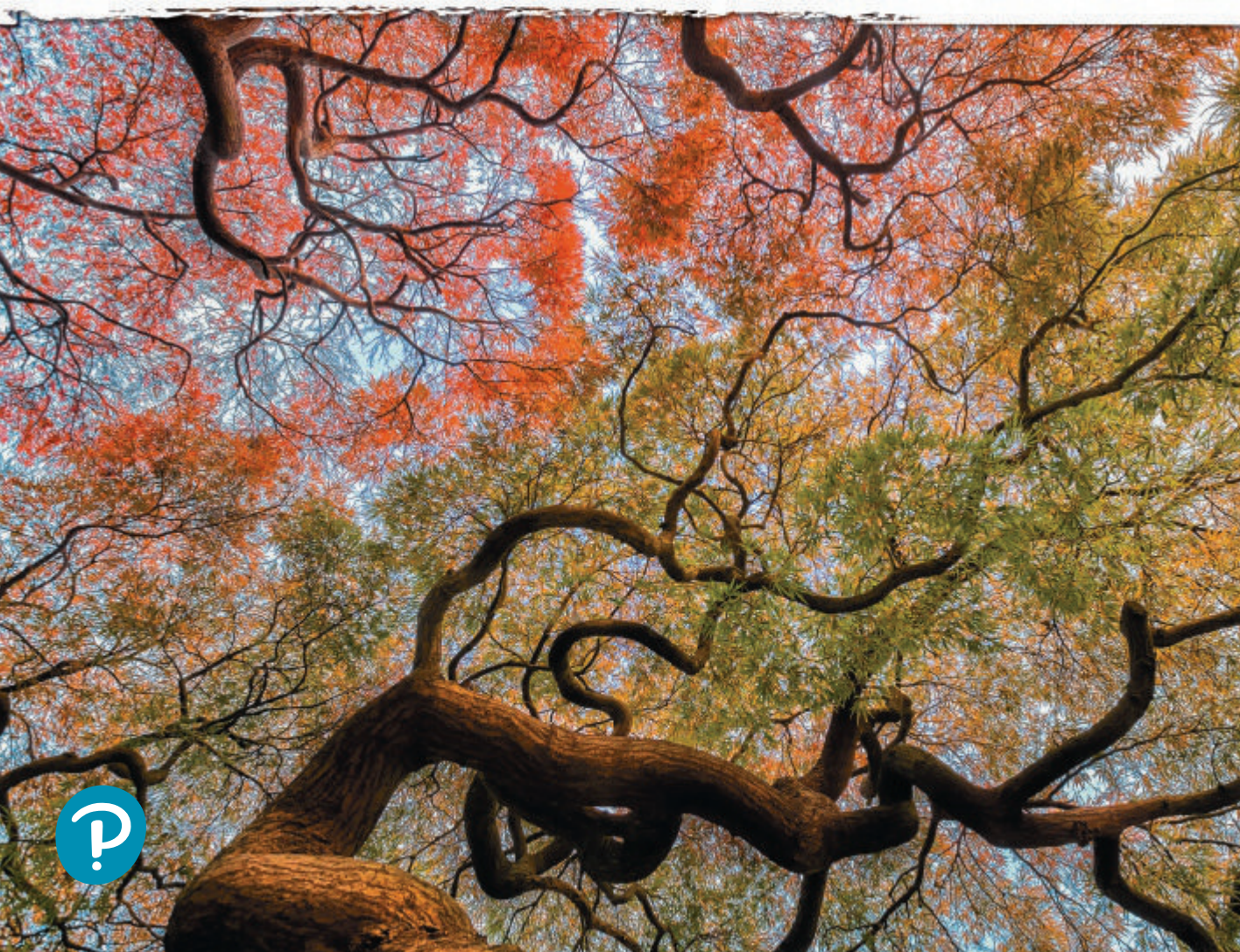
The Merrill Social Work and Human Services Series

5TH EDITION

SOCIAL WORK WITH OLDER ADULTS

A Biopsychosocial Approach to Assessment and Intervention

KATHLEEN MCINNIS-DITTRICH



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To Bill, with much love

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PREFACE

There is little doubt that social work with older adults is, and will continue to be, the hottest area of social work practice for the foreseeable future. The edge of the baby boomer generation has moved into retirement, with 10,000 people turning 65 years old every single day. No social institution has remained unchanged by this generation as they have moved through the life course. Baby boomers will forge new models of what constitutes "successful aging." They will also face challenges not yet imagined. This is an exciting time to be studying social work with older adults as endless possibilities for innovation await the next generation of social workers!

As always, I feel I have the great fortune to have met and worked with a phenomenal group of older adults both in personal and professional contexts. My own maternal grandmother defied all the conventions of her generation as a woman, serving to "do something that matters and have fun!" Indeed, social work with older adults has been just that. The older adults I have known in the New Orleans Central City Housing Project, the Oneida Indian Reservation in Wisconsin, the foothills of the Appalachian Mountains, older adult housing in Boston, and even my yoga class have made me a better social worker and a better person. How lucky I am to do this work.

When I wrote the first edition of this text, I was happily ensconced in early middle age. As a researcher and practicing social worker, I knew both the professional literature and the practice application of the material. Work with older adults has been my passion for my entire professional life. As I write the fifth edition, I have just joined the ranks of *being* an older adult, no longer studying it from afar. I would like to think I still know the professional literature and the practice application of the material in this text well. However, I also know some areas better than others because of my own personal experiences over the past 20 years. I am painfully (literally) reminded of an old field hockey injury when it revisits me as arthritis. I have lived the heartache of being a long-distance caregiver and having buried parents and siblings. I have completed my own and others' advance directives and know how important it is to have that conversation before it is time to make difficult decisions. I have watched friends show the early signs of dementia or struggle with the black cloud of depression. Like every older homeowner, I think about what will happen when doing yard work is too much or hauling around the snow blower in a typical New England winter is too challenging. And then, sometimes, I am most happy not thinking about it at all! I understand denial better than I did earlier in my life.

I also know the power and promise of how many older adults continue to live busy, productive lives. As a firm believer in the importance of volunteering, I have experienced the joy of helping other older adults navigate the Medicare jungle as a volunteer at Ethos, an Area Agency on Aging in Boston. I support a group of "old progressives" who are fearless in taking on immigration, affordable housing, and a fair minimum wage. I have become a passionate advocate for better public transportation and accessible health care. I suspect these and other issues facing older adults will continue to engage me as I approach retirement, but I also look forward to continuing to enjoy a long, happy marriage and a sailboat named *Time Enough*.

This text presents a comprehensive overview of the field of social work with older adults, from the basics of the biopsychosocial changes associated with the aging process through the assessment of older adults' strengths as well as challenges to the design and execution of problem-solving interventions. *Social Work with Older Adults* is written for both undergraduate and graduate students. It focuses on social work practice interventions with individual older adults, older adults' support systems, and groups of older adults. It is intended to cover topics

as basic as encouraging older adults to exercise to those as complex as the process of differential assessment and diagnosis of depression, dementia, and delirium. Important macro practice issues such as creating age-friendly communities, transportation, housing, income programs, and health insurance are covered in the final chapters of the text. The inclusion of this material reminds us as social workers that the influence of the greater social environmental system can be as powerful, if not more so, than the smaller systems of home and family. The most physically and mentally healthy older adult cannot thrive without adequate income, safe housing, and access to ongoing health care, all of which are determined by forces outside of the individual social work relationship with an older adult. The inclusion of this material honors the long tradition of the social work profession in social change directed at organizations, communities, and the policy arena.

Unlike many other texts on social work with older adults, this text includes a comprehensive array of topics within a single volume. It includes protocols for traditional and alternative interventions, recognizing the amazing heterogeneity of the aging population. In many respects, it can be considered as "one-stop shopping" for content on working with older adults. Content on diversity of gender, race, ethnicity, and sexual orientation is integrated into the discussion of each topic.

THE PLAN OF THE TEXT

Instructors who have used earlier editions of the text will see some of the same material as well as new material and an additional chapter. More material on cultural diversity and sexual orientation is included in every chapter, with attention to special issues facing LGBT older adults. Chapters that are clinically oriented contain more case material with questions for class discussion. Each chapter has Learning Integration Activities that offer suggestions for ways students can apply new material to their own field settings or communities. These ideas can also serve as projects or paper ideas, depending on student interest. Each of these ideas has been "field-tested" on my own graduate students at the Boston College School of Social Work. Students had a very enthusiastic response to finding out how much, or how little, was being done in their own communities in these areas of social work practice. Other activities ask students to pursue a topic covered in the chapter in more depth.

What is New to the Fifth Edition of *Social Work with Older Adults?*

- New content on the unique challenges baby boomers will face as older adults, including a detailed discussion of the opioid crisis and Hepatitis C.
- Enhanced content on the experiences of older adults of color in the health and mental health service system.
- Extensive new content on LGBT older adults.
- Integration of material on decision-making capacity of older adults throughout the text.
- A new chapter, Chapter Thirteen: Community Programs to Support "Aging in Place": Age-Friendly Communities, Transportation, and Housing. The chapter provides enhanced macro-social work content.
- More case examples followed by discussion questions that stress skill development.
- Integrated Learning Activities at the end of each chapter that offer suggestions for class projects or individual papers. These activities promote the integration of material in the chapter with students' experiences in field practicum or community work.

The following is a chapter-by-chapter summary of major updates to each chapter.

Chapter 1: The Context of Social Work Practice with Older Adults

- Updated demographic information on older adults
- An in-depth discussion of how the experience of aging baby boomers will transform work in this field
- Additional content on integrated care and hospice as areas of practice
- An enhanced discussion about the unique rewards of social work with older adults

Chapter 2: Biological Changes and the Physical Well-Being of Older Adults

- Inclusion of material on the radical restriction of caloric intake as an approach to lengthening life
- In-depth discussion of the issue of health disparities between different groups of older adults
- Material on the troubling prevalence of hepatitis C in baby boomers
- More comprehensive discussion on fall prevention
- More detailed discussion on behaviors and practices that promote healthy aging

Chapter 3: Psychosocial Adjustments to Aging

- Expanded discussion of the role of hydration and nutrition in maintaining healthy cognitive functioning
- More in-depth material on the development and significance of resilience for older adults
- Addition of Queer Theory to the list of theories of aging
- A critical examination of current paradigms about what constitutes "successful aging"

Chapter 4: Conducting a Biopsychosocial Assessment

- In-depth coverage of the significance on the assessment process of decision-making capacity in older adults with cognitive limitations
- Detailed presentation of evidence-based tools for assessing emotional, cognitive, and social functioning
- Discussion about the social worker's use of language interpreters

Chapter 5: Differential Assessment and Diagnosis of Cognitive and Emotional Problems of Older Adults

- Additional content on the differences in the presentation of depression in men and women
- More discussion on mild cognitive impairment as contrasted with dementia
- A tabular presentation of the different kinds of non-Alzheimer's dementia
- Class discussion questions about each of the cases presented in the chapter as a means of developing students' skills in differential assessment

Chapter 6: Interventions for Depression, Anxiety, and Dementia in Older Adults

- An expanded discussion of behavioral management techniques for older adults with dementia
- Expanded discussion on the use of medication to stabilize dementia
- Enhanced content on the barriers to mental health treatment faced by older adults of color, including stigma, cultural obstacles, and health care provider bias

