earlier in life to increase the probability of “successful aging.”

<vignette>

Bill and Sue were married and best friends for more than 35 years. Since they had no children, they spent most of their time in retirement doing things together—whether going on vacation or simply going for a walk in the park. Bill passed away from cancer, leaving Sue alone in their large home. Most of Bill’s relatives had been unaware of his condition because he was a private man. At the funeral, several family members noticed that Sue was asking the same questions over and over again.

In the following weeks, Sue seemed to get worse. She started to do strange things such as not remember how to make toast and answer the door half-dressed. Her nieces and nephews, all of whom had their own spouses, children, and grandchildren, did not know how to best care for Sue. It seemed she had dementia, a diagnosis that was confirmed by a psychologist. How could Bill not have told anyone about Sue’s condition, knowing he was sick and not going to outlive her? Why didn’t he ensure that Sue had care arranged for her when he was gone? Or, being with her every day, had he not noticed Sue’s symptoms of forgetting? What were her nieces and nephews supposed to do? Sue needed 24-hour care so that she would not wander onto the street or burn down her house, but they all had responsibilities to their own families and lived a good distance away.

Luckily, Bill and Sue had managed to save a good amount of money for their retirement, so it was possible for Sue’s extended family to arrange for formal care. However, they didn’t know what the best option would be. Sue didn’t want to leave her home but she was becoming progressively more forgetful and her personality was changing to the point where she often verbally abused the live-in caregiver. She also called her nieces and nephews every day, asking them to come over because she was feeling lonely. Then she would forget that she had called already and would fill up their voicemails with multiple messages. Would a nursing home that specialized in people with dementia be a better option? How would the family get Sue to agree to move there? Would it be wrong to suggest to her that it was her idea, knowing she wouldn’t remember if she had made that decision or not? If Sue and Bill had had their own children, would this have made a difference now that she needed care? What would have happened if Bill and Sue hadn’t saved for retirement and there were no funds to pay for formal care?

<end of vignette>

As you can see from the opening vignette, later life can bring a unique set of experiences to both the elderly person and their family members. For the elderly person, later life can be a time of new or renewed opportunity. One has the free time to travel and pursue hobbies and interests that had to be put on hold to fulfill work and family demands earlier in life. Later life can also bring its own set of challenges. The elderly person must adjust to physical and social changes, declines in health, and the death of loved ones. Family members of the elderly person also must make adjustments, most specifically in terms of planning care for the elderly family member within the context of their own busy lives. This chapter discusses some of the opportunities and challenges that later life brings to families.

WHAT IS AGING?

Research on aging looks at the effects of "getting older" in two ways. We can examine population aging and individual aging. Before we examine the effects of aging on the individual and his or her family, we need to briefly examine why the study of population aging is becoming increasingly important and the implications of population aging for family life.

Population Aging

Demographers examine **population aging**, or the distribution of a population's age structure. We say that a population is "old" when it contains a large proportion of elderly people (those individuals 65 years of age and older). In 2006, 13.7 percent of Canada's population were elderly individuals aged 65 years and older (Statistics Canada, 2007c). In comparison, in 1981 the elderly made up only 9.6 percent of Canada's population. It is expected that by 2026, the elderly will make up approximately 21.2 percent of our population (Statistics Canada, 2006c).

There are three major components that affect the aging of a population: mortality or death rates in a population, fertility or birth rates in a population, and migration or movement of people internally (within country) and externally (between countries). The combination of these three components causes changes in size and composition of a population. When at least 10 percent of a population is over 65 years of age, the population is considered "old." We can also look at the median age of a population (if we put all the people living in Canada in order from youngest to oldest, the middle person in this distribution would have the median age). In 2006, the median age in Canada was 39.5 years (Statistics Canada, 2007c).

Demographers, or people who study changes in populations, are interested in the age of a population because this will affect the need for specific types of social supports and resources (e.g., health care) and can help to inform policy-makers on where to allocate resources based on need. Since the population is expected to get older, we can expect that a greater number of elderly individuals will need assistance with such things as health care and assisted living housing. Areas of need in a population are measured by examining dependency ratios. There are three common ways to measure dependency in a population. The **aged dependency ratio** is measured as the number of persons 65 years and older divided by the number of persons between 20 and 64 years old. Note that the 20- to 64-year-old group is considered the group in society that will be working and thus be able to support the "dependent" segments of the population. The **youth dependency ratio** is measured as the number of individuals aged 0 to 19 years divided by the number of individuals aged 20 to 64 years. The **total dependency ratio** in a given population is measured as the number of individuals aged 0 to 19 years plus the number

Box 10.1

Adults Dealing with their Parents' Divorce

As mentioned, the structure of a population can change due to births, deaths, and immigration and emigration. Figure 10.3 shows that a large segment of the working cohort (aged 20 to 64 years) in Canada is made up of immigrants, those individuals who were not born in Canada or who did not have Canadian citizenship at birth (the figure compares the rates in 1981 and 2001). These immigrants will soon move into old age and will thus become "dependants."

What implications might this have on social policy geared toward the elderly and specifically toward elderly immigrants? What additional supports need to be put in place to serve this elderly group? Figure 10.4 shows the distribution of immigrant seniors by province and territory in 2001. Note that Ontario and British Columbia have the highest proportions of immigrant seniors compared to the other provinces and territories in Canada.

of individuals aged 65 years and older divided by the number of individuals aged 20 to 64. These dependency measures can tell us roughly the proportion of dependency in a population as well as where the majority of that dependency is located (young or old). This can affect family life directly as government resources are moved from one area (e.g., funding for youth) to another (e.g., funding for seniors). See Boxes 10.1 and 10.2 for a consideration of structural changes related to immigrant and Aboriginal elder groups that may require changes in policy and resource allocation in the near future.

Box 10.2

Structural Changes in Ethnic Diversity: Indigenous Peoples

First Nations and other Indigenous groups make up about 4 percent of the Canadian elderly population (Statistics Canada, 2005c). According to Statistics Canada, it was expected that the number of Indigenous elderly would double by 2017. the population. Although in terms of the whole population this proportion is still relatively small, this is a significant change for Indigenous communities. Many Indigenous elderly live in poverty. For example, according to the National Advisory Council on Aging (2004), half of the elders in Nunavut and the Northwest Territories receive the Guaranteed Income Supplement, and many more are eligible but have not applied to receive it. Levels of post-secondary education are at one third the rate of the rest of Canadians. More than one third work in unskilled labour (compared to 20 percent for non-Indigenous people). All of these factors affect the quality of Indigenous people's old age. Due to modernization and information exchange through mass media, the elderly are not sought out for their knowledge as much as they once were. However, elderly Indigenous people provide a significant link to Indigenous culture, especially in terms of maintaining language. What kinds of social policy should be put in place to help retain Indigenous culture and to better serve elderly Indigenous today and in the future?

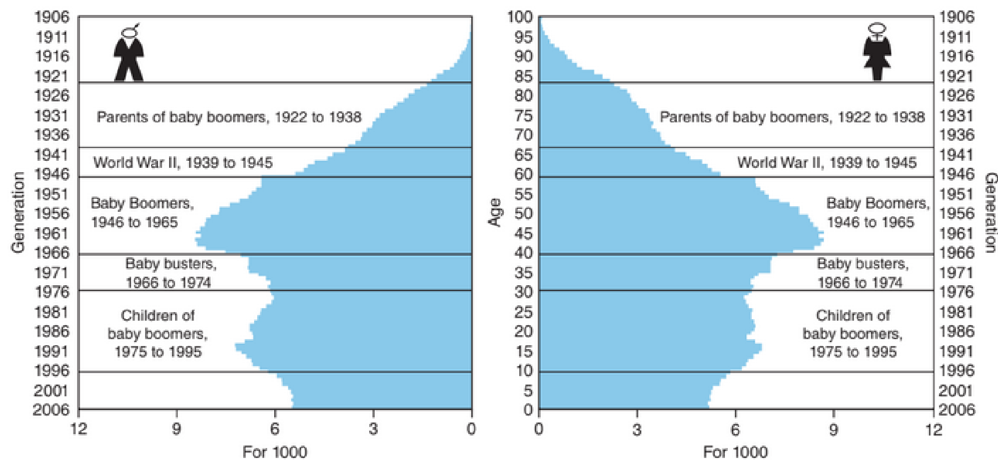


Figure 10.1 Canada's Population Pyramid, 2006

Source: Statistics Canada, Annual Portrait of the Canadian Population in 2006, by Age and Sex, 2006 Census, 97-551-XWE; http://www12.statcan.gc.ca/census-recensement/2006/as-sa/97-551/index-eng.cfm

Population pyramids are graphs that show the distribution of individuals in a popula- tion by age. Often these pyramids are also divided by gender. Figure 10.1 is an example of a population pyramid. This pyramid represents Canada's population structure in 2006. Notice that there are more elderly women than men at the top of the pyramid. Also notice the bulge in the population pyramid that represents the baby boom generation (those born between 1943 and 1960). These baby boomers are just starting to reach old age (65 years and older). If we think about this in terms of dependency ratios, there is some concern as to how the working cohort (those 20 to 64 years old) will be able to support such a large elderly population in the coming years. Another concern is the lack of children being born to "replace" the older group as they die. Notice the

much smaller proportion of children than adults at the bottom of the pyramid.

