The world today is experiencing unprecedented growth in older adult populations. Currently, 13% of the United States (US) population is over age 65, an increase from 4% in 1900. By 2030, it is estimated that approximately 20% of the US population will be over age 65, and by 2060, that proportion could be 24% (Population Reference Bureau [PRB], 2016). However, the US is a relatively young country compared to other developed nations where the population over 65 is already at 15% or more (e.g., Japan, Italy, Sweden, Norway) and the proportion of older adults is rising at a faster rate (United Nations, 2017). In most countries, older women outnumber older men. Thus, health problems in older age are faced disproportionately by women, contributing to lifetime health care expenditures that are 34% higher for women than for men (Alemayehu & Warner, 2004). In the US, the older adult population is becoming increasingly diverse; by 2060, it is expected that the percentage of white non-Hispanic older adults will drop from 78.3% to 54.6% (PRB, 2016).

A primary factor contributing to the worldwide growth of older adult populations is enhanced medical management of health conditions across the lifespan. As a result, the vast majority of older adults have at least one chronic health condition, and more than half have two or more conditions (Ward, Schiller, & Goodman, 2014). Aging is not a disease state per se (Rattan, 2014), but older age is a risk factor for chronic health problems (Siegler, Elias, & Bosworth, 2012).

Older adults often must implement strategies for managing, rather than curing, illness. Nearly 40 years ago, Fries (1980) suggested optimistically the notion of compression of morbidity, i.e., that increased life expectancy would be accompanied by decreased length of life in ill health. However, recent compelling data from an eight-year longitudinal study found no evidence of morbidity compression (Crimmins & Beltran-Sanchez, 2011). Instead, obesity appears to be a common factor contributing to morbidity at all ages, emphasizing the importance of primary prevention (e.g., exercise and diet in decreasing body fat) to reduce morbidity.

This chapter addresses data pertaining to personality, cognitive, and social influences on health in the context of aging. Relevant psychological and biological theories of aging and health are summarized, in addition to standard methods utilized in aging research. Where data are available, cultural influences in health psychology and aging within the US and around the world are considered. Due to the breadth of this topic, no individual area is covered in depth. Instead, summaries of recent findings are presented, with references for further study.
Developmental Perspective

Chronological age is generally utilized as the primary marker of aging, with 65 being a common indicator for the beginning of older age. The focus of this chapter will be primarily on health-related effects associated with older chronological age, but a developmental perspective is crucial. Aging begins at the moment of birth, and adverse life circumstances, poor health choices, and health problems occurring early in life may have negative repercussions for health and well-being in late life (Miller, Chen, & Parker, 2011).

Furthermore, there are multiple aspects of human aging, ranging from biological to psychological to social processes. Biological aging may begin in the mid-20s (e.g., decreases in pulmonary function, exercise capacity, t-cell production; DiGiovanna, 2000) and social experiences typical of older adulthood (e.g., bereavement, retirement) may occur in middle age. Thus, development and experience may have greater relevance than chronological age in understanding health psychology and aging. In considering developmental processes, it is helpful to distinguish between normal age-related changes in function, independent of disease or environmental factors (i.e., primary aging) versus disease-related changes (i.e., secondary aging; Spirduso, Francis, & MacRae, 2005).

Theories in Aging Research

Biological theories address the question of why humans age, while social and cognitive theories address adaptation to age-related changes. The genetic theory posits that cells of the body are pre-programmed to function for a specific time frame after which they cease replication and die (Hafflck, 1979). More recently, the location of the genetic clock was identified as the telomeres (caps) at the end of chromosomes (Blackburn, Greider, & Szostak, 2006), with each cell division accompanied by shortening of the telomeres. Shortened telomeres are found in various chronic health conditions (e.g., cancer, pulmonary fibrosis; Aubert & Landsdorp, 2008) and among individuals with greater life stress (Shalev et al., 2013).

Damage theory suggests that with time, systems of the body become less efficient due to oxidative damage from environmental factors, increased glycosylation, and other processes contributing to chronic health conditions such as diabetes or coronary heart disease (Spirduso et al., 2005). Emerging from this theory is the notion of allostatic load, defined as the cumulative, multisystem physiological toll on the body during adaptation to environmental stresses. Repeated engagement of the physiological stress response, as well as elevated activity of physiological systems when challenged, may predispose individuals to disease (McEwen, 2003), and reductions in allostatic load are associated with reduced mortality among older adults (Karlamangla, Singer, & Seeman, 2006).