Chapter 7: Complementary and Alternative Approaches to Treating Socioemotional Conditions in Older Adults

- The role of the social worker in incorporating alternative and complementary approaches in therapeutic interventions with older adults
- Exploration of the therapeutic benefits of humor and play on good mental health among older adults
- Expansion of materials from the National Center on Creative Aging

Chapter 8: Substance Abuse and Suicide Prevention in Older Adults

- Extensive discussion of the Screening, Brief Intervention, Referral to Treatment Model for the treatment of alcohol dependency
- Discussion of the increase in use and abuse of opioids and other prescription drugs among older adults
- Presentation of the psychoactive medications prescribed for common mental health issues among older adults
- Expanded discussion of why older adults contemplate suicide, including the influence of financial stressors or the development of a functional impairment
- Added material on the NASW Code of Ethics and high risk older adults for mandated reporting in cases of suicidal
- An additional case example followed by discussion questions to help students learn skills in identifying suicidal ideation in an older adult

Chapter 9: Social Work Practice in Identifying and Preventing Abuse and Neglect of Older Adults

- Comparison and contrast of guardianship, limited guardianship, representative payee, and conservatorship as legal arrangements for older adults who lack full decision-making capacity
- Expanded coverage of the problem of caregiver stress as it contributes to elder abuse and neglect
- Additional material on mandated reporting of elder abuse by social workers
- Expansion of coverage of the vulnerability of older adults of color
- Discussion of current financial scams targeting older adults
- Additional coverage of material on elder abuse and neglect among populations of color
- Class discussion questions following the case example to help students identify the ethical dilemmas raised by cases of self-neglect

Chapter 10: The Role of Spirituality in Social Work with Older Adults

- Enhanced content on men's spirituality and how it differs from women's spirituality
- Additions of guidelines on writing memoirs as an exercise in spirituality for older adults
- Expanded discussion of the role of religion in the lives of older adults and its importance based on gender, race, ethnicity, and sexual orientation.

Chapter 11: Advance Care Planning and End-of-Life Care for Older Adults

- Exploration of what "a good death" means to older adults and their families
- Suggestions and resources for starting the conversation with older adults and their families about advance care planning
- Discussion about advance care planning and the range of documents for advance directives is presented in the first part of the chapter to highlight their importance

- More comprehensive discussions of Do Not Resuscitate orders and detailed presentation on Physician's Orders for Life Sustaining Treatment
- A detailed comparison of the different end-of-life documents and advance directives discussed in the chapter, identifying the documents' purpose and legal standing
- Additional material on racial, ethnic, and religious variations in the use of advance directives
- New section on the unique challenges facing LGBT older adults in completing advance directives
- Case example about the use of advance directives with class discussion questions that help students develop skills in how to work with older adults and families at a difficult time
- Case example of anticipatory grief with class discussion questions to help students learn to identify how an older adult may be using protective mechanisms to process anticipated grief

Chapter 12: Working with Older Adults' Support Systems in Caregiving

- Expanded definitions of support systems for older adults to include gay and lesbian partners and families of choice
- Additional material on caregiving among racial and ethnic groups
- Specific guidelines for holding family meetings
- An enhanced section on caregiving burden and sources of stress in caregiving with specific suggestions for identifying caregiver stress
- More materials on moderators of caregiver stress and ways to support caregivers, including promoting self-efficacy
- Presentation of options for online support groups for older adults
- Case example of an older adult in need of caregiving with a focus on how the family can start the process of developing and implementing a caregiving plan
- Case example of grandparents raising grandchildren with discussion questions designed to help students develop skills to support a grandfamily while maintaining the connection to the child's absent parent

Chapter 13: NEW! Community Programs to Support "Aging in Place": Age-Friendly Communities, Transportation, and Housing Initiatives

- A discussion of the concept of "aging in place" with attention to populations who might not benefit from aging in their current residence
- Presentation of the 8 Domains of Livability for Age-Friendly Communities as identified by the World Health Organization with examples of how those domains influence programs for older adults
- A comparison between naturally occurring retirement communities and the village movement in providing a context for service provision for older adults
- An exploration of the challenge of older drivers, the significance of driving to older adults, and recommendations for implementing screening programs
- Discussion of other modes of transportation, such as mass transit, volunteer drivers, subsidized taxis, and ride-hailing services as reasonable alternatives
- Identification of housing choices available to older adults, including home ownership and subsidized rental properties
- An examination of the growing problem of homelessness among older adults

Chapter 14: Income Programs, Health Insurance, and Support Services for Older Adults: Challenges and Opportunities for the Future

- Coverage of the financial challenges facing the generation of approaching retirements due to prior economic conditions in this country and the maintenance of serious debt into retirement
- Inclusion of benefits available to veterans as they age
- Updated language on the Affordable Care Act (ACA)
- Updated information on changes to Part D of Medicare that result from the ACA and new choices for prescription coverage
- Inclusion of a discussion of the challenges faced by older immigrants as they "age out of place" rather than in place
- An expanded discussion of the challenges and opportunities the growing population of older adults presents to both society and the social work profession

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Special thanks go to my students at the Boston College School of Social Work, who were brutally honest about what they would like to see changed from earlier editions and were not the least bit impressed that their professor wrote the textbook! Teaching is the greatest joy of academic life and often the most humbling.

My deepest gratitude goes to my husband, Bill Dittrich, for his love, patience, support, and humor for so many years. His love is the anchor in my life. As Robert Browning said so eloquently, "Grow older along with me, the best yet to be." We are on that journey!

K.M.-D.

BRIEF CONTENTS

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CONTENTS

The Context of Social Work Practice with Older Adults

1

AGING IN THE TWENTY-FIRST CENTURY

One of the greatest challenges of the twenty-first century will be the tremendous increase in the number of older adults in both the United States and throughout the world. By 2030, when most baby boomers (individuals born between 1946 and 1964) have moved into older adulthood, one in every five individuals in the United States will be over the age of 65 (Administration on Aging, 2016). Social institutions, including the health-care system, education, income maintenance and social insurance programs, the workplace, and particularly social services, are bound to be radically transformed by these staggering numbers. Later in this chapter, the ways in which the baby boomer generation might transform the entire context of health and human services will be explored. As major providers of service to older adults and their families, social workers need a wide variety of skills and resources to meet these demands. Work with older adults is the fastest-growing segment of the social work profession. The National Institute on Aging estimates that between 60,000 and 70,000 new social workers will be needed to meet the demands of this growing population (as cited in National Association of Social Workers, 2006). This text is intended to provide a solid knowledge base about aging as a process and to introduce practitioners to a broad range of assessment and intervention techniques.

Diversity within the Older Adult Population

Age 65 is generally agreed on as the beginning of older adulthood only because until recently, it has been the traditional retirement age, not because there is a special social or biological reason for this choice. The population between 65 and 74 is generally referred to as the "young-old." Many young-old do not consider themselves to be old. The young-old may still be working or newly retired, have few if any health problems, and remain actively engaged in the social activities of life. These older adults may stay in the labor market for many years beyond retirement age or transfer their energy

Learning Outcomes

- Examine the current social and economic indicators for the older adult population in the United States.
- Analyze how the baby boomer generation will transform the health and social service system in the next 15 years with greater demand for services but fewer resources.
- Explore the variety of direct service and macro practice settings in which gerontological social work is practiced.
- Increase the reader's awareness of the personal and professional challenges often encountered in social work with older adults.
- Highlight some of the rewards of working with older adults.

Chapter Outline

and interests to creative writing, painting, music, or travel. They are most likely to continue to be engaged in their communities through volunteer work or political involvement.

The group of older adults aged 75 to 85, "the middle-old," may begin to experience health problems more frequently than their younger cohort. They may face some mobility restrictions and are more likely to openly identify as older adults. Most of these older adults are out of the workforce and may have experienced the loss of a life-partner or spouse. There is often a growing need for some type of supportive service to help these older adults remain in their own homes, if that is what they choose to do. It is among the "oldest old," those over 85, that the greatest needs exist. This group is most likely to have serious health problems and need assistance in more than one personal care area, such as bathing, eating, dressing, toileting, or walking. The needs of newly retired and healthy older adults to continue active and productive lifestyles are appreciably different from the needs of frail older adults forced into special living situations due to failing health. Somewhere in between the newly retired and frail older adults is the largest group of older adults, those who remain independent and function well in most areas of their lives but need specific social, health, or mental health services to maintain and maximize that independence.

Culture, ethnic group membership, gender, life experiences, and sexual orientation add to the uniqueness of the aging experience for each older adult. Some older adults have struggled with racial, gender, or sex discrimination throughout their adult years, factors that have a long-term effect on their socioeconomic well-being. Others bring significant health-care problems into old age, the result of inadequate health care since childhood. The dramatic rise in the number of divorces and fewer traditional family structures have created a complex web of blended families, stepchildren, multiple grandparents, and former spouses and partners expanding (and limiting) the support systems available to help an individual. Some older adults are "tech smart," whereas others have not had the opportunity or resources to access digital technology. While some older adults have used traditional social services at other times in their lives, many have never had to seek help until they reached their later years. The social work profession's commitment to recognizing and valuing the uniqueness of every individual is especially important in work with this population, as will become apparent throughout this text.

The Focus of This Chapter

This chapter is designed to introduce you to the demographic characteristics of older adults in the United States. This chapter also describes the variety of professional social work roles both as direct service providers and in macro-level settings. Direct service roles include work in community social service settings, home health-care agencies, primary care practices, aging life care practices (geriatric care managers), independent and assisted-living communities, adult day health settings, nursing homes, hospitals, and hospices. New social work roles are being defined in legal settings and in the field of preretirement planning. Macro-level roles include local, state, and regional planning; legislative advocacy; research; and consultancy in business and industry. These roles will be explored in depth later in this chapter along with factors that make this area of social work practice both rewarding and challenging.

THE DEMOGRAPHY OF AGING

The Growth of the Older Population

As of 2015, one in seven Americans was over the age of 65, or 14.9% of the general population (Administration on Aging, 2016). By 2030, when the last of the baby boomer cohort reaches age

65, older adults will comprise over 20% of Americans, or 72 million people (U.S. Census Bureau, 2010) (see Figure 1.1). The largest growth within the older population will be among individuals over the age of 85—older adults with the greatest health and social service needs.

The most notable growth in the older population will be among older adults of color, who will constitute 28% of the older adult population by 2030, as compared to 18% in 2005 (Federal Interagency Forum on Aging-Related Statistics, 2016) (see Figure 1.2). For example, the percentage of the population that is non-Hispanic White along will decline from 78% of the population to 55%, while older adults who identify as Hispanic or Latino will grow from 8% in 2014 to 22% in 2060 (Federal Interagency Forum on Aging-Related Statistics, 2016). Some of this growth among older adults of color is due to immigration, but much of it is due to improvements in childhood health care—increasing the likelihood that persons of color will even reach age 65—and improvements in the control and treatment of infectious diseases throughout the life cycle. Yet the consequences of a lifetime of economic challenge combined with a greater probability of developing chronic health problems will follow these older adults into this longer life expectancy. For older adults of color, living longer does not directly translate into living better. The special problems and challenges of growing older as a person of color are recurrent themes throughout this text.