Canada is not the only country in the world with an aging population. In fact, population aging is a worldwide phenomenon. Many populations have slow growth or no growth, meaning that the rate at which children are being born into a population is not replacing or is barely keeping up with the rate of people leaving a population (through mortality or migration). This phenomenon is split according to development. More developed countries, such as Canada and the United States, have an aging population. Less developed regions, such as Africa and Latin America, have "younger" populations since they have higher fertility rates as well as a shorter life expectancy. However, the birth rates in less developed regions are expected to decline (Kalache, Barreto, & Keller, 2005) and life expectancy is expected to increase (Hayward & Zhang, 2001), leading to aging populations in developing regions in the near future. Figure 10.2 is a graph of the percentage of the population who are seniors in select countries in 2005. Notice that Italy has the highest percentage of seniors while Mexico has the lowest (keep in mind that this graph represents only select countries).

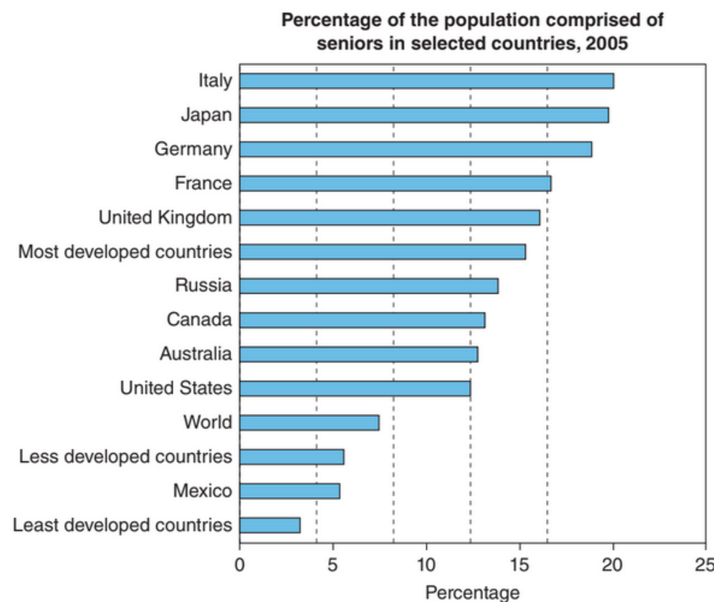


Figure 10.2 Percentage of the Population Who Are Seniors, Selected Countries, 2005

Source: Statistics Canada, A Portrait of Seniors in Canada, 89-519-XIE200600, February 2007; http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=89-519-XIE&lang=eng#formatdisp

Individual Aging

Individual aging consists of the biological, physiological, psychological, and social changes that occur over the life cycle. For example, individual

aging includes the greying of one's hair and the development of dementia. These changes have an impact on the elderly individual as well as on his or her family members, in both positive and negative ways. In this chapter, we examine common changes that occur as we move to the later stages of the life cycle.

Who Is Old?

When we talk about the elderly, we must keep in mind that there is intragenerational diversity within this group. As a result, subcategories for the elderly group have been developed. The **young-old** comprise those aged 65 to 74 years, the **old-old** are aged 75 to 84 years, while the **oldest-old** are aged 85 and older. We can measure "old" by **chronological age** (one's age in years) or by **functional age** (one's age measured by competence or performance). A person can have a functional age that is younger or

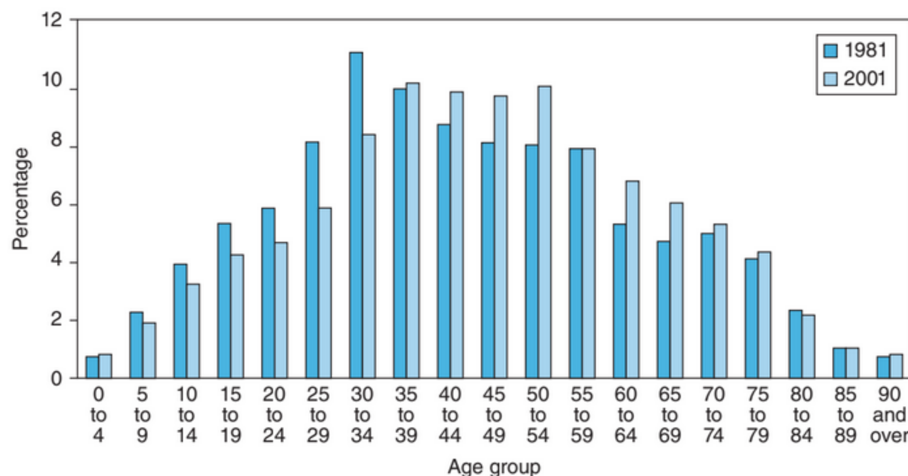


Figure 10.3 Distribution of the Total Immigrant Population, by Age Group, 1981 and 2001

Source: Statistics Canada, A Portrait of Seniors in Canada, 89-519-XIE200600, February 2007; http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=89-519-XIE&lang=eng#formatdisp

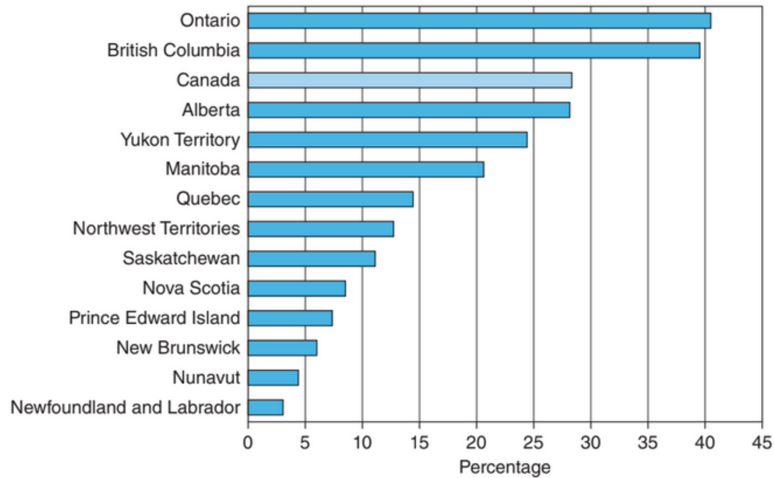


Figure 10.4 Percentage of Immigrants among Seniors, by Province and Territory, 2001

Source: Statistics Canada, A Portrait of Seniors in Canada, 89-519-XIE200600, February 2007; http://www.statcan.gc.ca/bsolc/olc-cel/olc-cel?catno=89-519-XIE&lang=eng#formatdisp

Life expectancy at birth, by sex and province/territory, Canada, 2002			
	Both sexes	**Men**	**Male/Female difference**
Canada	79.7	77.2	4.9
Newfoundland and Labrador	78.3	75.7	5.2
Prince Edward Island	78.8	76.2	5.1
Nova Scotia	79.0	76.4	5.1
New Brunswick	79.3	76.5	5.5
Québec	79.4	76.6	5.4
Ontario	80.1	77.7	4.5
Manitoba	78.7	76.2	4.9
Saskatchewan	79.1	76.3	5.7
Alberta	79.7	77.4	4.5
British Columbia	80.6	78.2	4.7

Yukon	76.7	73.9	6.4
Northwest Territories	75.8	73.2	6.4
Nunavut	68.5	67.2	2.4

Figure 10.5 Life Expectancy at Birth, by Sex and Province or Territory, Canada, 2002

Source: Statistics Canada (2002, p. 45).

older than his or her chronological age. We can also think about "old" in terms of **life expectancy**, or the number of years an individual born in a particular year (cohort) can expect to live (that is, how many years of life he or she can expect to have left). Figure 10.5 shows the life expectancy at birth of Canadians by sex and province or territory, estimated in 2002. Box 10.3 highlights individuals who have lived past their expected lifespan.