Developmental theories are useful in understanding psychosocial adjustment to biological aging. The selective optimization with compensation (SOC) model describes processes by which individuals manage gains and losses with age (Freund & Baltes, 1998). SOC is an interactive age-related process of (1) selecting a more restricted range of goals reflecting changes in adaptive potential; (2) optimizing functional capacity within the chosen range of goals; and (3) compensating for behavioral limitations via alternative behavioral choices.

Additional theories within health psychology relevant to aging include personal control theory (Heckhausen & Schulz, 1995) and socioemotional selectivity theory (SST; Carstensen, Isaacowitz, & Charles, 1999), which both posit a shift in goals and behaviors due to increasing age (personal control theory) or perception of limited time. These theories of adaptation reflect the importance of interactions between the individual and the environment, and implicitly or explicitly suggest that flexibility in goals and optimization of function are essential for successful adaptation, especially in response to limitations associated with disability and chronic illness.
Rowe and Kahn (1997) defined successful aging as (1) minimizing risk of disease and disability, (2) maintaining physical and mental function, and (3) continuing engagement with life. Thus, successful aging requires engaging in preventive health behaviors such as physical exercise, optimal nutrition, and avoidance of smoking. One widely researched model of health behavior is the Transtheoretical Model (TTM; Prochaska & Velicer, 1997), which posits cognitive stages of behavior change to describe a process by which individuals may decide to engage in healthy behaviors. Although the model is not age-specific, it has proven useful in predicting exercise behavior among older adults in the US (Kirk, MacMillan, & Webster, 2010) and in the Middle East (Salehi, Eftekhar, Mohammad, Taghdisi, & Shojaeizadeh, 2010).

Research Methods

Most studies in aging and health are cross-sectional, providing important data on correlates of health, but not causal processes. Longitudinal studies provide an opportunity to evaluate observable intra-individual change with age as well as inter-individual variability in intra-individual change (Schaie & Hofer, 2001). Of particular interest is the ability to examine relationships among changes in two or more variables over time, the determinants of those changes, and inter-individual variability in determinants of intra-individual change over time. Advanced statistical methods such as dual change score models (DCSM) facilitate analysis of bi-directional influences in longitudinal changes of two different variables (McArdle, 2001). Developmental epidemiologic studies address early risk factors (e.g., childhood trauma) for adult illness, as well as the effects of cumulative life stresses on health in late life (Brenner & Arndt, 2004).

Longitudinal behavior genetics studies of monozygotic and dizygotic adult twins provide an opportunity to explore further the mechanisms of aging-related change in a range of domains including cognitive functioning, personality, psychological well-being, and physical functioning (Kremen & Lyons, 2011). Data from longitudinal twin studies facilitate computation of genetic and environmental contributions to age-related changes (Plomin & McClearn, 1990).

The growth of neuroscience has led to numerous additional approaches for assessment of brain function, in particular, in response to both cognitive stimuli as well as emotionally laden stimuli. With neuro-imaging techniques such as functional magnetic resonance imaging (fMRI) as study outcomes, it is possible to document changes in brain function and distribution of brain activity occurring in the context of normal development and age-related disease (Sperling et al., 2003) or in response to behavioral intervention (Voss et al., 2010).

Psychological and Personality Functioning

A widely held misperception is that the prevalence of depression and anxiety increases among older adults (Jorm, 2000). Although sub-clinical symptoms of distress may increase with age, and the presence of chronic health problems has been associated with a 2.3-fold increase in anxiety symptoms (Gould, O’Hara, Goldstein, & Beaudreau, 2016), the overall prevalence of depressive disorders and anxiety disorders generally decreases with age (Barry & Byers, 2015). Thus, a focus on symptoms of depression and anxiety is important because sub-clinical symptoms of distress may influence physical health outcomes.

Depression and Anxiety

Among older adults, symptoms of depression and anxiety are associated with disease onset and disease progression. Cardiovascular disease (CVD) is especially relevant for health psychology and
aging because it remains the leading cause of death in the US and around the world (World Health Organization, 2017). Among Medicare patients over age 65, depressive symptoms were significantly higher for those with a current CVD diagnosis and those who reported a new CVD diagnosis in the following year than for those without a diagnosis (Choi, Kim, Marti, & Chen, 2014). Additionally, depressive symptoms were positively associated with elevated cholesterol and hypertension, risk factors for CVD morbidity and mortality (Maatouk et al., 2016). Similarly, elevated symptoms of anxiety and anxiety disorders were associated with a 52% increased incidence of CVD, including coronary heart disease, myocardial infarction, and stroke (Batelaan, Seldenrijk, Bot, van Balkom, & Penninx, 2016), as well as with increased risk of heart failure and mortality from CVD (Chang et al., 2016; Emdin et al., 2016).