Life Expectancy and Marital Status

A boy born in 2018 can expect to live to 79 years of age and a girl 83 years (Social Security Administration, 2018). This compares to a life expectancy of 47.3 years for a child born at the beginning of the twentieth century (National Center for Health Statistics, 2011). Women have a life expectancy of 80.4 years compared to 75.4 years for men. The projection of life expectancy changes as individuals get older. A man reaching 65 today can expect to live to 84.3 years, and a woman reaching 65 can expect to live to 86.6 years (Federal Interagency Forum on Aging-Related Statistics, 2016). If an individual lives to age 85, a woman can expect to live another 6.8 years and a man another 5.7 years. Just reaching the milestones of 65 or 85 suggests the individual is healthier in general and more likely to live longer than the general projections for the population

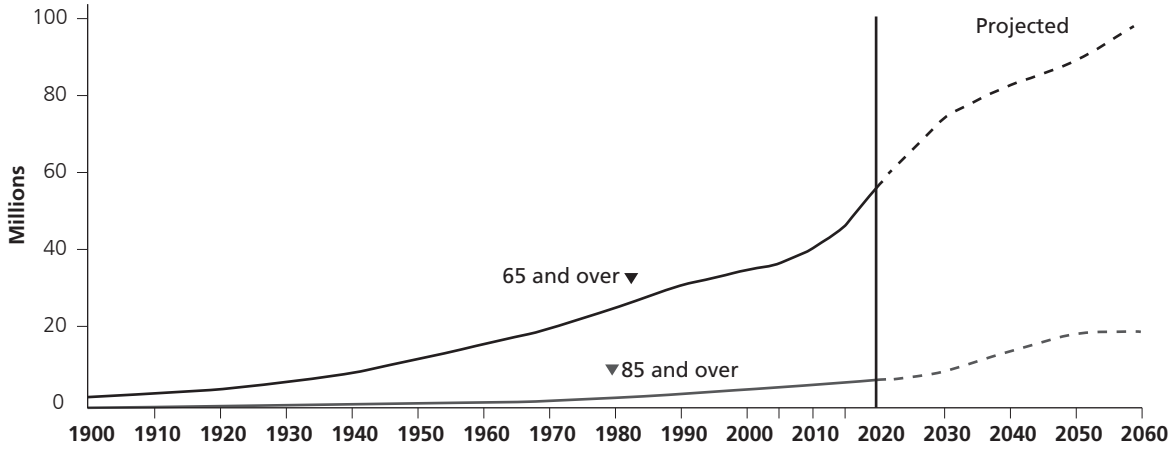

FIGURE 1.1 Number of Persons 65+ Years Old, 1900–2050 (numbers in millions)

Source: U.S. Census Bureau. *Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin of the United States: April 2010 to July 2014.* (PEPASR6H); U.S. Census Bureau, Table 1; Projected Population by Single Year of Age, Sex, Race and Hispanic Origin for the United States: 2014–2060 (NP2014_D1).

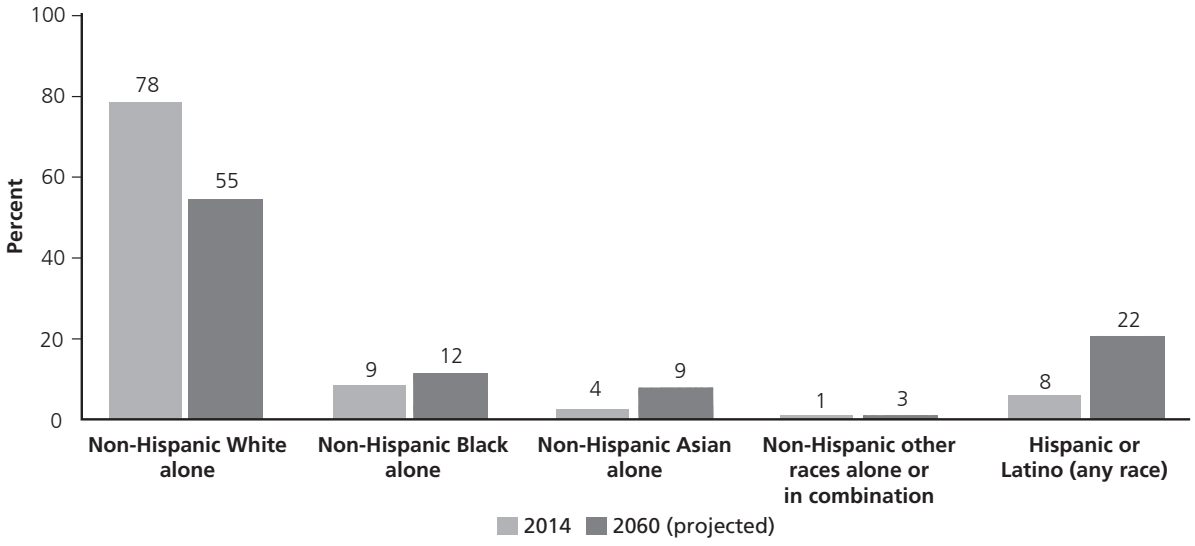

FIGURE 1.2 Percent of Population over 65 Years: By Race and Hispanic Origin, 2014 and 2050

Source: U.S. Census Bureau. *Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin of the United States: April 2010 to July 2014.* (PEPASR6H); U.S. Census Bureau, Table 1; Projected Population by Single Year of Age, Sex, Race and Hispanic Origin for the United States: 2014–2060 (NP2014_D1).

as a whole. This is particularly noteworthy when looking at racial differences among Black and White older adults. If a Black older adult reaches age 85, the life expectancy is higher for him or her than it is for a comparable White older adult by 1.5 years.

In 2016, older men were more likely to be married than were older women, 70% and 45%, respectively, reflecting the differences in life expectancy between the genders (Administration on Aging, 2016). Although men and women not married are most likely to be widowed, there was an almost threefold increase in divorced older adults from 5.3% in 1980 to 14% of the population by 2016.

Living Arrangement

Older men are more likely than older women to live with their spouses, 73% and 47%, respectively (Administration on Aging, 2016). Women are twice as likely to live alone than older men. By age 75, 46% of women live alone. This difference reflects the disparities in life expectancy, with older women being more likely to have outlived their spouses than older men.

One of the most significant shifts in living arrangements for older adults in recent years is the increase in the number of grandparents raising grandchildren. These numbers have increased due to deployment in the military, greater incarceration, and parent abandonment because of the opioid and methamphetamine crises. Approximately 2.9 million grandparent-headed households were raising grandchildren in 2015 (Administration on Aging, 2016). This number is disproportionately higher among African American, American Indian or Alaska Native, and Hispanic older adults, populations already at risk for being low income and in poorer health. The increase in the number of grandparents raising grandchildren presents a formidable challenge in terms of meeting the parenting needs of the children at a time when the older adult's economic and personal resources are often challenged by their own needs.

In 2015, 54% of older adults lived in just 10 states: California, Florida, Texas, New York, Pennsylvania, Ohio, Illinois, Michigan, North Carolina, and New Jersey. Thirty percent of older adults lived in areas considered "central cities," with 53% living in suburban areas. The remaining one-fifth of older adults lived in small cities and rural areas, those areas of the country most likely to have fewer health and social services available to the aging population (Federal Interagency Forum on Aging-Related Statistics, 2016).

Although 90% of nursing home residents are over the age of 65, they represent only 3.1% of the older population, according to the Administration on Aging (2016). This small percentage challenges the common perception that large numbers of older adults end up in nursing homes due to failing health. The percentage of older adults living in institutions goes up dramatically with age, from 1% of older adults between 65 and 74 years of age to 9% of women over the age of 85 (Administration on Aging, 2016).

Poverty

The change from Old Age Assistance to Supplemental Security Income in 1972 and the expansion of government-funded health-care programs for older adults have reduced the overall poverty of older adults since the 1960s, when 29% of individuals over the age of 65 had incomes below the poverty line (Federal Interagency Forum on Aging-Related Statistics, 2016). In 2016, 9.7% of older women and 7% of older men still had incomes that categorized them as poor (National Women's Law Center, 2016). A closer look at the poverty statistics indicates that individuals who have low incomes throughout their working lives are most likely to continue to have low incomes or drop into poverty in their later years. Older women are more likely to be widowed or living alone than are their male counterparts—thus relying on one income, rather than two. However, poverty is not a new experience for many women. Women experience higher poverty rates throughout their lives, whether due to the financial demands of raising children as single mothers, disrupted labor market histories, or low-wage occupational choices (National Women's Law Center, 2016).

There are disproportionately high poverty rates among older adults of color, with 18.4% of African American older adults showing incomes below the poverty line. Hispanic and Asian/Pacific Islander older adults have poverty rates of 17.5 and 11.8%, respectively (Administration on Aging, 2016). These poverty levels are more evident in women of color, with 20.6% of Black women, 19.8% of Latina, 13% of Asian, and 22.4% of Native American women reporting incomes below the poverty line (National Women's Law Center, 2016). Social Security benefits are lower for women and individuals of color who have low lifetime earnings. Limited incomes do not enable individuals to accumulate assets, such as property or personal savings accounts, and low-wage jobs rarely have pension or retirement plans. When low-wage workers retire, they simply do not have the financial resources to ensure an income much above the poverty line. On the other hand, high-wage workers have higher Social Security payments, have greater asset accumulation, and are more likely to have private pensions or employer-supported retirement savings (Social Security Administration, 2018). Older adults' retirement incomes mirror their lifetime earnings.

Although not technically considered "poor," millions of older adults struggle every month to meet living expenses. The average Social Security check is $1314 a month, and 21% of married recipients and 43% of single recipients depend on Social Security for 90% or more of their income (Social Security Administration, 2018). Although $1314 a month is above the poverty line, it is still a very meager income. One-third of households headed by an individual over 65 has no money left or is in debt after meeting basic living expenses. According to Trawinski and AARP (2012), almost 4 million older adults owe more money on their homes than they are worth

or have no equity. These findings suggest that although the sheer numbers of older adults below the poverty line have declined, the actual economic well-being of older adults is still precarious.

Employment

About 18.9% of the current population of older adults remains in the workforce beyond the traditional retirement age of 65, a rate that has actually risen since 2002 (Administration on Aging, 2016; Bureau of Labor Statistics, 2017). Baby boomers are expected to remain in the workforce at much higher numbers than the current cohort of older adults, with "more than three-quarters of boomers seeing work as playing some part in their retirement" (Bureau of Labor Statistics, 2017). However, these workers are likely to seek "bridge jobs," employment arrangements that allow them to work fewer hours with more workplace flexibility as they transition into full retirement. Changes in the retirement age under Social Security, the decrease in the number of guaranteed retirement pensions, and a decrease in the amount of private savings for retirement contribute to both the interest in and necessity of baby boomers remaining connected to the workforce longer (Munnell, 2014).