Box 10.3

What Are the Limits of the Human Lifespan?

According to the *Guinness World Records*, the oldest person alive (at the time of writing) is Besse Cooper, who was born in Sullivan County, Tennessee, on August 26, 1896. *Guinness World Records* states that based on authenticated records, Jeanne Louise Calment (from France) is the person who lived the longest. She lived to 122 years and 164 days; she was born on February 21, 1875, and died on August 4, 1997. Keep in mind that this is based on documented evidence. Record keeping in the past was not as good as it is today and these claims have been contested. A simple Google search will show many different individuals listed as the oldest man or woman alive.

Image 10.1

https://www.pexels.com/photo/elderly-women-looking-outside-together-6919285/

AGING: A CHALLENGE OR AN OPPORTUNITY?

Individual aging can be perceived as a challenge or an opportunity, or both. Several theorists have marked mid to later life as a time that involves a shift from a focus on self to a focus on others. Erikson (1950), for example, describes mid-life as being a challenge between generativity and self-absorption and stagnation. **Generativity** is the ability to move beyond your own interests and toward helping the generation to come. Stagnation, in contrast, is the inability to find value in guiding and aiding the next generation. Erikson describes this as feeling bored with life tasks and feeling that life is adequate but unsatisfying. Late life, according to Erikson, has its own challenge between finding integrity and living in despair. **Integrity** is the ability to accept one's life as something that had to be rather than regretting what it was not. Despair is the feeling that life has been in vain and is felt by a person who is still not satisfied with how his or her life turned out. Later life, then, can be a time for reflection on the life that was lived with integrity or in despair.

Kotre (1984) also talks about generativity as a major life task for the older adult. He expands generativity to four primary areas in life. There is **biological generativity**, in which people contribute to society by having children. **Parental generativity** involves nurturing and socializing children (who may or may not be one's biological children). **Technical generativity** involves contributing by teaching skills to the next generation, while **cultural generativity** involves passing on cultural values and traditions to the next generation. A person can be generative in one or all of these areas, suggesting that an individual can contribute to society in a number of important ways and, in the process, give their life purpose.

Baltes (1987) suggests a proportional shift in the ratio of gains to losses one experiences over the life course. As we age, we may experience more losses

than gains, but it is important to remember that there are still gains to be made in later life! The following sections discuss some of the major changes that occur in later life, both in terms of loss and gain.

Ageism

One challenge that the elderly face is **ageism**, or the stereotyping of older persons (see Box 10.5 for myths about aging). This is usually negative but may be positive. Ageism is thought to be the result of our fear of and vulnerability to our own aging and eventual death (Martens, Goldenberg, & Greenberg, 2005) and of the fact that, in Canada, the young and old cohorts are largely separated in society (Hagestad & Uhlenberg, 2005). For example, leisure activities are often age-based, which keeps younger and older individuals from interacting with one another. This separation does vary depending on ethnic or cultural background, with many First Nations cultures, for example, integrating the young and the old in traditions and rituals (which may result in less ageism among these groups).

Box 10.4
Thinking about Ageism
Let's end ageism | Ashton Applewhite Watch the above video and answer the following questions: What are your views on aging? Do you feel similar fears to the ones described at the beginning of the TedTalk? Where do you think these common fears come from?

One important point to consider when studying the elderly is that our research must be designed in a way that age, cohort, and period effects are not confused. **Age effects** are outcomes that occur due to one's age or developmental stage. **Cohort effects** are outcomes that occur because one is born in a particular cohort. People born in a particular period share certain socio-historical experiences. For example, individuals who were working adults during the Great Depression often have a "save for the future" mentality and are reluctant to spend money frivolously. **Period effects** are outcomes that occur due to what is happening at the time of measurement. For example, there may be period effects in studies

Box 10.5

Myths of Aging

1. Senility is a normal part of the aging process.
   - Becoming a little forgetful is a normal part of aging. Forgetfulness so severe that it disrupts one's daily life is not normal. Dementia is a severe form of memory loss and is not a normal part of aging.
2. Most older people are lonely.
   - Actually, the number of close friends a person has remains relatively stable over the adult life course. The number of casual friends may decrease. Family is also an important part of life and older people see their adult children and grandchildren often.
3. Most older people are sick.
   - Physical changes do occur as we age but most older adults state that their health is "good" or "excellent."
4. Most older people are victims of crime.
   - Older individuals are more fearful of crime but they are less likely to be robbed, assaulted, or raped. They are more likely, however, to be victims of crime committed by their own family members.
5. The elderly become more religious as they age.
   - The **lifetime stability theory** states that people remain the same throughout their lives. Thus people do not become more religious but rather have been religious throughout their lives. This myth is a result of cohort differences in religiosity.
6. Most older people are non-productive.
   - Older individuals may not be as active in the workforce due to retirement. However, they are "productive" in that they are active grandparents, involved in volunteer activi- ties, and sometimes employed part-time.
7. People who retire experience a decline in health and die quickly after retirement.
   - This used to be true when the typical lifespan was 46 years. Today, with people living well into their eighties and nineties, this is simply not true.
8. Older people have no interest in and lack the ability for sex.
   - Once again, the lifetime stability hypothesis applies here. People who were active sexually in early

adulthood will continue to be so in later life. The way in which people express sexuality may change (e.g., more cuddling) to accommodate physical changes, but sexuality is still a large part of life.

9. Most older people end up in nursing homes.
   - The majority of elderly people live in their own homes or with family and friends. Community support makes it possible to live independently. Only about 5 percent live in nursing homes long term. Often these residences are used for rehabilitation purposes and the older individual returns home afterwards.

Source: Adapted from Wilken (2002).

conducted during the bursting of the dot-com bubble or during the introduction of a particular technology (e.g., televisions, computers, ultra-broadband). Failing to separate age, period, and cohort effects leads to the **developmental fallacy** in which cross-sectional age differences are interpreted as developmental change. For example, in early studies of intelligence quotient (IQ), it was believed that IQ drops with age (e.g., see Wechsler, 1939). This is because the effects of age (natural aging) and cohort were not taken into account (separated). Giving the same IQ test to an elderly individual and a young adult may show a drop in IQ. However, we need to consider different educational standards and opportunities (young adults today largely finish high school and attend university, while a very small proportion of the elderly had the opportunity to go to university in the past) (Novak & Campbell, 2010). The way in which tests are constructed may also be a factor (again, young adults today have much more practice with multiple-choice exams, whereas the elderly may not have had as much exposure to these types of tests). Longitudinal studies of intelligence (in which the same individuals are followed and retested over time) show much less decline in intelligence (Schaie, 1990).

Types of Aging

Aging can be examined in several ways. **Chronological aging** is measured as the passage of time. Some events that occur during the life course are based on our chronological age. For example, Canada has a legal drinking age (which varies by province or territory), a legal driving age (assuming that you pass the driving exam), and a legal voting age. **Biological aging** deals with the physiological changes that occur over time. For example, bone mass loss (Bee, 1998) and a reduction of growth hormones occur as we age (Murray, Zentner, Pangman, & Pangman, 2006). **Psychological aging** deals with changes in personality, cognition, emotional arousal, memory, learning, and motivation. **Social aging** includes the changes in our social roles and social status over time (e.g., retirement is a status change from “working” to “non-working”). We will

focus on biological and psychological aging in the following subsections. A discussion of social aging follows that.

Biological Aging Biological aging is a process of physical deterioration that occurs over time. Biological aging can occur due to internal (intrinsic) factors. For example, as we age, we lose lung capacity and brain cells and our arteries harden (McPherson & Wister, 2008). Biological aging can also occur due to external or (extrinsic) factors. For example, exposure to the sun and loud noise and our personal health habits (diet and exercise) can all have effects on the aging process (Health Canada, 2003).

There are three main areas of physiological effects with regard to aging: effects on the musculoskeletal system, effects on the endocrine system, and sensory changes. Musculoskeletal effects include losses in muscle mass and bone density as we age (Bee, 1998). This process begins between the ages of 20 and 30 years! Exercise can help to reduce muscle loss and the rate of bone decline. Weight-bearing exercise, in particular, builds muscle, increases bone density, improves balance, maintains weight, and lubricates joints (Blumenthal et al., 1991).