The second and third most common causes of death in the US and other industrialized countries are cancer and chronic obstructive pulmonary disease (COPD). Studies of individuals with various types of cancer indicate elevated symptoms of anxiety in 19% to 41% and elevated symptoms of depression in 13% to 29% (Linden, Vodermaier, MacKenzie, & Greig, 2012). Although symptoms of distress generally decrease with age, anxiety symptoms remain elevated in 12% to 21% of older people with cancer, and symptoms of depression are elevated in 13% (Weiss Wiesel et al., 2015).

The increasing prevalence of COPD, especially among older women, is due primarily to past smoking behavior, with more women smoking since the 1950s. Individuals with COPD are more likely than age-matched peers to report symptoms of distress; up to 20% of people with COPD have significant symptoms of depression, and up to 30% have serious symptoms of anxiety (Di Marco et al., 2006).

Obesity is a risk factor for many diseases associated with age (e.g., CVD, cancer, diabetes). Among adults of all ages, obesity is associated with elevated depression (Luppino et al., 2010) and with reduced quality of life and functional ability (Minniti et al., 2011). However, there are racial/ethnic group differences in the degree to which obesity affects emotional and physical functioning. Although older African-American women experience higher rates of obesity than other racial groups, resulting in poorer physical functioning, more bodily pain, and worse emotional well-being, they also report higher satisfaction with body shape and function, which appears to protect against emotional distress (Sabik & Versey, 2016).

**Personality**

Much research in aging has focused on health in the context of the ‘Big Five’ personality traits from the Five Factor Model of Personality (FFM; McCrae & Costa, 2003). Generally, traits of openness, conscientiousness, extroversion, and agreeableness are associated with positive health outcomes, while the trait of neuroticism is associated with negative health outcomes.

Among older adults, greater openness has been associated with more positive health perceptions (Jerram & Coleman, 1999). Conscientiousness has been associated with larger networks of healthy social relationships, better physical health and functioning, greater longevity, and more participation in healthy behaviors (Friedman & Kern, 2014; Hall, Fong, & Epp, 2014; Jaconelli, Stephan, Canada, & Chapman, 2013). In the domain of conscientiousness, self-discipline may be one of the strongest predictors of survival among older adults (Weiss & Costa, 2005). Among middle-aged and older adults, extroversion has been associated with positive affect, more engagement in healthy behaviors, better self-rated health, and greater physical functioning (Aiken-Morgan, Bichsel, Savla, Edwards, & Whittfield, 2014; Jaconelli et al., 2013; Margrett et al., 2011). Additionally, extroversion has been associated with reduced mortality, which is mediated by greater engagement in healthy lifestyle behaviors (Rizzuto, Mossello, Fratiglioni, Santoni, & Wang, 2017). Agreeableness has been associated with more positive health perceptions (Jerram & Coleman, 1999) with the straightforwardness facet of agreeableness more positively associated with longevity (Weiss & Costa, 2005).
In contrast, neuroticism has been associated with engaging in fewer health behaviors and worse physical functioning (Hall et al., 2014; Jaconelli et al., 2013), poorer subjective well-being, and higher mortality risk among women (Friedman, Kern, & Reynolds, 2010). Surprisingly, Weiss and Costa (2005) found that the impulsiveness facet of neuroticism was positively associated with survival among older adults, but the mechanism is unknown.

Among African-American older adults, agreeableness and conscientiousness have been associated with fewer reported health problems, while neuroticism is associated with more health problems (Aiken-Morgan et al., 2014). Among older adults in Taiwan, successful aging (e.g., fewer diseases, greater cognitive and physical capacity, more social engagement) was associated with agreeableness and extraversion, whereas openness was associated with lower cognitive impairment (Chiao & Hsiao, 2017). In Japan, openness was associated with increased participation in mass health checkups (Iwasa et al., 2009). Thus, across cultures a consistent pattern emerges of openness, conscientiousness, extraversion, agreeableness, and low neuroticism being associated with better health, better health behaviors, and lower mortality.