Health Status and Disability

In 2012, 60% of older adults managed two or more chronic health conditions (Ward, Schiller, & Goodman, 2012). Heart disease, arthritis, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, and diabetes are the most frequent chronic health conditions found in individuals over the age of 65 (Federal Interagency Forum on Aging-Related Statistics, 2017). By age 85, over half of older adults need some assistance with mobility, bathing, preparing meals, or some other activity of daily living (Centers for Disease Control and Prevention & the Merck Company Foundation, 2007). Despite these numbers, three-quarters of individuals between ages 65 and 74 and two-thirds of individuals over age 75 self-rated their health as good or very good (Administration on Aging, 2016), suggesting that older adults with chronic conditions may see those conditions as manageable and not necessarily debilitating.

Economic well-being and health status are intricately linked in the population. Chronic poverty restricts access to quality medical care, contributes to malnutrition, and creates psychological stress, all of which influence an individual's health status. For low-income older adults of color, late life becomes the manifestation of a lifetime of going without adequate medical care. Chronic conditions become more disabling. Prescriptions cannot be filled or glasses purchased because of limited financial resources. Poor older adults may have to choose between food and medicine.

The economic burden of an acute or chronic illness can devastate middle-class older adults' financial resources, quickly moving them from economic security to poverty. Much of this is due to the mechanics of financing health care for older adults. Medicaid, the health insurance program for low-income individuals, is available to older adults who qualify on the basis of low income and limited assets. Low-income older adults may be eligible to combine Medicaid coverage with Medicare, the federal health insurance program that covers 93% of individuals over age 65 and does not have a means test. With the combination of both programs, most major health-care costs are covered, although accessibility to health-care services may still be a problem for low-income older adults (Administration on Aging, 2016). Medicare covers only a portion of health-care costs for older adults and is not sufficient to provide adequate coverage. For middle- and upper-income older adults, Medicare is frequently augmented with supplemental insurance of Medicare Advantage Plans—private insurance that covers what Medicare does not. For older adults who do not qualify for Medicaid and cannot afford supplemental policies, a significant gap in coverage

exists. The National Center for Health Statistics estimates that almost 10% of older adults, most of whom are poor, women, and of color, have unmet health-care needs due in part to the gaps in the Medicare system (National Center for Health Statistics, 2011). This population is least likely to have routine physical exams, be immunized against the flu and pneumonia, have early screening for diabetes and hypertension, or take medications that prevent the development of more serious medical conditions. Therefore, when illness occurs, it is more likely to be serious. Prevention costs less than treatment for most chronic conditions, but a portion of the older population cannot afford preventative measures.

This overview of the demographics of aging shows a population of individuals over the age of 65 that is growing and will continue to grow rapidly during the twenty-first century. Despite a higher incidence of chronic health problems, most older adults are not sick, not poor, and not living in nursing homes. The vast majority of older adults struggle with occasional health problems but continue to be active, involved, and productive members of society, defying the stereotype of sick, isolated, and miserable old people. The economic picture, however, is bleakest for older adults of color, women, and the oldest of the old in the United States. If current trends continue, older adults will continue to live longer but not necessarily healthier lives unless chronic poverty and health-care inadequacies are addressed.

How Baby Boomers Will Change Aging in the Twenty-First Century

As mentioned earlier in the chapter, baby boomers will likely change the face of aging in the twenty-first century in dramatic ways. Just the sheer size of the cohort born between l946 and 1964 has sent ripples through every major social institution from education to health care. This cohort is better educated and is more likely to occupy professional and managerial positions (Frey, 2010). However, better education and higher lifetime earnings have not translated into economic security for the retirement years. According to Collinson (2016), the median retirement savings among baby boomers is $147,000, woefully inadequate to provide enough income to supplement Social Security income. Not surprisingly, two-thirds of baby boomers are planning to work beyond the age of 65 or do not plan to retire at all. That is a sensible plan to make up for inadequate savings but is contingent on staying healthy enough to continue to work (Collinson, 2016). Boomers have longer life expectancies than prior cohorts in part due to better information available on self-care and maintaining health (Manton, 2008) and to the development of medical advances in fighting infections and communicable diseases (Population Reference Bureau, 2016). However, boomers are not immune to the chronic conditions of aging such as hypertension, arthritis, cancer, and heart disease (Lin & Brown, 2012), which will threaten the feasibility of staying in the labor market indefinitely.

Baby boomers have higher rates of separation and divorce than previous population cohorts (Administration on Aging, 2016; Population Reference Bureau, 2016). They have fewer biological children and more "blended families" born of divorce and remarriage, which may lead to weaker family ties and less caregiving support if family is needed to provide instrumental or financial support. This creates a serious challenge if the number of individuals with Alzheimer's disease continues to grow from 5 million in 2017 to 14 million in 2050 (Alzheimer's Association, 2018). If a cure is not found and these projections come to fruition, the health and human services system will be overwhelmed.

As is demonstrated in Figure 1.2, the baby boomer generation is more racially and ethnically diverse than the previous cohort of older adults. In 2050, 46% of older adults will be members of a racial or ethnic minority, with the largest numbers being Hispanics (U.S. Census Bureau, 2010). The

challenge then becomes not diversity itself but the cumulative effects of lower educational attainment, greater health disparities, and lower lifetime income among racial and ethnic groups and the effect of these factors on health and economic well-being (Villa, Wallace, Bagdasaryan, & Aranda, 2012). The disparity between White older adults' economic well-being and the economic stability of populations could be even more pronounced than the current gap between these two populations.

USING THE STRENGTHS PERSPECTIVE IN WORK WITH OLDER ADULTS

The demographic overview of the older adults may leave you wondering how the social work profession can even begin to help the current (and future) population of older adults, which faces so many problems with limited income and chronic health problems. If a social worker focuses on all the things that are "wrong" in an older adult's life, the challenges are indeed overwhelming both to the social worker and the older adult. This text uses the strengths perspective, which focuses on what is "strong" in an older adult's ability to rally personal and social assets to find solutions to the problems he or she faces in the aging process. The strengths perspective is based on the philosophy that building on strengths, rather than problems and personal liabilities, "facilitates hope and self-reliance" (Saleebey, 2013, p. 2). To work effectively with older adults, the social worker has to believe that older adults continue to have the power to grow and change as they face challenges of aging and that they want and need to continue to be involved in decisions and choices about their care.

The focus of this text is on very specific challenges facing older adults, including health and mental health issues, substance abuse, abuse and neglect, family relationships, housing and transportation, and end-of-life issues, but incorporates the strengths perspective as an underlying theoretical approach to practice. The strengths perspective focuses on the ways in which clients have overcome challenges throughout their lives using a broad repertoire of coping and problem-solving skills (Fast & Chapin, 2000; Probst, 2009). An older adult who is experiencing the difficult decision to sell a much cherished family home and move into independent or assisted living has had to make painful decisions before and found the inner strength and social support to do so. An older adult struggling with a late-onset drinking problem has the physical and emotional ability to overcome an unhealthy reliance on alcohol. The strengths perspective affirms a basic tenet of social work practice: self-determination. If the social worker sets the goals for an intervention, and those goals are not those of the older adult, the worker should not be surprised when the older adult is resistant or uncooperative. "Clients create change, not helpers" (Glicken, 2004, p. 5). The social worker's roles are to help older adults identify strengths, resources, and goals; connect the older adult with personal and community resources to meet those goals; and facilitate and coordinate the process, if necessary. You will see how this approach is used throughout the text in specific areas of gerontological social work. There are other excellent resources that present the strengths perspective in more detail, and you are encouraged to consult them for a more in-depth discussion of this approach (Fast & Chapin, 2000; Glicken, 2004; Probst, 2009; Saleebey, 2013).

SETTINGS FOR GERONTOLOGICAL SOCIAL WORK

Older adults' need for social services falls along a broad continuum from the need for a limited number of support services such as housekeeping and meal services to extensive needs in a long-term or rehabilitation setting. Likewise, social workers' roles range from the traditional assistance as broker, advocate, case manager, or therapist to nontraditional roles such as exercise coach, yoga teacher, and spiritual counselor. Nursing homes and hospitals are often seen as the most familiar

settings for gerontological social work practice, but these settings represent a small part of the variety of opportunities available for social workers with passion for and knowledge about the older adult population. With only 4.1% of the older population in nursing homes, social service agencies, home health-care agencies, life care specialists (geriatric case managers), adult day health, and independent and assisted-living settings are more common settings for direct service or clinical practice. Social work roles in legal settings and in the expanding field of preretirement planning are additional settings for gerontological social work that function in a complementary role to the existing social service system. Social workers serve important roles in macro-level settings that serve older adults, such as community organizations and public education, local, state, and regional planning agencies; age-friendly communities initiatives; and organizations that engage in legislative advocacy. The future roles of social workers in the field of aging are limited only by practitioners' imagination and initiative.

Community Social Service Agencies

In large communities, social service agencies offer a wide range of counseling, advocacy, case management, and protective services specifically designed for older adults. These services may be housed in the local Council on Aging, Area Agency on Aging, or Department of Social Services, or may be provided by sectarian agencies, such as Catholic Social Services, Lutheran Social Services, Jewish Family and Children's Services, and so forth. Older adults or their families may feel more confident working with agencies that reflect their own religious affiliation. In small communities or rural areas, services to older adults may be contained within a regional agency that serves as an Area Agency on Aging (AAA), an Aging and Disability Resource Center (ADRC), or an agency serving other populations that has a social worker with particular expertise in working with older adults. The purpose and organization of AAAs and ADRCs will be discussed in detail in Chapter 14.

Employment opportunities exist in these agencies for both BSW and MSW social workers depending on the complexity of the work. Contact with a social worker at a social service agency is frequently initiated by a concerned family member who is unsure about how to begin the process of obtaining services for a family member. In addition to conducting the assessment process to determine what services might be helpful to an older adult, social workers can play an important role in initiating and coordinating services from a variety of agencies in a care management role. In some cases, the family of a frail older adult becomes the client. Although families can successfully provide caregiving, they may feel the strain of this responsibility and benefit from a support or educational group and respite services. As the contact is often precipitated by a crisis, families and older adults may need reassurance and support as well as solid information to stabilize a chaotic situation.

Home Health-Care Agencies

Home health-care agencies, such as the Visiting Nurses Association, often have gerontological social workers on staff as part of a team approach to providing services to older adults. Although the primary focus of home health care is to provide health-related services, such as checking blood pressure, changing dressings following surgery, or monitoring blood sugar levels for diabetic older adults, social workers can also play an important role in addressing older adults' psychosocial needs. An older adult who has had a stroke may not only need medication and blood pressure monitoring from a health-care provider but also need help with housekeeping, meal preparation, or transportation. The social worker can arrange for these support services and coordinate the

total care plan. Older adults who are essentially homebound due to chronic health problems often experience intense isolation and may benefit from regular phone calls from an older adult call service or friendly visitor volunteer. Gerontological social workers who work in home health care often provide supportive or psychotherapeutic counseling services or arrange for those services from another agency in the community, so they are most likely MSWs.

Social workers also play an important role in helping older adults work out the financial arrangements for home health care. Advocating for the older adults to receive the care they are entitled to under private insurance, Medicare, or medical assistance can involve myriad phone calls and personal contacts that are difficult for an ill older adult to handle. When older adults are not eligible for needed services under existing insurance coverage, creativity is often needed to obtain additional financial resources, including working with older adults' families or identifying low-cost community services that older adults can afford. If an older adult's illness becomes more debilitating, the social worker may need to work with the older adult to identify care arrangements that offer greater support, such as assisted-living services or adult day health care. It is the social workers' knowledge of community services and financial aid programs that makes them a valuable asset to home health care. These positions are filled by both BSW and MSW social workers.