In the endocrine system, during later ages, a water imbalance in the kidneys may occur due to a malfunctioning hypothalamus (Gormly, 1997). Adrenal glands also decrease the production of sex hormones (Murray et al., 2006). Menopause begins between the ages of 45 and 55 years in women. Men, too, experience decreases in testosterone levels beginning in their twenties.

Box 10.6

The Drug Dilemma: The Need for “Elder-Friendly” Medications

Katherine asked her elderly father if he would mind taking care of her dog while she was away on a business trip. The dog, also in its elderly years, and her father were very fond of each other and had spent many afternoons going on long walks together while Katherine was at work. Katherine’s father immediately agreed.

The dog needed to take several different medications twice a day, as it had developed a heart

Just write this down. She needs one large white pill, one small white pill, one-and-a-half green pills, and one blue pill.”

Her father started to get agitated. “Okay, I have the large white pill and the small white pill, but I only see green pills. There aren’t any blue pills . . . there aren’t any blue pills!”

Suddenly Katherine realized that this wasn’t going to work. Because her father was elderly

condition. To make things easier for her father, Katherine arranged the dog's pills in a pillbox that had compartments for each day of the week (Monday to Sunday) and also had AM and PM compartments per day. All her father had to do was

open the correct compartment (e.g., Monday AM or Monday PM) and add the pills to the dog's food. As Katherine was settling into her hotel room, her father called in a panic: "I opened the pill box and all the pills fell onto the floor—all of the pills for the *whole* week! I picked them up but now I don't know what pills to give the dog! They all look the same!"

"Don't worry, Dad," Katherine said, "I will tell you which pills you need over the phone.

and had some yellowing of the lenses in his eyes, he could no longer distinguish between the colours light green and light blue. Giving the wrong pills in the wrong doses could cause her dog to have heart failure.

"Don't worry, Dad," she said, "I'll call Frank. He'll be able to sort this out." Frank was Katherine's brother.

"Katherine," her dad said, "what if these were my pills and you or your brother weren't around to help? How would I know what pills to take?"

"If that time comes, Dad, I'll be sure to get the pharmacist to cut the pills into shapes for you," she said.

Sensory changes also occur. A decrease in our ability to smell can cause a loss of interest in food and an inability to smell rotten food (Stevens, Cruz, Marks, & Lakatos, 1998). A loss in temperature and vibration sensations (touch) can lead to slower reaction time to pain and the potential for burns (Gescheider, 1997). Several changes in vision can occur (see reviews by Fozard & Gordon-Salant, 2001; Kline & Schaie, 1996). A reduction in our ability to make tears can lead to "dry eye" syndrome. Yellowing of the lenses can make distinguishing between colours such as green and blue or yellow and white difficult (Murray et al., 2006). This can be problematic when taking several medications that are all the same shape but "colour coded" for the normal eye (see Box 10.6).

Weakened eye muscles can lead to limitations in eye rotation (and thus have effects on peripheral vision). A loss of sensitivity to light can make it difficult to drive or to read a menu in a dimly lit restaurant. Hearing loss can lead to social isolation and depression since the individual is not able to participate fully in discussions (Murray et al., 2006). Older adults also report sleep difficulties (Dowling, 1995). They may compensate by taking naps, but one aspect of sleep called "slow wave" sleep declines as we age (Weiten & McCann, 2007). Loss of this type of sleep does not allow an individual to wake up feeling refreshed from a good night's sleep. Other sleep disorders that occur with age include respiratory problems, sleep apnea, and restless leg syndrome (American Nurses Association, 1995). Elderly individuals and their families must learn to cope with these changes. Although these changes sound negative, keep in mind that these sensory changes occur gradually and individuals generally learn to adapt and adjust as they occur.

On the positive side, the **compression of morbidity hypothesis** states that more people today than in the past postpone the onset of chronic disability; therefore, the period between being seriously ill and death has been compressed (shortened). The three most prevalent illnesses causing death and functional disability in later life are heart disease, cancer, and stroke (Statistics Canada, 2007b).

Acute (short-term) conditions are more debilitating and require more care. Chronic conditions are considered long term (more than three months), and often these are permanent conditions that require long-term management. Assessing an older person's capacity to be able to perform basic self-care is measured by the activities of daily living (ADL) and instrumental activities of daily living (IADL) scales. The ADL scale assesses whether individuals can bathe themselves, dress themselves, go to the bathroom on their own, get out of a bed or chair on their own, walk on their own, get outside, and feed themselves. The IADL scale measures more complex activities, such as one's ability to prepare meals, go shopping, manage money, use the phone, do light housework, and do heavy housework. Difficulties in these areas have been found to be related to age and sex. Increasing age is associated with more difficulties with these tasks, as is being female. There are three proposed reasons why women report more difficulty with items on the ADL and IADL scales. Culturally, it is more acceptable for women to be ill (the stereo- type that women are fragile), and therefore women are more comfortable reporting such difficulties. Women also use medical services more than men, so difficulties with ADL and IADL tasks are more likely to be detected. Finally, women's roles may in fact be more stressful (e.g., the double shift), and therefore there may be more real illness among women (McPherson & Wister, 2008).

Psychological Aging As mentioned in Box 10.6, there are some losses associated with memory as we age. Large losses occur in **episodic memory**, or memory for personal events and experiences (Bäckman,

Small, Wahlin, & Larsson, 2000), and in **working memory**, or our ability to hold a small amount of information in an available state (Hoyer & Verhaeghen, 2006). Smaller losses are found in **implicit memory,** a type of memory where you do not need to think to perform a task—a sort of automatic pilot based on previous experiences and skill development. For example, once you learn how to play the piano, as long as you continue to practise you will not have huge deficits in your ability to play. You certainly will remember where to place your fingers on the keyboard. There are also smaller losses associated with **semantic memory**, or memory for factual information (Hoyer & Verhaeghen, 2006).

The main factor that affects our ability to process information is attention (Weiten & McCann, 2007). **Selective attention** is the ability to focus on relevant information while ignoring what is irrelevant. **Sustained attention** is the ability to stay focused on a particular thing over time. **Attentional control** is the ability to multi-task with our attention, so to speak—to allocate our attention over several different things at the same time. These abilities are learned! Therefore, losses in these areas as we age are a result of our lack of practice.

One of the “gains” in terms of psychological change in later life is the development of wisdom. **Wisdom** is the ability to apply knowledge of life events and conditions to make optimal decisions when trying to solve life problems. What this means is that older people may be better at foreshadowing problems (problem finding) and problem solving due to their vast life experiences (Dixon, 2000). First Nations cultures hold their elderly in high regard because they are believed to hold wisdom. In this sense, later life is a stage one aspires to reach, as one becomes the holder of valuable life knowledge.

The most common psychological disorders in later life are depression, anxiety, dementia (including Alzheimer’s disease), and alcoholism (McPherson & Wister, 2008). However, for most elderly individuals, global or subjective well-being does not decline with age (McPherson & Wister, 2008). Compared to younger adults, older adults tend to have less negative emotion, comparable positive emotion, more emotional control, and more emotional stability. Thus for most individuals in later life, negative emotions are not a problem; instead, the elderly tend to be as happy as those in mid-life (Ebersole & Hess, 2004).

What causes some elderly individuals to be depressed while others feel happy? Ryff (1995) proposed seven key dimensions of well-being. These include (1) positive self-evaluation and self-acceptance, (2) positive relationships with other people, (3) having autonomy and self-determination, (4) having mastery over one’s environment, (5) effectively managing one’s life, (6) having a sense of purpose, and (7) having a feeling of growth and development as a person. Among older individuals, environmental mastery and autonomy are higher but purpose in life and personal growth are lower than for younger adults (Ryff, 1995).

Problems occur when psychological stress develops. Negative cognitive and emotional states result when the demands of life exceed one's ability to cope. As stress increases, negative emotions increase. For the elderly, stress leads to related impairments in cognitive ability (such as the ability to perform a task), attention, concentration, memory, and judgment. One important side effect of stress is that stress causes the body to release a chemical that stops the activity of the thymus gland (Karren, Hafen, Smith, & Frandsen, 2006), which is the master gland involved in the immune system. When an individual is highly stressed or stressed for long periods, the thymus gland stops producing T cells, which are needed to fight viruses and bacteria. This makes the individual more vulnerable to infectious agents.