Personality traits beyond the FFM also have been investigated. For example, optimism has been associated with better health status among community-residing older adults (Steptoe, Wright, Kunz-Ebrecht, & Iliffe, 2006). Optimism may have direct positive effects on the neuroendocrine and immune systems and indirect effects on health outcomes through greater engagement in healthy behaviors, adaptive coping strategies, and positive affect (Avvenuti, Baiardini, & Giaroldi, 2016). In contrast, hostility has been associated with elevations in inflammatory markers linked to heart disease (i.e., C-reactive protein) among older adults (Graham et al., 2006).

Personality dimensions have been studied in relation to specific disorders among older adults. For example, dispositional optimism has been associated with lower risk of coronary heart disease in older men (Kubzansky, Sparrow, Vokonas, & Kawachi, 2001) and greater neuroticism has been associated with somatic complaints (e.g., chest pain, chest discomfort) among older individuals with CVD (Costa, 1987). Among older people with cancer, low extraversion and high openness were related to current and average reported pain, respectively, possibly because individuals higher in openness are likely to seek out new experiences and social activities; however, they may be more sensitive to limitations imposed by their disease and report greater symptoms as a consequence (Krok & Baker, 2014). Among older people with COPD, self-reported impact of disease was associated with greater neuroticism and, surprisingly, greater agreeableness, while conscientiousness was associated with less impact of COPD on daily life (Topp, Vestbo, & Mortensen, 2016). Additionally, increases in neuroticism and decreases in openness and conscientiousness have been observed among older adults with Alzheimer’s disease (Duchek, Balota, Storandt, & Larsen, 2007; Henriques-Calado, Duarte-Silva, & Ferreira, 2016).

**Cognitive Function**

Aging has been associated with increased risk of cognitive decline and impairment across various domains including working memory, attention, executive function, visual-spatial abilities, and processing speed (Gross et al., 2012; Karbach & Verhaegen, 2014; Mewborn, Lindbergh, & Miller, 2017). Chronic illness may exacerbate age-related cognitive changes. Summarized next are cognitive changes associated with prevalent health conditions among older adults.

**Cardiovascular Disease**

Hypertension, the most common chronic health problem in older adults, has been associated with adverse effects on cognitive function, including declines in processing speed, phonemic fluency, and
non-verbal reasoning (de Moraes, Szklo, Knopman, & Sato, 2002; Elias, Elias, Robbins, & Budge, 2004), episodic memory performance (Elias, Wolf, D’Agostino, Cobb, & White, 1993) and global cognition (Gifford et al., 2013). Longitudinal studies indicate that high blood pressure during middle-age increases risk of dementia in late life (Elias et al., 2004; Whitmer, Sidney, Selby, Johnston, & Yaffe, 2005). Interestingly, low diastolic blood pressure in late life also may be associated with increased risk of dementia (Pandav, Dodge, DeKosky, & Ganguli, 2003).

In cross-sectional studies, coronary artery disease has been associated with poorer verbal fluency and slower perceptual-organizational speed (Verhaegen, Borchelt, & Smith, 2003). Atrial fibrillation is associated with increased risk of cognitive impairment independent of stroke history (Kalantarian, Stern, Mansour, & Ruskin, 2013) and with increased risk of developing dementia (Abete et al., 2014). Heart failure has been associated with lower learning capacity, attention, and greater delayed recall, working memory, psychomotor speed, and executive function (Abete et al., 2014).

**Cancer**

Prior studies have addressed the effects of breast cancer and associated therapy on cognitive outcomes. Longitudinal studies indicate that older women with breast cancer may experience significant cognitive decline post-treatment (Hurria et al., 2006), including poorer performance on tasks assessing working memory, divided attention, and executive function (Ahles, Root, & Ryan, 2012; Yamada, Denburg, Beglinger, & Schultz, 2010). From 17% to 75% of breast cancer survivors have reported cognitive decline within 6 months to 20 years after chemotherapy (Ahles et al., 2012; Koppelmans et al., 2012). However, a population-based Danish study found no effects of cancer therapies on cognitive function among older women with breast cancer (Debess, Riis, Engebjerg, & Ewertz, 2010).