Integrated Care Management

Facilitated by the Patient Protection and Affordable Care Act of 2010, one of the newest roles for gerontological social workers is that of a behavioral health-care specialist in integrated management setting. Integrated care management is an intentional effort by both behavioral and physical health-care providers to work together to reform the ways services to both high-risk populations and those with complex, chronic medical conditions, such as older adults, are provided (Stanhope, Videka, Thorning, & McKay, 2015). In a traditional model, primary health care is provided by primary care providers in a clinic setting. If behavioral health-care services are provided at all, it is likely at another location and not in coordination with health-care providers. In integrated care management, health-care providers receive a per capita payment to provide integration of behavioral health care into physical health care specifically for purpose of providing more comprehensive care and better monitoring of issues that may be affecting the quality of an individual's health status (Mann et al., 2016). This is consistent with the social work profession's belief that an individual's well-being is contingent on addressing both biopsychosocial and spiritual factors. The necessity of billing insurance companies for reimbursement requires an MSW in this line of social work.

For example, a social worker housed at a primary care provider's office may be asked to work with an older man who is returning home from a stay in the hospital after a brief illness. During or after the physician's office visit, the social worker meets the man to assess what kinds of service or behavioral supports he needs to live safely at home and minimize the chances he will be re-hospitalized. The social worker finds the older man is capable of caring for himself in terms of bathing and light housekeeping but is not consistent in meal preparation or medication management. If he does not eat on a regular basis, and especially if he does not take his medications appropriately, he will end up back in the hospital very quickly. The social worker finds he is highly motivated to stay out of the hospital but is mildly depressed. Even a minor depression can deplete what energy he does have to make an effort to prepare meals or even remember to take his medication. The role of the social worker, in conjunction with the health-care team, is to address the mild depression, explore options for easy meal preparation, and help set up a method

for organizing his prescriptions. Treating his health in this case is an interdisciplinary approach to supporting both the physical and behavioral aspects of his health. The point is that social workers can play a valuable role in preventing poor health-care outcomes for an older adult and the family by identifying what risks are present and taking a proactive stand to intervene before a crisis. The way in which affordable care organizations have evolved to provide better care, more efficiently, at a lower cost will be discussed in detail in Chapter 14.

Aging Life Care Professional (Geriatric Care Management)

Families in the twenty-first century are increasingly juggling the demands of full-time employment, hectic family schedules, and geographical separation from aging family members. An option available to families who may not have the time, knowledge, or availability to negotiate with community social services agencies or home health-care agencies is that of using an aging life care professional, also known as geriatric care managers. Geriatric care management has emerged as one of the newest and most rapidly growing professional settings for MSWs in gerontological social work.

Most geriatric care managers are social workers, nurses, or other specially trained counseling or health-care workers who may work as independent professionals or in conjunction with a health-care facility or social service agency. Aging life care professionals offer family members or other caregivers services in planning, implementing, and coordinating a wide range of services for older adults (Aging Life Care Association, 2018). These individuals have a specialized knowledge in assessing the biopsychosocial needs of an older adult and in locating the appropriate service in the community to meet those needs, the perfect role for social workers.

It is the role of the aging life care specialist to identify and coordinate the most appropriate support services needed to enhance the older adult's well-being. This may be as simple as arranging for health-monitoring services for an older adult who is recuperating from surgery or as complex as relocating the older adult to an assisted-living facility or nursing home (Aging Life Care Association, 2018). Geriatric care managers provide assessments and screening, arrange and monitor in-home help, provide supportive counseling to the older adult and the family, support crisis intervention, and even offer family mediation and conflict resolution when families have opposing views of what an aging parent needs or wants. They may also act as liaisons to families separated by long distances to report on the older adult's well-being or alert the family when an older adult's physical, psychological, financial, or social health changes.

The cost of geriatric care management can be substantial, with fees running between $50 and $200 per hour, depending on the type, complexity, and location of the services provided and the credentials of the care manager (Aging Life Care Association, 2018). These care management fees are typically not covered by Medicare, Medicaid, or traditional private health insurance, although the cost of the support services identified by the care manager are often part of the home health-care services financed by public and private health insurance programs.

Independent and Assisted-Living Settings

Specialized independent living settings for older adults in the community, such as low-income or moderate-income housing, frequently have social workers on staff to provide a variety of services. Helping older adults secure transportation to appointments or shopping centers, arranging opportunities for social activities such as plays and concerts, and promoting on-site activities are frequently under the auspices of a social worker in an independent living center. The social worker may be instrumental in helping the older adult to make the decision to add additional home care

services or transition to a housing setting that offers more support as the older adult's needs change with changing health conditions.

Another option in the range of services available to older adults in the community is the assisted-living center. Assisted living is defined as a residential, long-term arrangement designed to promote maximum independent functioning among frail older adults while providing in-home support services (Argentum, 2018). The assisted-living model fits in between completely independent living and the intensive care provided in a skilled nursing home. Some assisted-living facilities are part of a larger complex known as a continuum of care facility. Older adults may purchase or rent an apartment while they are still completely independent. As their health changes, necessitating increasing levels of support, older adults may need to move within the same complex to semi-independent living and perhaps eventually into an adjacent skilled nursing facility.

It should be noted that the quality and quantity of services available to older adults to support independent living varies widely among assisted-living facilities (Argentum, 2018). Although some facilities are more accurately described as "real estate commodities with food service and social activities," others are comprehensive health-care settings offering a wide range of physical, health, and social supports that truly do offer older adults healthy, high-quality care (Cutler, 2007). The assisted-living industry does not require nor regulate the use of professional social workers, although positions such as the care or service coordinator utilize the skills associated with professional social work practice. Both BSW- and MSW-level social workers are hired in these settings; however, if social work services are billed, MSW social workers are often given preference.

In high-quality assisted-living facilities, the focus is on as much self-maintenance as possible for each resident. Residents live in private or semiprivate rooms that have a private bathroom and, in some facilities, a small kitchen. The monthly fees include rent, utilities, a meal plan, and housekeeping services. Other services such as laundry, personal care services, and transportation are provided on an individual basis as part of a total care plan. Assisted living is expensive, usually between $3000 and $5000 a month, making it affordable only for middle- and upper-income older adults (Genworth Financial, 2014). However, some states are working to obtain Medicaid waivers to demonstrate the cost-saving effect of using the assisted-living model for low-income individuals as opposed to placing these older adults in skilled nursing facilities (Centers for Medicare and Medicaid Services, 2018).

The purpose of assisted living is to help older adults maintain and improve their psychosocial functioning through a variety of activities that maximize choice and control. Social workers conduct intake assessments to review the medical, functional, and psychological strengths and weaknesses of incoming residents. These assessments play an important role in identifying those areas in which an older adult may need supplementary services, such as chore services, assistance with bathing or dressing, or social activities to ease isolation.

Families and residents may need both information and support to make a successful transition to the facility. The decision to leave one's own home, even to move into the privacy of an apartment, is a traumatic experience for older adults and may require professional support to work through the grief and depression (Edelman, Guihan, Bryant, & Munroe, 2006). Assisted-living centers can offer a variety of challenging social and recreational activities that help older adults make the center their new home. Helping a resident find the right balance between private time and social activities is another important role for a social worker in this setting. In assisted-living centers, social workers often function as part of a multidisciplinary team composed of nurses and occupational, physical, and recreational therapists.

Adult Day Health Care

A setting for older adult care that falls between independent living and skilled nursing care is adult day health care. Adult day health care can provide individually designed programs of medical and social services for frail older adults who need structured care for some portion of the day. Older adults who live with their families or other caretakers or even live in semi-independent living situations and have some physical, cognitive, emotional, or social disability are typical users of adult day health care. These older adults do not need full-time nursing care or even full-time supervision but do require assistance with some of the activities of daily living. This type of care provides a valuable role as respite care for caregivers as well. Adult children may be willing and able to have older adults live with them if they can obtain supplementary care during the day while they work or for occasional respite (National Adult Day Services Association, 2018).

Many adult day health centers only take older adults who are able to be active participants in the development of their own service plans and consent to placement in the adult day health center. This type of care focuses on maximizing an older adult's sense of choice and control in their own care. A smaller number of centers work exclusively with older adults who have dementia, including Alzheimer's disease, who may be less able to be full participants in the decision-making process.

Social workers are involved with an older adult from the extensive pre-placement process through the execution of a service plan. Social workers and older adults explore the older adult's needs and interests together and select from a variety of rehabilitative and recreational services available at the adult day health center. An older adult may need physical or occupational therapy to compensate for losses due to a stroke or heart attack. Others may need supervision to take medication. Both BSW and MSW social workers in adult day health care are instrumental in coordinating all the physical needs frail older adults require during the day. In this setting, social workers may serve as care managers.

Group work is an essential role for social workers in adult day health centers. In most centers, older adults belong to a specific group that meets on a regular basis to talk about the issues they face. This may involve problems with families and caregivers, concerns about friends and members of the group, or more structured topics such as nutrition, foot care, or arthritis. The group becomes a focal point for older adults in the adult day health setting. It gives them an opportunity to maintain social skills or renew them if they have been socially isolated. The group is helpful in making new older adults feel welcome and helping them access all of the services available to them.

In addition to running a therapeutic group and a variety of social and recreational activities, the social worker meets individually with each older adult for counseling, advocacy, or problem solving. This individual attention plays an important role in maintaining the dignity of the older adult in what is predominately a group setting and in helping the worker monitor the older adult's mental and physical health status. At times, older adults may be reluctant to share deeply personal issues such as family problems, depression, and incontinence with members of their group and benefit more from a private discussion with the social worker.

When older adults are not meeting with their group or social worker, they are usually involved in a wide variety of activity groups geared to their special interests. Physical fitness, music, education, current events, arts and crafts, and creative writing are among the types of groups found in adult day health centers.

Nursing Homes

One of the greatest fears of older adults is that they will end up living in a nursing home. This fear explains why older adults fight so hard to maintain their independence. Nursing homes are seen as a place older adults are sent to die, neglected and forgotten by their families. Although this fear may be legitimate for some older adults, nursing homes serve an important role in the continuum of care for frail older adults. When independent living becomes impossible and more structured nursing care is needed, a nursing home may be the most appropriate service.

With a growing older population, it would be expected that the number of nursing homes would be increasing proportionately. However, between 1995 and 2005 the actual number of nursing homes decreased by 16%. The number of beds increased by 9%, meaning that today's nursing home is likely to be bigger than in previous years and that nursing home care is available in fewer locations (Centers for Medicare and Medicaid Services, 2015). The decrease in the overall number of nursing homes reflects the improvement in choices available to older adults for health care. Older adults are opting to stay in their own homes longer with the help of less-costly home-based alternatives to skilled nursing care.

The primary role of the social worker in a nursing home is to serve in both a supportive and an educational role to older adults and their families (Vourlekis & Simons, 2006). Social workers begin to work with older adults and their families prior to admission to a nursing home—arranging preadmission visits, doing a preliminary assessment of what kinds of services will best meet the needs of the older adult once admitted, and working out financial arrangements. Nursing home care can cost more than $6000–$14,000 a month and is not routinely covered by private insurance or Medicare unless it is a time-limited stay (Centers for Medicare and Medicaid Services, 2018). Some older adults will spend only a few months in a skilled nursing facility—for instance, recovering from an acute illness or surgery—so the social worker's job may include discharge planning as well.