There are three basic types of coping associated with positive emotions during chronic stress. **Positive reappraisal** occurs when an individual tries to focus on the good aspects rather than the bad. **Problem-focused coping** occurs when an individual focuses his or her thoughts and behaviours on things he or she can do to manage or resolve the underlying cause of the stress. The third method of coping is to create positive events for oneself. For example, a person can take pleasure in a beautiful day or have a good laugh.

Coping is also dependent on one's locus of control. If a person has an **internal locus of control**, he or she believes that control over life events resides within himself or herself. Thus, the individual is more likely to confront a problem directly because he or she expects that his or her behaviour will make a difference in the outcome. The individual is more likely to accept responsibility for what is happening in his or her life. If a person has an **external locus of control**, he or she believes that life outcomes are due to fate, chance, God, or other people. The individual tends to respond defensively to a problem or deny that it exists. He or she lacks action to deal with the problem. Research has shown that individuals in later life with an internal locus of control tend to have higher well-being and a more positive view of themselves (Karren et al., 2006). Therefore, it seems that having an internal locus of control is the better way to go. However, when the cause of stress is something that cannot be controlled (e.g., a life-threatening disease such as cancer), individuals with an internal locus of control have lower well-being than those with an external locus of control because they cannot actually control the outcome!

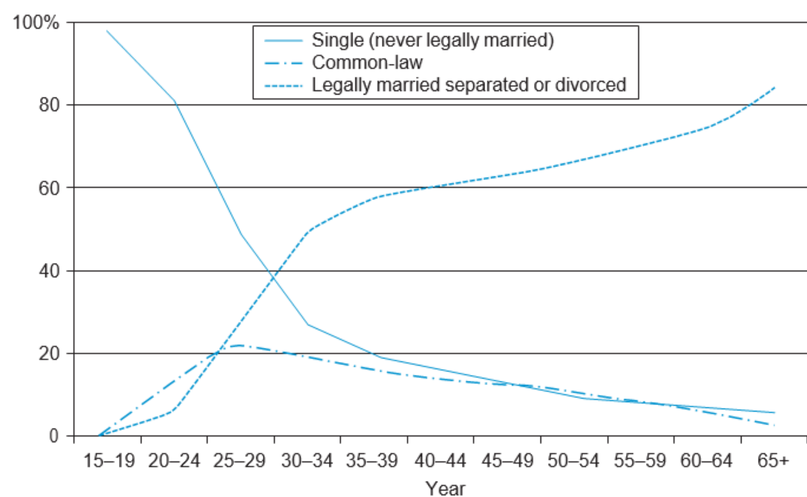
Thus far we have discussed changes within the individual with which the elderly person and his or her family members must learn to cope. This stage of life also has several social changes that affect interactions between family members.

Changes in Relationship Status

As in other life stages, changes in relationship status occur during later life. Although most young-old continue to remain married, one new stage that occurs for the majority of elderly individuals is widowhood. According to Statistics Canada (2006d), approximately 30 percent of individuals aged 65 years and older are widowed. Widowhood occurs more frequently for women than for men. About half of women aged 75 to 79 years are wid- owed, while only 16 percent of men of this age are widowed. This occurs in part because women marry older men (about two years older on average) and are less likely to remarry (Beaujot, 2000).

Only about 5 to 6 percent of the elderly are divorced and 10 to 13 percent of those aged 65 years and older have experienced a divorce in their lifetime (see Figure 10.7). We expect these rates to increase as younger cohorts move into later life, since there is more acceptance of divorce today than in the past. An interesting point to consider when talking about rates of divorce and remarriage across the life course is that for many older individuals, there are few benefits to divorcing. Often older adults will simply separate and live the rest of their lives as separated individuals. Without the need or desire to remarry, the costs of a formal divorce may outweigh the benefits. Divorce in general is more difficult economically for women than for men (Galarneau & Sturrock, 1997), because traditionally men have been the breadwinners and women are the homemakers depending on their husbands for financial support and because women are less likely to form a post-divorce union.

Figure 10.5 Conjugal Status of Population by Age Group, Canada, 2006



Source: Statistics Canada (2006c).

However, older men also lose financially after divorce because they cannot regain their lost income since they are no longer working (at least

not full time) (Keith, 1985). Divorce also erodes one's support network (Martin-Matthews, 1991). Friends do not want to have to pick sides in terms of to whom they will be loyal. The loss is said to be greater for men than for women, as men typically have a smaller support network (friends who they can emotionally talk to and rely on) (Lin, 2008). Women are often **kinkeepers**, or the individual in the family who keeps family members connected, so men tend to lose family connections as well. Divorce can also affect grandparent–grandchild relations as it changes the balance of resources (Downs, Coleman, & Ganong, 2000). Whereas the older person could once buy things for the grandchild, he or she may no longer be able to do so as easily. Divorce also disrupts family links, making it difficult for adult children and grandchildren to spend time with both parents, especially on holidays.

Following divorce is the potential for remarriage. Remarriage rates are higher for men than for women (Calasanti & Kiecolt, 2007). Often this is due to a marriage squeeze (discussed in Chapter 5). An imbalance in the **sex ratio** (the number of marriageable men to the number of marriageable women) can make it difficult for older women to find new partners. Since women live longer than men (there are fewer men in the oldest-old group) (Statistics Canada, 2002) and heterosexual men tend to marry women younger than themselves, older heterosexual women often are squeezed out of marriage (Chappell, McDonald, & Stones, 2008). Generally, those in poor health, those with poor finances, and the very old do not remarry. There also are fewer incentives to remarry at this stage in life. There is no need to conform to life cycle timing for marriage (which occurs in the late twenties and early thirties), the elderly are not going to have children together (another main reason why people decide to get married when they are young), and often older individuals feel the need to protect their estate (and sometimes there is strong pressure from the family to do so!) (Talbott, 1998). Positive reasons to remarry include enlarging your kin network, being generally happy with the relationship, having increased financial and emotional stability, and enhancing relationships with your children (if the children are supportive) since you will become less of a burden to them.

One group of elderly we don't want to forget about is those who never married. Educated women make up the largest proportion of this group (Seccombe & Ishii-Kuntz, 1994). With no economic need for a spouse, decreasing stigma associated with remaining single, and the marriage squeeze as described above, getting an education before getting involved in a serious relationship often leads women to be squeezed out of marriage. The assumption about never-married individuals is that they are lifelong social isolates (Gubrium, 1975). Although they do spend less time with their relatives (Seccombe & Ishii- Kuntz, 1994), never-marrieds have a high rate of co-residency (Stull & Scarisbrick-Hauser, 1989), strong friendship groups (McDill, Hall, & Turell, 2006), and close ties with their siblings (Rubinstein, Alexander, Goodman, & Luborsky, 1991).

Never-married individuals usually have no children, although this isn't always the case. Some say that they regret never marrying (Rubinstein, 1987) and some report being lonely, but they generally have high well-being and are spared spousal bereavement and desertion (Pudrovska et al., 2006).

Empty Nest

A new stage for most elderly individuals (those who have children) is called the **empty nest**. This occurs when their children leave the family home to start their own lives and establish their own residences. For most, this is a time of increased satisfaction (Guttman, 1994). The job of parenting is more or less done and one has time to pursue new or old hobbies and interests that may have been put on hold while busy with parenting (see Box 10.7 for an example). Children leaving the home is called **launching**. Delayed launching, however,

Box 10.7
The Red Hat Society
The Red Hat Society is an international society for women in mid-life and later life. It was founded by Sue Ellen Cooper in 1998 and currently has more than 20,000 chapters across the United States and in 25 other countries. Women over age 50 are called "red hatters" and women under 50 are called "pink hatters." The purpose of the group is to encourage women to pursue their lifelong dreams, fun, freedom, friendship, and fitness. The group is dedicated to "reshaping the way women are viewed in society" by raising the visibility of aging women. Members wear red and purple at their events (or pink and lavender if under 50).