**Chronic Obstructive Pulmonary Disease**

Chronic obstructive pulmonary disease (COPD) has been associated with deficits in perception, memory, and psychomotor speed (Dodd, Getov, & Jones, 2010). Although standard measures of pulmonary function predict cognitive function among healthy older adults (Emery, Finkel, & Pedersen, 2012; Emery, Pedersen, Svartengren, & McClearn, 1998), pulmonary function is not predictive of cognitive performance among adults with COPD. Hypoxemia is associated with cognitive deficits, but cognitive function in COPD is impaired in the absence of hypoxemia (Dodd et al., 2010). The mechanism for neuronal damage in COPD requires further investigation. Most studies of cognitive function in COPD have been conducted in Westernized, developed countries despite the rapidly growing aging population with COPD across Asia, and recent evidence of cognitive impairment in a large sample (n = 16,629) of older adults in China (Yin et al., 2016).

**Diabetes**

Past studies have focused primarily on type 2 (insulin resistant) diabetes mellitus (T2DM), which affects 25% of adults over age 65. T2DM has been associated with decreased capacity for learning, memory, cognitive flexibility, and processing speed. Longitudinal studies indicate that T2DM increases the risk of mild cognitive impairment, vascular dementia, and Alzheimer’s disease (Cheng, Huang, Deng, & Wang, 2012).

African-American and Hispanic individuals are disproportionately affected by T2DM. Among older Mexican-Americans, individuals with diabetes had a twofold higher rate of dementia or cognitive impairment (Mayeda, Haan, Kanaya, Yaffe, & Neuhaus, 2013). T2DM among African-Americans living at or below the poverty level was associated with lower performance on verbal memory,
working memory, and verbal attention (Dore, Waldstein, Evans, & Zonderman, 2015), but racial/ethnic differences were not evident among those above the poverty level.

**Pathways Linking Aging and Health**

Both biological and psychosocial factors appear to exacerbate the risk of health problems among older adults, especially in the context of elevated life stress.

**Inflammation**

With increasing age there are typically elevations in C-reactive protein, interleukin-6 (IL-6), tumor necrosis factor (TNF), and other standard markers of inflammation (Franceschi et al., 2007). This inflammatory response is relevant because obesity and many of the chronic illnesses experienced by older adults (e.g., CVD, cancer, COPD) are associated with increased inflammation (Coussens & Werb, 2002). Likewise, psychological distress has been associated with heightened inflammation (Glaser & Kiecolt-Glaser, 2005). Thus, there are multiple factors contributing to elevated inflammation and associated symptoms (e.g., fatigue) and heightened inflammatory factors may then accelerate the onset and/or progression of diseases associated with aging, such as CVD, cancer, and T2DM (Kiecolt-Glaser & Glaser, 2002).

**Social Influences**

Social integration and social support have been associated with reduced risk of all-cause mortality (Holt-Lunstad, Smith, & Layton, 2010), but older adults are increasingly vulnerable to social isolation and emotional loneliness (Boss, Kang, & Branson, 2015), contributing to poorer health (Cornwell & Waite, 2009) and impaired cognitive function (Boss et al., 2015). A systematic review of studies from the US, England, and several Asian countries found that perceived social support, quality of relations, and the presence of a confidant were associated with lower depression among older adults (Schwarzbach, Luppa, Forstmeier, König, & Riedel-Heller, 2014). In a systematic review of studies among older adult medical patients and community residents in Middle Eastern countries, social support was positively related to mental health, but not to self-reported physical health outcomes (Tajvar, Fletcher, Grundy, & Arab, 2013). Thus, data from multiple countries reflects the importance of social connectedness for mental health, but the path to physical health may be influenced by additional factors.

As a proxy for social support, being married appears to protect against morbidity and mortality in older adults (Manzoli, Villari, Pirone, & Boccia, 2007). In a review of 33 studies from cultures and countries around the world, being widowed, unmarried, or single was associated with poorer health (Tatangelo, McCabe, Campbell, & Szoek, 2017), and marriage provided greater health benefits for men than for women.

Caregivers of older adults with chronic illness often experience stresses such as increased financial burden, reduced psychological well-being, and interpersonal strains, contributing to negative effects on caregiver physical and mental health (Kim & Schulz, 2008; Revenson et al., 2016). Dementia caregiving is strongly related to depression, anxiety, and perceived burden (Seeher, Low, Reppermund, & Brodaty, 2013).