Nursing home social workers also assume a supportive role in their work with the friends and families of residents. Placing a family member in a nursing home frequently generates guilt and anxiety among family members. They may feel they are abandoning their older adults, despite the fact that less drastic measures have already failed. Maintaining the relationship with the resident, identifying resources for handling the financial demands of placement, and processing the conflicting feelings that accompany placement are common responsibilities for nursing home social workers.

Hospitals

Forty percent of hospital admissions are individuals over the age of 65, and care for this population cost one-half of all health-care dollars spent (Agency for Healthcare Research and Quality, 2008), due primarily to the presence of chronic health-care problems in this population. The complexities of chronic health problems make hospital social work with older adults an essential part of the recovery process. Hospital social workers, the vast majority of whom are MSWs, provide a wide variety of services, including crisis intervention, client advocacy, client education, family liaison work, care management, and discharge planning (Volland & Keepnews, 2006).

Hospitalization is a crisis for anyone of any age, but with older adults there is always the fear that the hospital is the gateway to either a nursing home or the grave. Older adults may be anxious about upcoming surgery or be lost in the maze of medical jargon they hear. They may be concerned about what happens to them during the recovery process when they return home by themselves. Families may be concerned that their loved ones will receive too little care or be

hooked up to life-sustaining equipment against their will. In sum, the hospital setting can be a very chaotic environment for older adults and their families. Crisis counseling in a hospital setting involves helping the older adult and families reestablish an emotional equilibrium, begin to understand the medical condition, prioritize tasks, and develop a short-term action plan. The primary focus of the social worker is to help with the psychosocial needs of the older adult in the hospital setting while medical personnel attend to physical health.

Client advocacy is another appropriate role for hospital social work with older adults. Older adults may find the cold, impersonal atmosphere of the hospital frightening and confusing. They may need help in making their needs known or advocating on their own behalf. For example, a Chinese woman may need a translator, require a special diet, or wish to meet with a herbal healer. Social workers can work with other health-care professionals to find the best match between what the client wants and what the health-care system can tolerate. A part of client advocacy is client education, working with older adults and their families to better understand the presenting illness and its course of treatment. Client education is aimed at empowerment of the older adult. The more older adults know and understand about their illness, the better their own sense of control. When they feel they are part of the treatment process, they are more likely to be active participants in their own healing.

Social workers may also serve as family liaisons for the hospitalized older adult. The older adult's family needs to understand what is happening to the older adult, the prognosis for the illness, and what plans need to be made following the hospitalization. For many families, contact with a hospital social worker is the first contact they have had with the social services system. Up until that point, they may have struggled to provide care on their own, unaware of the range of community services available to them. The process of discharge planning, another important hospital social work role, involves developing and coordinating the support services for post-hospitalization. Meals-on-Wheels, home health care, chore services, and homemaking services can be very effective in helping older adults to maintain their independence while providing invaluable support.

Social workers can provide an educational and supportive presence in helping older adults and their families make difficult end-of-life decisions. Helping older adults make choices about what circumstances warrant being connected to life-support equipment, whether they want to be resuscitated after a heart attack, or who should make those choices when they are unable to are sensitive issues. Facilitating the discussion between an older adult and the family about these questions may be among the most difficult tasks in hospital social work.

Hospice and Palliative Care

Social workers are also integral to the provision of end-of-life care either in a palliative care or a hospice setting. Palliative care is comfort care aimed at providing as pain-free an experience as is possible to an individual with a serious or life-threatening illness. It is not necessarily available only to people at the end-of-life. Hospice care is provided when the individual's prognosis in a serious illness is that he or she will likely die in six months or less. The social worker's roles in these settings are to provide emotional support to both the individual and the family and to connect the family to support services that will ease the emotional or physical demands of the illness. In some hospice settings, the social worker and a nurse are the interdisciplinary team leaders doing the initial assessment and coordination of all hospice services such as medical oversight, behavioral management, or spiritual comfort. In other settings, health-care providers head the team, and social work plays a supporting role. The specific roles of social workers in end-of-life care are detailed in Chapter 11 but most often require an MSW because of insurance reimbursement.

DEVELOPING AREAS FOR DIRECT PRACTICE

Although social workers will be needed in the most traditional areas already discussed, there is unlimited potential for direct practice in other areas with older adults with the growth of this population. Two specific areas that will need a greater number of social workers are legal services and preretirement planning programs in both the public and private sectors.

Legal Services

Law and social work have had a long and sometimes tumultuous history. Although the professions share the joint goal of problem solving, the clash between legal and social work professions' foci in the resolution of problems is a major challenge to interprofessional cooperation. Law uses strict interpretations of existing laws and legal precedents, the confines of administrative rules and regulations, and a much more factual, not feeling, approach to problems. Social work's approach, on the other hand, is more deeply rooted in the consideration of the biopsychosocial factors that influence the development and perpetuation of a problem facing a client (Slater & Finck, 2012; Taylor, 2006). However, these professions can work together very effectively once each profession's expertise is clarified. This is particularly beneficial in areas of elder law. Helping an older adult and his or her family make provisions for a power of attorney or durable power of attorney for health care or determine competency in the case of dementia are good examples of the necessity of social workers and lawyers working collaboratively. When an older adult is competent but needs assistance in managing property or finances, lawyers and social workers are both important members of a team that will set up (and explain) guardianship (Sember, 2008; Slater & Finck, 2012). Another example is when an older adult is facing a problem that has very distinct social and legal implications, such as housing. What may have started out as an occasional lapse in the older adult's ability to remember to pay the rent may escalate into an eviction proceeding. The immediate legal action necessary to halt the physical removal of the older adult from the residence is the lawyer's role. The social work role involves long-term solutions to the housing crisis, such as finding a way to pay back rent, identifying another party to act as a fiscal agent, or considering the move to a safer, more structured living situation. One of the fastest-growing areas of elder law is that of the legal issues facing grandparents raising grandchildren. Issues in custody of dependent grandchildren, financial support, and discrimination in housing lead the list of socio-legal challenges facing this population (National Academy of Elder Law Attorneys, 2017). Lawyers are invaluable in navigating the complex system of child welfare law, whereas social workers are better prepared to handle the social and mental health challenges facing these older adults and their dependent grandchildren. The best solutions to these challenges will come only by interprofessional teamwork.

Preretirement Planning

Preretirement planning often is equated with financial planning; however, an adequate income is only half of the challenge of retirement. It is easy to see how the demand for services in this area is growing as the first group of baby boomers is facing retirement. The area of preretirement planning that receives the least attention is the psychosocial aspect of the transition from full-time employment to whatever is next. For people who have defined themselves in terms of their jobs or have relied almost exclusively on the workplace for social contacts, retirement can be very challenging. What do people do now? How will they redefine their lives to create a balance between the joys of leisure activities and continued productivity? How will couples

manage relationships when they are together all the time as opposed to having separate lives at work? Most important, what challenges face individuals who simply cannot afford to retire, even in the face of serious chronic health conditions? These questions embody the very essence of social work's expertise in the biopsychosocial dimensions of people's well-being. The social work profession is only now beginning to define its role in this process, usually in the context of employee assistance programs, also known as employee wellness programs, available in both the public and private sectors. The most exciting aspect of this area of practice is that the roles for social workers are yet to be clearly defined. How social workers can facilitate a healthy adjustment to retirement will be shaped by the next generation of gerontological social workers.

MACRO SETTINGS FOR GERONTOLOGICAL SOCIAL WORKERS

The role of social workers in direct service settings is readily apparent, but gerontological social workers also play an invaluable role in macro settings, such as community practice, planning, and legislative and political advocacy at the BSW and MSW levels. The United States has a well-developed federal aging services and programs network, authorized by various titles of the Older Americans Act of 1965. These include an authorization for a national, regional, state, and local structure to plan and deliver a wide range of services to older adults as well as to systematically plan for the future needs of older adults and advocate on behalf of this population in the legislative setting. Some of the macro practice roles for social workers fall directly within this network. The aging services network and the programs it oversees will be discussed in detail in Chapter 14. Other gerontological social workers practice within private and community agencies specifically dedicated to the planning and legislative advocacy interests of older adults.

Community Practice

The major foci of community practice with older adults is to mobilize and empower the older adult population to take an active role in their own problem solving by emphasizing the shared concerns of a community rather than solving one individual crisis at a time. Community work with older adults encompasses a wide variety of settings. Community can mean something as specific as a congregate housing setting or as broad as a city or town. In smaller community settings, organizers can be instrumental in mobilizing older adults to get improved public transit, organize a building crime watch network, or improve snow removal in front of a housing development (Massachusetts Senior Action Council, 2018). Social workers can also help mobilize older adults to petition a city government to grant a property tax exemption, improve access to health and social services through development of neighborhood centers, or develop an emergency plan for weather- or health-related emergencies.

Public education is another function within the general category of community practice for macro social workers. For example, when Medicare Part D, the prescription drug program, was being implemented in 2006, older adults desperately needed simple, clear information about the program. Providing this education either on an individual level or within the context of a community setting was often the responsibility of a social worker who had a strong knowledge base in all aspects of Medicare and was particularly sensitive to older adults' needs and concerns. As a result of a continuing need for older adults to have access to information and counseling about Medicare, Medigap, and Medicare Advantage programs, state governments have established State

Health Information Programs, with services available to anyone on Medicare who has questions or problems. These programs will be discussed in depth in Chapter 14.

Likewise, social workers are currently involved in offering educational campaigns about HIV/AIDS, fraud and financial abuse prevention, home safety, and advance directives, all of which are discussed later in this text. Public education is not just "telling" people what they need to know. It involves a comprehensive and understandable presentation of why the information is crucial and the patience to listen to the questions and concerns of older adults.

Planning

Social workers also practice in the planning offices of state offices on aging and area agencies on aging, or aging and disability resource centers. Social planning involves the process of exploring community needs and assets, developing plans of action, and evaluating future and existing policies and programs (Wacker & Roberto, 2014). The answer to the growing population of aging baby boomers is not to simply build lots of new older adult centers. The real crisis lies in areas such as developing alternative housing, health, and leisure programs that reflect the needs of a very different generation of older adults. Planning involves comprehensive needs assessment, an in-depth understanding of changing demographics, and sensitivity to how new and existing services will be financed. How do the needs of urban older adults differ from those of suburban older adults? What kinds of emergency programs need to be designed to adequately protect older adults in case of natural disaster, a health epidemic, or weather crisis? What kinds of programs need to be developed to meet the needs of older adults who still need to work but require more flexible work arrangements or training to keep up with technological advances? These are the challenges to public planning officers who must not only know what is currently working but what will be needed in the future.

Legislative and Political Advocacy

Advocacy and empowerment are central tenets of the social work profession, in their roles of acting on behalf of individuals and on behalf of specific vulnerable client populations in the political arena. Most programs and services for older adults are funded by federal and state funds and thus require both supporting legislation and administrative authority to operate. The social work role in legislative advocacy involves creating public awareness among older adults about pending legislation that may affect them and mobilizing this population to pressure legislators to act on their behalf. The legislative process is complex and may be confusing to older adults without access to the inside issues around the legislation. State chapters of the National Association of Social Workers (NASW) have rallied member and client support for such issues as mental health coverage parity laws, loan forgiveness for social work education, immigration rights, age and gender discrimination, and property tax relief for older adults.