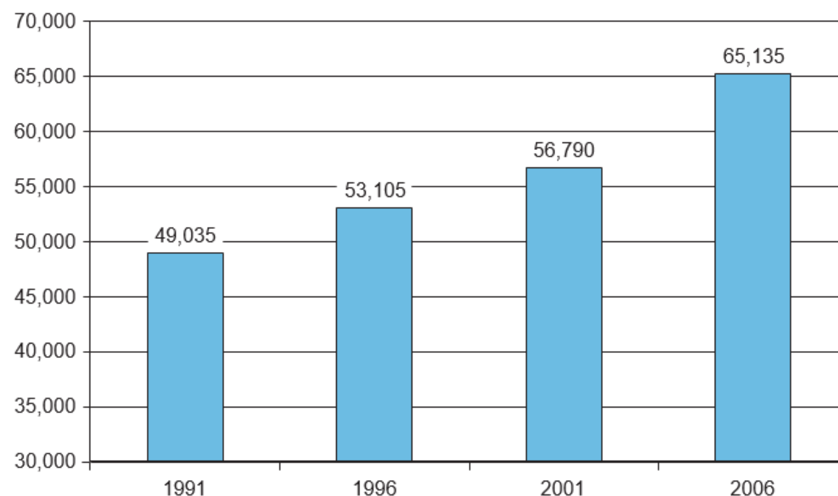
can decrease satisfaction. Parents think that they have failed in some way because their children are not moving on to become responsible, productive members of society. As more and more young adults pursue higher education, taking longer to settle into careers and as a result partnering at older ages, launching often does not occur until the children reach their late twenties (Statistics Canada, 2001). This varies by culture and ethnicity, with many individuals of South Asian, Asian, and European descent staying in the parental home well into their late thirties (Gee, Mitchell, & Wister, 2001).

Another issue is the return of adult children to the parental nest. This may occur due to the children's separation or divorce, job loss, or simply an inability to "make it" on their own. When children refill the nest, they are called **boomerang children**. Sometimes, children never leave but rather establish their new families as co-residents in the family home. Once

again, this varies by cultural background; it is a common residential pattern for those of Asian descent, for example. In these cultures, the adult child is expected to reside with his or her parents and take care of them. This is called a **cluttered nest** and occurs when the family home has more than one family of procreation living in it. According to the Vanier Institute of the Family (2010), 60.3 percent of adult children aged 20 to 24 years and 26 percent of adult children aged 25 to 29 years lived in the parental home in 2006. Approximately 34.7 percent of boomerang children return home to attend school, 24 percent return for financial reasons, and 10.5 percent return due to a relationship ending.

Finally, there is a growing trend for the elderly to take on the responsibility of raising their grandchildren as primary caretakers (see Figure 10.6). This, however, is not normative (Stepan, 2003) and may occur for a number of reasons. The biological parents may be in trouble with the law, have addictions, be dead or ill, or be teen parents who are unable to cope with the demands of parenting.

Figure 10.6 Children (All Ages) Living with One or More Grandparents with No Parent Present, Canada, 1991 to 2006.



Source: Statistics Canada (2006d).

Grandparenthood

Grandparenthood usually occurs in middle age. By the time a person reaches later life, they usually have teen grandchildren. However, since the age at marriage and the age at first birth have been increasing, this may not remain the case among future generations of the elderly. There has been a steady increase in the number of grandparents who become custodial caregivers of grandchildren (see Figure 10.8), although this is not the dominant role of grandparent. Generally, the role of grandparent is

more flexible than that of parent. Grandparents are usually told what not to do by their adult children. The role of grandparent is also not chosen; you become a grandparent if your own children choose to become parents. As well, parents often mediate the relationship between the grandparent and the grandchild. For example, they do not get to visit each other unless the parent approves.

There are three main types of grandparents. The **companionate grandparent** is the most common type. These grandparents are close to their grandchildren but do not have a parental role. **Remote grandparents** are the next most common type. Here the grandparent is less involved in the grandchild's life, usually because they live far away from one another. **Involved grandparents** are the least common type, but they have parent-like duties. They are less warm than companionate and remote grandparents (because they must discipline their grandchildren). Grandmothers generally tend to emphasize closeness and fun. Grandfathers like to assume the role of adviser (Russell, 1986). Gender differences are exaggerated depending on lineage. Paternal grandfathers are more masculine (e.g., they play-fight more often) than maternal grandfathers (who are more nurturing).

When the grandchild becomes a teenager, the relationship may become more withdrawn as the teen tries to become more independent (Cherlin & Furstenberg, 1986). Often teen grandchildren do errands for the grandparent. The age of the grandchild affects the amount of control the parents can have in mediating the grandparent–grandchild relationship (Troll, 1985). Young grandchildren have no control over visits by grandparents. Teen or adult grandchildren can form independent relationships with their grandparents. Thus, contact with a grandchild depends on the age of the grandchild. Another factor affecting the amount of contact is the relationship with the parent. Conflict with their own adult children can limit contact with grandchildren (King & Elder, 1997). Separation or divorce of adult children can also have an impact. Contact will increase if the grandparent's own child has primary custody of the grandchildren (Hilton & Macari, 1997). Conflict with ex-spouses reduces contact. Since child custody used to go to mothers more often than not, maternal grandparents tended to have more contact with grandchildren than paternal grandparents (Uhlenberg, 2004). With child custody arrangements changing, the impact on grandparent–grandchild relationships is also changing. In addition, as middle-aged children repartner or remarry, the elderly also may become step-grandparents. This is a new role with few established expectations and thus one that may require some negotiation.

Image 10.2

Retirement

In the past, retirement was viewed as a negative event. The purpose of one's life (especially for men) was diminished since they were no longer in the workforce. This is no longer true. Early retirement is now seen as a worthwhile goal (only those that "have made it" can afford to do so in style). Greater retirement income makes it possible for some workers to quit earlier than the established standard retirement age of 65 years. Typically, people choose to retire earlier rather than later (Statistics Canada, 2003b). An equal number of individuals say that they retired "just because" as those who say that they did so for health reasons.

As the provider role for men is diminished in retirement, they must search for substitute activities. For an elderly couple, this can be a challenging time if the couple failed to establish shared interests before retirement. More time available to spend together can lead to irritation or to greater intimacy (Chappell et al., 2008). Men seek increased companionship from their wives. Many homemakers, however, report less freedom as they increase couple activities at the expense of individual ones. Married women tend to retire earlier than unmarried women. This is due to economics (having adequate income saved) as well as to the age of their spouse (women in heterosexual relationships specifically tend to retire around the same time as their husbands do, although this trend is in decline). Older couples also make other adjustments, such as reducing their work hours. According to the Vanier Institute of the Family (2010), 11

percent of older men and 28 percent of older women worked part-time in 2006.

Among the current cohort of elderly, the pattern of work and retirement is rather uncomplicated. The general life course was to marry young (heterosexual women marrying men slightly older than themselves) and soon after have children. Divorce was unlikely and there was a gendered division of labour (men as the breadwinners and women as the homemakers). Men tended to go to work once they finished their schooling and worked until retirement. Women worked in the domestic sphere and if they did work outside the home, it was secondary to their domestic work (McDonald, 2002). Thus, "retirement" is less meaningful for the current cohort of elderly women, as domestic work continues regardless of one's age (that is, you don't get to retire from doing housework).

Income of unattached elderly (never married, separated, divorced, and widowed) has increased. According to the Vanier Institute of the Family (2010), these improvements reflect gains from "market" sources (private pensions, investment income, and earnings) as well as significant increases in transfer payments received through government programs (see Figure 10.7). The poverty rate among the elderly has declined from 29 percent in 1976 to 4.8 percent in 2007 (Vanier Institute of the Family, 2010). Levels of poverty are higher for unattached elderly individuals than for those in families, but have dropped to 13 percent and 14.3 percent for unattached elderly men and women, respectively (Vanier Institute of the Family, 2010). See Figure 10.8 for median net worth by age of the major income recipient in the family.