**Interventions**

In light of age-related changes in physical health, psychological functioning, and cognitive functioning, a number of interventions have been evaluated.
Physical Activity

Exercise interventions (typically aerobic exercise three times per week over 3 to 12 months) among healthy older adults have demonstrated beneficial effects for physical endurance (Chou, Hwang, & Wu, 2012), mental well-being (Barbour & Blumenental, 2005) and cognitive function (Colcombe & Kramer, 2003). Exercise has been associated with improved physical endurance, cognitive performance, and psychological well-being among older adults with COPD (Emery, Schein, Hauck, & MacIntyre, 1998) and physical activity has been associated with reduced fatigue among older women with breast cancer (Luctkar-Flude, Groll, Tranmer, & Woodend, 2007). The question of exercise intensity is debated, but the data generally support physical activity of various kinds for maintaining health among older adults (Nelson et al., 2007).

Therapeutic Strategies

Cognitive-behavioral interventions have proven effective in treating depression and anxiety among older adults (Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012), as well as in treating older adults with physical health problems and comorbid psychological distress. Mindfulness meditation (see Chapter 39) is increasingly endorsed by practitioners for a wide range of problems. Although experimental data are limited, mindfulness interventions may have beneficial effects on immune function and feelings of loneliness among healthy older adults (Creswell et al., 2012). Problem-solving therapies also may benefit older adults coping with depression or distress for whom pharmacotherapy may be inappropriate (Areán et al., 2010). These treatments are typically short-term and designed to help patients define goals and establish strategies for achieving goals. Thus, this approach also is useful among older adults with medical problems (D’Zurilla & Nezu, 2010).

Future Research

As the number of older adults has increased worldwide, characteristics of the aging US population are changing due to a number of demographic shifts including larger proportions of minorities, older adults remaining in the workforce for longer periods of time, and legalization of same-sex marriage. To date, most research has been conducted among Caucasians, and changes in workforce participation and marital status have received limited attention. As demographic changes in ethnicity and social relationships continue to alter the characteristics of the aging population in the US, further attention is required to understand related influences on physical and mental health. For example, caregiving has been well-researched to date, but will evolve further because of demographic and social changes occurring among the current population of older adults. Influences of culture-bound self-expectations (e.g., of physical function, sexual function, body shape) among older adults also require further examination.

Evidence from longitudinal and cross-sectional studies indicates that research and clinical intervention with older adults should account for developmental growth and experience in the realms of physical and mental health. Adaptation to age-related changes is an ongoing process, thus research and clinical work with older adults requires understanding the developmental trajectory of aging individuals on multiple dimensions. Older adults are likely to experience chronic health problems, but also have life experience coping with stress. The influence of past successes and failures is important to consider.

Although older adults are less likely to meet thresholds for mental disorders such as depression and anxiety, sub-clinical symptoms are relevant for physical health and require observation and study, along with personality factors. Further evaluation is needed of the mechanisms by which sub-clinical
Aging and Health

and clinical symptoms on various dimensions of functioning (e.g., personality, psychological well-being, cognitive functioning) may influence physical health in older adults.

Cognitive function is negatively affected during normal aging, and the observed cognitive changes with age are generally exacerbated by age-related illness. Thus, influences of both primary aging and secondary aging may be especially important to consider in evaluating cognitive functioning. In addition, implementing interventions for older adults requires sensitivity to the cognitive changes that may exist.

Beyond chronic, life-threatening conditions (CVD, cancer, COPD), older adults also are more likely to experience chronic health problems (osteoarthritis, osteoporosis, chronic pain) that are not life-threatening but that have negative effects on behavioral and psychological functioning. Indeed, largely due to obesity and related health complications, there appears to be no compression of morbidity with age. Thus, there is a need for further examination of psychological and behavioral predictors and outcomes of chronic health conditions, including obesity. SES may be especially important to consider, due to influences of SES on access to health care and to health education. The cross-cultural data among older adults appear to reflect more similarities than differences across ethnic and cultural groups, but SES and related expectations/beliefs may contribute to varying health trajectories.

Conclusion

Health psychology with older adults presents both challenges and opportunities for future research and clinical intervention. Because aging is associated with increased variability on most dimensions, chronological age is less useful in understanding the interrelationships of physical and mental health among older adults. Instead, it is important to focus on models of change that account for changes occurring on multiple dimensions (e.g., physical, psychological, cognitive, social), as well as interactions among areas of change over time.

References


272


Charles F. Emery, Jacob D. Landers, and Jocelyn D. Shoemaker