NASW's Political Action for Candidate Election, the political action arm of the organization, works on behalf of candidates whose views on a variety of social welfare issues support the organization's policy agenda. They support these candidates through fund-raisers, campaign contributions, and public endorsement of the candidates during the elective process (National Association of Social Workers, 2018). The social work profession's role in legislative and political advocacy is a combination of local, state, and national efforts, all aimed at advocating for and empowering clients who are directly affected by the policy framework affecting policies and programs.

PERSONAL AND PROFESSIONAL ISSUES IN WORK WITH OLDER ADULTS

Although deeply rewarding both personally and professionally, work with older adults requires a high level of self-awareness on the part of the social worker. In all intervention efforts, workers bring their own emotional baggage to the helping process. However, in gerontological work, the issues are more complex. Unlike social work practice in the areas of alcoholism, drug abuse, family dysfunction, or domestic violence—social problem areas that may or may not personally affect the worker—everyone must eventually face the experience of aging and death for themselves and their families. Aging is not a social problem; it is a developmental stage. The universality of the aging experience influences work with older adults on both a conscious and subconscious level. Among the most significant issues workers will face are the subtle influences of lifelong social and personal messages about ageism, countertransference of feelings toward older adults, and conflicting issues surrounding independence versus dependence.

Ageist Personal and Social Attitudes

The term *ageism* refers to the prejudices and stereotypes attributed to older individuals based solely on their age (Butler, 1989). These stereotypes are usually negative and convey an attitude that older adults are less valuable as human beings, thus justifying inferior or unequal treatment. These attitudes develop early in life as children observe parental, media, and social attitudes toward older adults. Parents may unintentionally send the message that aging parents and grandparents are a nuisance to care for, demanding, needy, or unpleasant. Even simple comments, such as "I hope I never get like Grandma" or "Put me to sleep if I ever get senile," may be interpreted literally by children. Every time parents refer to aches and pains as "I must be getting old," the subtle message becomes clear that aging is destined to be painful and debilitating. Although ageism is an attitude that hinders everyone's ability to adjust to the normal changes of aging, it also serves a more destructive social justification. Ageism rationalizes pushing people out of the labor market in the name of maintaining productivity without much thought to what happens to people when their lives are no longer centered on work as an organizing principle. Ageism justifies segregated living arrangements, substandard medical care, and generally derogatory attitudes toward older adults. Blatantly racist or sexist comments and open discrimination would not be tolerated in today's business and social arenas, yet ageist attitudes and comments are rarely challenged.

Countertransference

Countertransference is defined as the presence of unrealistic and often inappropriate feelings by the social worker toward the older adult that distort the helping relationship (Nathan, 2010; Reidbord, 2010). The worker displaces feelings or attitudes onto the client based on a past relationship rather than on the real attributes of the older adult with whom he or she is working. Countertransference develops from two primary sources in working with older adults. Internalizing ageist attitudes reflected in society can lead a social worker to intensively dislike working with older adults because they are subconscious reminders of death and illness. On an unconscious level, the social worker may believe his or her work is wasted because the older adult will soon die, benefiting minimally from the social worker's time and attention. Countertransference can also develop when a social worker is unaware that positive or negative relationships from the past are distorting the present relationship.

For example, a young social worker is assigned to work with an older woman in identifying an appropriate assisted-living facility, a painful but necessary move for the older woman. When she goes to the woman's house, the older woman insists on serving cookies and tea to her, and they end up visiting for several hours rather than attending to the task at hand. When her supervisor inquires as to the decision about assisted living, the young woman hesitates and responds that she thinks it is "mean" that the family is making her go to assisted living, that this older woman wants to stay in her home and maybe with enough services she could stay there. She hasn't actually had the discussion about which assisted-living facility the older woman might select as it is just too awkward to bring up the topic. After the supervisor explores the situation with the worker, it becomes apparent that the worker overheard her own mother arguing with her grandmother a few years ago about the same kind of decision. She remembers her grandmother saying, "if I have to leave my house, I might as well just die!" which in fact, she did shortly after moving into assisted living. The older woman struggling with the decision to leave her own home was a subconscious reminder to the social worker of a painful situation in her own life. In order to alleviate her own pain and guilt, the worker was trying to avoid her client facing the same situation. The worker's need to "save" the older adult may rob the older adult unintentionally of his or her self-respect and personal dignity. It is essential to explore issues in countertransference with supervisors.

Ageism and Death Anxiety

Internalized negative attitudes toward the process of aging and older adults contribute to a pervasive presence of "death anxiety" in contemporary society. Death anxiety is a highly agitated emotional response, invoked by reference to or discussion of death and dying (Iverach, Menzies, & Menzies, 2014). Working with older adults is a constant reminder to the social worker of the logical progression of the life cycle—from youth to aging and death. American society does not deal well with death or any discussion of death. Consider all the phrases used to avoid saying the word *death*, such as "passed on," "expired," "gone on to the next world," and many others not quite so polite.

Facing a variety of situations surrounding death is an inevitable part of work with older adults. Many older adults will admit that death does not frighten them as much when they are older as it did when they were younger. They see friends and family members dying. Throughout their lives, they have thought about what death means to them, whether they believe there is an afterlife, and what their lives have been all about. If they have escaped the discomfort of chronic medical problems, they consider themselves lucky. If they live with a disabling or painful condition, they may welcome death as an end to the physical discomfort. Older adults often want to talk about funeral arrangements or make plans for disposing of their personal possessions even when family members do not. Although older adults' families may cling to denial as a means of warding off a critically ill older adult's death, hospital policy may simultaneously ask the family to make difficult end-of-life decisions. All these issues are examples of how social work with older adults requires some level of comfort on the part of the social worker in acknowledging and processing death not only with clients but also in one's own work in self-awareness.

The Independence/Dependence Struggle

One of the most frequently stated goals older adults voice is their desire to maintain their independence for as long as possible. This desire coincides with the social work profession's commitment

to promote self-determination and preserve the dignity of the individual. On the surface, there appears to be no conflict. In reality, as older adults require more and more support services and experience increasing difficulties in maintaining independent living, tensions between older adults' desires and families' and social workers' perceptions of need are inevitable. A worker can appreciate the desperate efforts on the part of an older adult to stay in his or her own home. Yet when an older adult is struggling with stairs or a deteriorating neighborhood, and difficulties in completing the simple activities of daily living challenge the feasibility of that effort, professional and personal dilemmas abound. Who ultimately must make a decision about an older adult's ability to stay in his or her own home? Who decides that an older adult is showing poor judgment about financial decisions? When does Protective Services step in to remove an older adult from a family member's home due to neglect or abuse, despite the older adult's objections? When do the wishes of the family supersede the wishes of the older adult, or do they ever? These are difficult questions for which there are no simple answers.

Despite functioning an entire lifetime as an independent adult, an older adult can be reduced to dependency by a single illness more quickly than he or she can emotionally process. In an effort to counteract a diminished sense of self-esteem, older adults may fight dependency to the point that they put themselves in physical jeopardy rather than risk relying on others. They may act out, show extreme anger, or make excessive demands on social workers and family members that cannot be met. Maintaining independence should be a critical goal of all gerontological social work, and throughout this text, various ways of promoting independence, even among older adults with disabilities, will be presented.

Other older adults react by assuming dependent roles sooner than they need to and become more passive and resistant than their physical condition warrants, assuming a kind of "learned helplessness." Rather than fighting for their own independence, they give up and willingly relinquish the decision-making issues in their own care. Although giving up their own rights to decision making may make case planning easier for workers and families, this situation lends itself to the development of other, more subtle problems. One of the fundamental concepts of social work practice is the importance of clients' choice of goals for intervention and their personal commitment to work on those goals, a basic tenet in adapting the strengths-based perspective discussed earlier in this chapter. For example, a social worker may decide an older adult needs to attend an older adult center program to decrease personal isolation. Even though the older adult may agree so as not to offend the social worker and out of gratefulness for all the worker has done for the older adult, the older adult will not go to the older adult center and participate if he or she does not want to go. The older adult may not blatantly refuse to go but rather will make appropriate excuses for nonattendance. Although well intentioned, the social worker has decided on a goal for the older adult that is the social worker's goal, not the client's. It is not surprising that family and workers become frustrated when older adults find ways to avoid doing something that is not their goal in the first place.

The process of relinquishing independence is the beginning of a very delicate process, even among older adults who are sincerely willing to let others make decisions for them. Older adults become reactors rather than actors in their lives. Perceiving that they have little control over their lives, older adults may fall into a deep depression and relinquish their will to live along with their independence. Families and caregivers, who perceive that older adults have given up even when they are capable of some independent activities, may react with anger and hostility. The social worker's role is to help the older adult and family find common ground that promotes self-determination and meets the need for services.

Self-Awareness and Supervision

The challenges of working with older adults within a societal context of ageist attitudes—which contribute to deeply seated fears about one's own aging and death—may seem a bit overwhelming at this point in the text, but there are resources for resolving these issues. Through developing self-awareness with professional supervision, social workers can effectively work through these issues. They are discussed early in the text because they should be clearly present in your mind as you study this field of practice. Developing self-awareness is a process that takes time and continues to challenge professionals throughout their careers. It may take a lifetime of working with older adults (and your own relatives) to recognize your own personal triggers for problematic feelings.

Workers need to take a critical look at any concurrent challenges they are facing in their own lives that could contribute to professional problems. A social worker who is also balancing the demands of an aging spouse, parents, or grandparents may feel such excessive demands on his or her own resources that working effectively with older adults may not be possible. Although such experiences may be helpful to the worker in developing compassion for an older adult's family, it may be counterproductive in the intervention process.

The ability to keep feelings at a conscious level is one of the most important parts of the process of developing self-awareness in working with older adults. One's personal feelings toward a client, family members, and the quality of the professional relationship are important clues to the worker about his or her own emotional issues. Supervisors can be helpful in diversifying tasks for the worker in an effort to defuse the emotions generated by intense cases. Working exclusively with highly dependent older adults or those with Alzheimer's disease can tax even the most well-adjusted, experienced workers.

THE REWARDS OF WORKING WITH OLDER ADULTS

After such an in-depth discussion of some of the personal and professional challenges of working with older adults, you might be wondering: What are the positive aspects of working with this population? Why would anyone even want to do this kind of social work? The answers to these questions are derived from the professional experiences of the author and her students over a span of many years.

Perhaps the greatest reward gerontological social workers find is the amazing pleasure of getting to know older adults as the resilient, determined, creative, and sometimes stubborn people they are. Their stories about falling in love, raising a family, surviving bumpy times, maintaining lifelong friendships, and facing the challenges of being older can be inspirational. Their stories are a reminder that the battle against ageism, sexism, homophobia, racism, and discrimination is lifelong. Their willingness to share the wisdom of a life lived takes the professional social work relationship to a deeper level of significance. Some relationships with older adults will be very short and solution-focused. Others will be forged over long-term efforts to solve complex problems. Some older adults will have limited capacity to interact; others will be the smartest, most articulate people you have ever met, and you will wonder how you got so lucky to be able to work with them. Some older adults will be stereotypical cranky older individuals, and others will have such a joyful and playful spirit, they will be your role models for growing older. But every older individual you meet in this work will touch you in ways that will shape you as a social worker for the rest of your career.