Box 10.8

The Retirement Gap in the Australian Indigenous Community

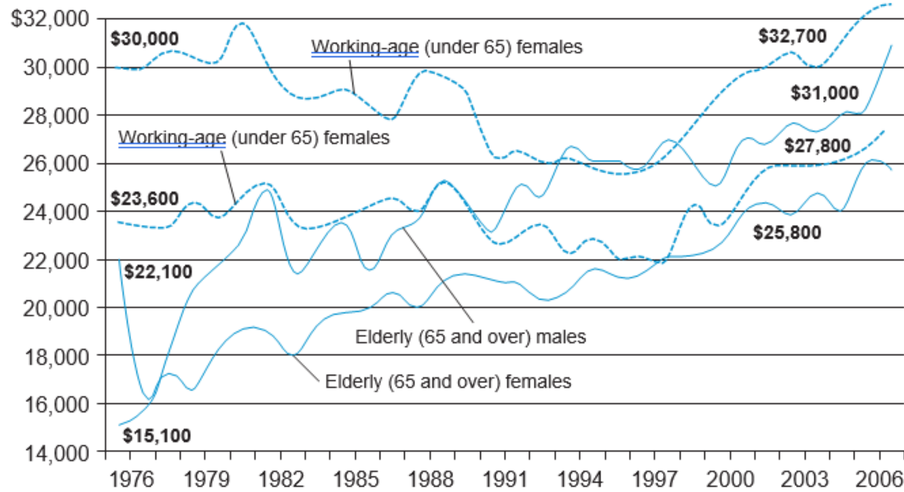
The retirement gap, which refers to the gap between one's retirement savings and the actual cost of retiring, is 27% among Indigenous workers in Australia than non-Indigenous workers. Improving educational attainment and programs to help improve Indigenous health may help narrow this gap. When life expectations are improved for the indigenous population, other measures like higher contribution rates may then be considered to narrow the retirement gap.

Source: Bianchi, R. J., Drew, M. E., Walk, A. N., & Wiafe, O. K. (2016). Retirement adequacy of Indigenous Australians: A baseline study. *Economic Papers: A journal of applied economics and policy*, *35*(4), 359-374.

Caregiving

As the vignette at the beginning of this chapter illustrated, family members often face the need to provide care for their aging relatives. In 2006, about 21 percent of

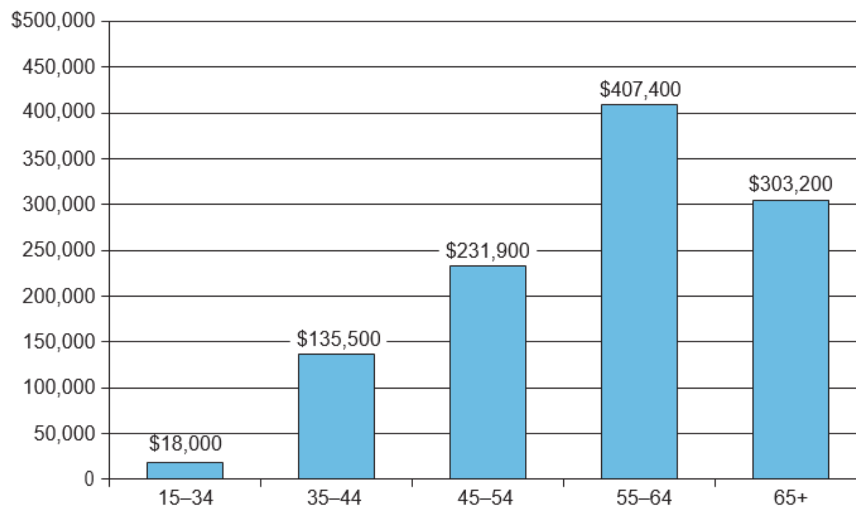
Figure 10.7 Average After-Tax Incomes of Unattached Individuals, in Constant 207 Dollars, 1976 to 2007



Source: Statistics Canada (2009).

women and 16 percent of men provided care to an elderly individual. Individuals aged 45 to 54 years are most likely to provide care (Vanier Institute of the Family, 2010). Many of these individuals are also providing care to their children. Thus,

Figure 10.8 Median Net Worth by Age of Major Income Recipient, 2005



Source: Statistics Canada (2006g).

Table 10.1 Profile of Caregivers Providing Elder Care to Seniors with Long-Term Health Conditions, Population Aged 45 Years and Older, 2007

	Caregivers	Non-Caregivers
	Percentage Distribution	
Age		
45–54	43%	38%
55–64	32	28
65–74	16	18
75+	8	16
Gender		
Men	43	49
Women	57	51
Marital Status		
Single	7	6
Married or common-law	76	72
Widowed	7	11
Divorced	10	11
Work Status		
Employed	57	51
Retired	31	34
Other	12	15

Source: Cranswick and Dosman (2008).

they are often referred to as the **sandwich generation**. Most caregivers report coping "very well" (54 percent), many said they were "managing" (42 percent), and others reported giving up their own social activities (34.7 percent) and spending less time with their spouses (17.5 percent) and their children (15.1 percent) as a result of caregiving (Vanier Institute of the Family, 2010). As shown in Table 10.1, the majority of caregivers are in mid-life, partnered (married or common law), employed, and female, suggesting that those providing care to the elderly are juggling other family and work responsibilities.

When an older person needs care, it can be psychologically difficult for both them and their family members. Adult children feel a sense of irredeemable obligation; they can never do enough for their parents. The elderly parent, however, feels a loss of power. The primary reason why children report caring for their parent is because the parent looked after them when they were young (Dwyer, Lee, & Jankowske, 1994). If they were parented poorly, they feel less obligated to their aging parent. Although less able to provide forms of support that require physical functioning, an elderly person generally can still provide emotional, practical, and financial help to the adult children. This helps to maintain a sense of power. However, when an elderly person receives assistance due to his or her own failing health, an emotional strain is felt (Newsom & Schulz, 1996). Interestingly, the amount of help received from a child is not equal to the level of affection an elderly person feels for that child. The

generational stake hypothesis states that “older parents have a greater stake than children do in the parent–child relationship because of their desire to see their value and lives continued through their children” (Connidis, 1989, p. 60). Thus, the elderly parent will report more affection between themselves and their children than the children do.

Abuse

Abuse occurs across the life course, and later life is no exception. **Elder abuse** is defined as any act occurring within a relationship where there is an implication of trust that results in harm to an older person. Abuse can be physical, psychological, sexual, financial, or neglect. **Physical abuse** includes any use of physical force against the elderly person. This can include an inappropriate use of drugs or restraints, or punishing the elderly person for misbehaving. **Psychological abuse** includes verbal threats, intimidation, enforced social isolation, and humiliation. **Sexual abuse** is any non-consensual sexual contact. This also includes having sexual contact with a person incapable of giving consent (e.g., a person with dementia). **Financial exploitation** is the illegal or improper use of an older person’s funds, property, or assets. This can include cashing cheques without permission, forging a person’s signature, misusing or stealing possessions, coercing or deceiving a person into signing documents he or she does not fully understand, and improper use of conservatorship, guardianship, or power of attorney. Elder neglect can include active neglect, passive neglect, and self-neglect (although in this last case, the elderly person is abusing himself or herself). **Active neglect** occurs when a caregiver refuses to provide the services that the elderly person needs. **Passive neglect** is the non-intentional failure of a caregiver to provide appropriate services to the elderly individual because he or she does not have adequate knowledge of what is available and what is necessary for proper care. **Self-neglect** occurs when the elderly person himself or herself fails to follow medical directives (intentionally or unintentionally) and does not take proper care of himself or herself.

Who is abusing the elderly? Research has shown that 71 percent of abusers are adult children and spouses. Elderly women are equally as likely to be abused by a child (37 percent) as by a spouse (36 percent) while elderly men are most likely to be abused by a child (43 percent) (National Advisory Council on Aging, 2003–2004). Risk factors for abuse include shared living situations, dementia, social isolation, caregiver mental illness or substance abuse, and the caregiver being dependent on the elderly person (Lachs & Pillemer, 2004).

There are many reasons why elder abuse is hard to detect and prevent. The older adult may not seek help because he or she may not recognize the situation as abuse (McPherson & Wister, 2008). Often abuse starts

earlier in the life cycle and becomes “normal” in the eyes of the elderly individual. For example, a spouse could be psychologically abusive for many years before becoming half of an older couple. Older persons may not report abuse because they think they will not be believed, they think nothing will change, or they think their caregivers will get angry and the abuse will get worse (Beaulaurier, Seff, Newman, & Dunlop, 2007)! Often they are also ashamed and embarrassed. The abusing caregiver is usually a family member, and thus older adults are reluctant to let others know they have a “bad” son, daughter, or spouse. They may even blame themselves for the abuse, thinking that if they weren’t such a problem or so much work, their caregiver would not get so angry. Some individuals cannot report abuse because they are socially isolated (by the caregiver or by their own disabilities) and physically unable to report the problem (McPherson & Wister, 2008). Cognitive diseases and communication deficits make reporting difficult. The elderly are also prone to bruising and falling, so outsiders may not be sure whether outward signs of abuse are actually the result of abuse.

End of Life

The response to impending death varies from person to person and can be influenced by cultural or religious beliefs about what occurs to the individual following death. Dying is more than just a biological act. There are social and emotional implications for the individual and his or her family and friends. Kübler-Ross (1969) proposed five stages that an individual will go through in the process of dying: (1) denial, (2) anger, (3) bargaining, (4) depression, and (5) acceptance. Not everyone will go through all of these stages or go through the stages one at a time, but this describes the general pattern of moving to acceptance for most individuals in North America. The grieving process for those left behind includes letting go of the dying individual as well as coming up with new ways to maintain connections with other family members and friends. Conflicts may occur as family members try to determine how the loved one should be cared for at the end of life (Matthews, 2002). The role of non-kin is often unclear. They may be cut off from the loved one and excluded from end-of-life planning. Institutions often will not allow non-kin to visit those who are critically ill and dying. This has been a concern among older gay and lesbian couples. They are concerned that their role in their partner`s health care plan will not be recognized by service providers (McFarland & Sanders, 2003). Care homes, hospices, and hospitals also can be restrictive for Indigenous individuals, as they often have policies that prevent end of life ceremonies such as smudging (Anderson, 2018).

“Death rituals are rites of passage that provide formal recognition of the transition from life to death” (Chappell et al., 2008, p. 432). These rituals

help family and friends to accept the death of their loved one and provide support so they can continue in life without them. Common options in Canada include burial, cremation, and entombment. Cremation is becoming more and more popular, as it costs less than a traditional burial. First Nations groups celebrate the “circle of life,” and see death as another stage in that circle (Anderson, 2018). This is often represented in Medicine Wheels which are divided into physical, emotional, and spiritual parts - these parts emphasize the fact that death in the traditional sense is only physical, and that death of all parts of the self may not occur simultaneously (Anderson, 2018).

CONCLUSION

This chapter has examined what it means to “age,” both from a demographic and individual point of view. Demographically speaking, we are concerned about the aging of a population since it may have implications for available resources and the allocation of these resources to various segments of the population. From an individual perspec- tive, this stage in the life course can bring many changes—physical, psychological, and social—that the individual and his or her family members must adjust to and negotiate. These changes can be seen as new opportunities (e.g., retirement, grandparenthood) or as new challenges (e.g., physical slowing and decline, widowhood). Maintaining a positive attitude throughout these changes can help to ease the transition, but what else can one do to age successfully?
Successful aging is defined as a combination of physical health, psychological health, and an active involvement with society (Rowe & Kahn, 1997; see Figure 10.12). A few key tips to successful aging are eating a low-fat diet and getting adequate exercise (Health Canada, 2003). Having a body mass index (BMI) that is either too low or too high causes health burdens (Must et al., 1999). Thus, eating a proper diet can help to increase longevity. Both heart disease and cancer have been found to be reduced by exercise. Staying fit can prevent, delay, or even ease some chronic conditions (Ebersole & Hess, 2004). Exercise also has psychological benefits (Blumenthal et al., 1991). Having an exercise partner, education about appropriate exercises to perform, and recommendations from doctors can boost exercise regimens. Finally, having a strong social support network (family and friends) can help to buffer an individual from the effects of stress (Ross, Mirowsky, & Goldsteen, 1990). As well, these social supports can step in to help when needed.

Glossary

active neglect Neglect that occurs when a caregiver refuses to provide the services that an elderly person needs.

age effects Research outcomes that occur due to one's age or developmental stage (e.g., greying hair).

aged dependency ratio A measure of elderly dependency in a population measured as all persons 65 years and older divided by all persons aged between 20 and 64 years in a given population.

ageism The stereotyping of older persons.

attentional control The ability to multi-task with our attention—to allocate our attention over several different things at the same time.

biological aging Physiological changes in the body that occur over time.

biological generativity Contributing to society by having children.

boomerang children Adult children who return to their parents' home to live with them again after having moved out.

chronological age One's age in years.

chronological aging Measured as the passing of time.

cluttered nest This occurs when two or more generations of family members live in the same family home.

cohort effects Research outcomes that occur because one is born into a particular cohort.

companionate grandparent A type of grandparent defined by a close relationship with grandchildren, without the parental (disciplinary) role.

compression of morbidity hypothesis A hypothesis that states that more people today than in the past postpone the onset of chronic disability; therefore, the period between being seriously ill and death has been compressed.

cultural generativity Contributing to society by passing on cultural values and traditions to the next generation.

demographers People who study stability and change in populations.

developmental fallacy An error made when cross-sectional age differences are interpreted as developmental change.

elder abuse An act occurring within a relationship where there is an implication of trust that results in harm to an older person.

empty nest This occurs when children leave the family home and the parents are alone in the household.

episodic memory Memory for personal events and experiences.

external locus of control The belief that life outcomes are due to external factors (e.g., fate, chance, God, or other people).

financial exploitation The illegal or improper use of an (older) person's funds, property, or assets.

functional age One's age measured by competence or performance on tasks.

generational stake hypothesis Parents and grandparents (older individuals) have more of an interest in the parent–child or grandparent–grandchild relationship because they want to see their values and lives continued through their children or grandchildren. Thus the older individual will invest more in the relationship than the younger individual.

generativity The ability to go beyond one's own interests and help the generations to come.

implicit memory A type of memory in which you do not need to think to perform a task (e.g., acting on automatic pilot).

individual aging The biological, physiological, psychological, and social changes that occur over the life cycle.

integrity According to Erikson, the ability to accept one's life as something that had to be rather than having regret over what it was not.

internal locus of control The belief that control over life events resides within oneself.

involved grandparent A type of grandparent that has parent-like duties toward the grand-children (e.g., providing care and discipline).

kinkeeper The individual in the family who keeps family members connected with one another.

launching This occurs when children leave the family home and move out on their own.

life expectancy The number of years that an individual born in a particular year can expect

to live.

lifetime stability theory People remain the same throughout their lives (e.g., if an individual is active when young, he or she will be active when old).

Old-old Individuals 75 to 84 years of age.

Oldest-old Individuals 85 years of age and older.

parental generativity Contributing to society by nurturing and socializing children.

passive neglect Neglect that is a non-intentional failure of a caregiver to provide appropriate services to an elderly individual because he or she does not have adequate knowledge of what services are available and what is necessary for proper care.

period effects Research outcomes that occur due to what is happening at the time of measurement (e.g., feelings of safety would show serious decline if safety was measured right after).

physical abuse Any use of physical force against an (elderly) person.

population aging The distribution of a population's age structure in which there are increasing proportions of older people.

population pyramids Graphs that show the distribution of individuals in a population by age (and sometimes by sex).

positive reappraisal A form of coping in which an individual tries to focus on the good aspects of a situation rather than the bad aspects.

problem-focused coping A form of coping in which an individual focuses his or her thoughts and behaviours on things that can be done to manage or resolve the underlying cause of stress.

psychological abuse Verbal threats, intimidation, enforced social isolation, and humiliation of an (elderly) individual.

psychological aging Changes in personality, cognition, emotional arousal, memory, learning, and motivation over time.

remote grandparent A type of grandparent that is less involved with the grandchildren, usually due to physical distance between them.

sandwich generation Middle-aged adults who must look after their elderly relatives as well as take care of their own children.

selective attention The ability to focus on relevant information while ignoring what is irrelevant.

self-neglect Neglect that occurs when an elderly person fails to follow medical directives (intentionally or unintentionally) and does not properly take care of himself or herself.

semantic memory Memory for factual information.

sex ratio The number of marriageable men to the number of marriageable women in a given population.

sexual abuse Any non-consensual sexual contact.

social aging Changes in our social roles and social status over time.

sustained attention The ability to remain focused on a particular thing over time.

technical generativity Contributing to society by teaching skills to the next generation.

total dependency ratio A measure of dependency in a given population, calculated as the

number of individuals aged 0 to 19 years and 65 years and older divided by the number of individuals aged 20 to 64 years.

wisdom Knowledge of what is true or right coupled with the ability to act appropriately in a given situation.

working memory The ability to hold a small amount of information in an available state (often called short-term memory).

young-old Individuals 65 to 74 years of age.

youth dependency ratio A measure of dependency in the young, calculated as the number of individuals aged 0 to 19 years divided by the number of individuals aged 20 to 64 years.