Work with older adults is a field where it is infinitely possible to actually accomplish major change in that individual's life. There *are* treatments that can alleviate depression and anxiety in an older adult; depression is not a normal part of aging. We can do something! There *are* resources

to provide home health care services or housekeeping services or transportation. We can do something! We *will* find a cure for Alzheimer's disease in the decades ahead, and it will be one of the most important medical accomplishments of this century. If working on behalf of a vulnerable population, scouring for resources to meet a client's needs, and serving the cause of social justice are why you are studying social work, there is no population that needs committed advocates more than older adults. The personal and professional fulfillment that come from working with an older adult to find the solution to a problem and seeing the gratitude in their smiles are the greatest rewards of this profession. Your journey is just beginning!

Summary

One of the greatest challenges to society and the profession of social work is the dramatic increase in the number of individuals over age 65 in the twenty-first century. Although the baby boomer generation will no doubt forge new ways to meet the demands of this developmental stage, quality health care, a productive postretirement lifestyle, and adequate financial resources pose challenges to today's and tomorrow's older adults. For some older women and older adults of color, the devastating effects of a lifetime of poverty and substandard health care will follow them into old age. These groups are the most vulnerable older adults.

The future of gerontological social work is bright not only because of the growing demand for specially trained practitioners but also because of the variety of settings in which social workers will be needed. In addition to traditional settings, such as hospitals and nursing homes, social workers can be found in community settings, legislative offices, and legal environments. These settings will demand a high level of skill in specific practice techniques and a willingness to engage in the self-awareness necessary for professional work with older adults. Working with older adults can trigger powerful feelings about death, the aging of family members, and your own attitudes about helping this vulnerable population. However, this population is also one of the most rewarding for social workers.

Learning Integration Activities

1. If you were born between 1982 and 2002, demographers consider you a member of the Millennial generation, deemed to be as influential a generation as baby boomers but for different reasons. Using data from the U.S. Census, American Community Surveys, or other reputable sources, describe what is unique to your generation. What role will technology, social media, education, and other demographic factors play in shaping your generation's influence as they age? How might social institutions anticipate those changes and plan accordingly? How do you anticipate your experience as an older adult will be different from your parents' experiences?
2. Interview a social worker employed in one of the settings described in this chapter for either direct service or macro social work. How do they describe their work? What qualifications are needed for that type of work? What have they enjoyed in the work? What parts of the work are challenging? How do they describe their interaction with older adults? What advice do they have for anyone planning to work with older adults?
3. Although work with older adults is not the biggest field within social work, it draws some of the most passionate social workers. What draws you to work with older adults? Do any of the challenges identified in this chapter resonate with you? Do you bring any valuable experiences with you into this field? Where have you gotten your messages about older adults and growing older?

4. Analyze advertising online, in popular magazines, or on television for subtle messages about older adults and getting older. Do you think the ads are blatantly "ageist"? Do you see advertising that sends positive messages about aging? Do you expect advertising will change as the population grows older (or not)?

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2 Biological Changes and the Physical Well-Being of Older Adults

Learning Outcomes

- Distinguish the influence of normal biological changes associated with aging from changes that suggest the presence of an acute or chronic disease
- Identify the key changes that occur in each of the body's major biological systems.
- Define the influence of urinary incontinence, HIV/AIDS, and hepatitis C on the quality of life for some older adults.
- Appraise the factors that have been shown to promote healthy aging.

Chapter Outline

Biological changes associated with the natural aging process are often the first overt signals to adults that they are moving from middle age to older adulthood. Although changes associated with aging are inevitable in all people, the extent to which these changes precipitate chronic illness or impair functioning varies dramatically. Many older adults remain physically active well into their 80s, experiencing only minor inconveniences caused by sight, hearing, or skeletal-muscular changes. Others struggle with debilitating chronic illnesses beginning in their 60s and are actually quite frail by their 70s. These differences are due to a variety of factors, including genetic predisposition to certain physical ailments, general lifetime health status, and, most important, the influence of lifestyle choices, including nutrition and exercise. This chapter begins with a discussion of what physical changes associated with aging mean to older adults themselves. While every stage in human development brings significant biological changes, those associated with the aging process often limit people's life choices and functioning rather than enhance them.

This chapter will explore the normal biological changes associated with the aging process, including the discussion of theories about why aging occurs at all and how cellular-level changes affect all the physiological systems of the human body. Once a baseline is established for what are considered expected developmental changes as the body ages, illnesses and conditions not considered inevitable in older adults are discussed. Special consideration is given to the problem of urinary incontinence, a life-changing development that challenges the capability for independent living for some older adults. A growing concern for gerontological social workers and health-care providers is the increasing incidence of HIV/AIDS, and more recently hepatitis C, among older adults, which is discussed as well. The chapter concludes with a discussion of the influence of nutrition, fall prevention, and exercise on an older adult's health and well-being, factors

that have substantial influence on the quality of physical health for older adults, regardless of genetic predisposition to the development of disease or the natural changes that accompany the aging process.

WHAT DO BIOLOGICAL CHANGES MEAN FOR OLDER ADULTS?

Daily Decisions Are Contingent on Physical Health

For older adults with physical limitations and chronic illness, daily decisions about what they can or cannot do are often contingent on day-to-day health status. How they feel physically is the barometer for their willingness to leave their homes, participate in social activities, and interact with others. Some older adults may feel their bodies have become prisons. As much as they might want to be more active, their physical well-being, rather than personal motivation, dictates what is possible. Consequently, older adults may be evasive about committing to participation in future activities. Although willing, they may feel it is more practical to say, "Well, I'll see how I feel on that day." Older adults with chronic health problems may experience good days and bad days that are impossible to predict. This hesitancy to make firm plans should not be interpreted as resistance but rather as a very practical way to handle the uncertainties of fragile health. This can be a source of endless frustration for the social worker in trying to facilitate involving an older adult in activities outside the home.

However, even significant chronic health conditions do not mean older adults have to completely withdraw from interaction with others. Too many older adults simply assume that nothing can be done about the aches and pains they associate with aging. They may resolve themselves to suffer silently. The aging process should not be synonymous with pain. The strengths perspective proposes that older adults can find physical and social activities that are geared to the remaining abilities, and the benefits from adaptive activities far outweigh the risks. For example, an adaptive yoga program can actually help minimize arthritis pain rather than exacerbate it. An amplification device in a movie theater will help an older adult with a significant hearing loss enjoy a movie along with friends or family. The social worker's role is twofold: to help older adults identify the physical abilities they have *not* lost and to encourage older adults to remain connected to enjoyable activities by facilitating adaptation when necessary. For older adults, physical health will continue to be an organizing principle in their lives, but there are a host of possibilities for working with and around health limitations.

An important premise of gerontological social work is that older adults have the right to maximum physical and emotional comfort whenever possible. It is paramount that social workers encourage older adults to seek medical attention when they experience pain and to be assertive when dealing with their physicians. Social workers can play an important role in empowering older adults to help physicians and other health-care providers to be more responsive to their needs.

Abilities and Attitudes Are at Odds

One of the most common reactions social workers hear from older adults as they face the changes that accompany the biological changes of aging is how much younger older adults feel in their minds than their aging bodies would suggest. They are acutely aware of (and infinitely frustrated by) the sense that chronic health problems are a form of betrayal by their bodies. Older adults

may experience a form of cognitive dissonance in which they feel strangely alienated from their bodies, thus being more likely to overestimate (or underestimate) what they can or cannot do. For example, every year an older man may insist on going up on the roof to clear the gutters of leaves and debris even though his balance is compromised or his sight is impaired. What looks like a foolish move by his family may be the man's assertion that he always has been able to do this chore and will continue to do it. He is proving something to himself and others. An older woman's refusal to use a cane, even though she is unsteady on her feet, may be a combination of denial of her physical limitations and a fear of being seen as "old" by others. While family members may describe aging relatives as stubborn, it may be one of the few ways left for an older adult to exert mastery in his or her life.

This process also may limit older adults from continuing to engage in activities because they underestimate what they still can do. An underlying premise of the strengths perspective is that even the most seriously compromised older adult is still capable of engaging in some level of self-care or enjoyable activity. Even with serious sight limitations, an avid reader can use "talking books" to continue the connection to reading. A lifelong runner who develops arthritis may need to substitute walking for running, but it still means vigorous physical exercise. Perhaps an older adult with Alzheimer's disease can no longer play the piano, but he or she can listen to music. A major goal of social work with older adults is finding a way to keep them connected to activities and others.

Personal Issues Become Public Business

Discussing physical health problems with a social worker or even health-care providers may be particularly uncomfortable for older adults An older woman who has been very modest about personal matters such as bladder and bowel functions may find it awkward to discuss these topics with a relative stranger. The same is true for an older man who does not feel his difficulties with maintaining an erection or urinating are anyone's business. What have been personal issues for older adults all their lives tend to become public business when helping professionals get involved. Although a solid understanding of an older adult's health problems is essential to the development of an intervention plan, it is important to be sensitive to the deeply personal nature of this discussion.

Older adults may bring an obsession to the discussion of health-care issues as these issues become more influential in their lives. It does not take long in a group setting of older adults for the issue of health to emerge as a major topic because it has such a profound effect on older adults' lives. If it is true that "misery loves company," it is easy for group social activities to be obsessed with common health problems. Older adults need to feel they can express their health concerns, but when it becomes perseveration, it becomes an obstacle to the older adult's ability to mobilize remaining strengths and preserve the best quality of life possible.

Often for the first time in their lives, older adults and their families are coming in contact with the health and social services system. It may be a very humbling experience for an older man who has been fiercely self-reliant for his entire life to need assistance in such activities as bathing and dressing from a relative stranger. For a woman who has always been able to balance the demands of both a career and family, it may be a painful to admit that even managing her own finances has become a challenge. An older adult's refusal or resistance to getting help needs to be handled with sensitivity. In the effort to be helpful, family and professionals can unknowingly contribute to an older adult's feelings of inadequacy.

Environmental Obstacles Should Challenge Assumptions about Accessibility

With a strong knowledge base in the physical changes associated with aging, social workers can be helpful to institutions and families in designing environmental adaptations to accommodate these changes, part of the effort toward developing older-adult-friendly communities. Handrails can help the unsteady older adult manage stairs or negotiate hallways. Using bright colors to distinguish individual steps and non-glare surfaces on floors can help the sight-impaired older adult avoid falls. Large-print signs and color-coded doors can help older adults reorient themselves in unfamiliar environments. Avoiding background music in older adult centers and nursing homes helps older adults concentrate on conversations without having to filter out distracting noises. Anticipating the kinds of environmental changes necessary for older adults with sensory and physical limitations can be helpful in avoiding accidents and making older adults feel more confident in both home and public settings.

However, the awareness of the necessity of environmental adaptations needs to move beyond an individual's home or a community institution. Inadequate accessible public transportation, car-centric communities, poor street lighting and signage, crumbling sidewalks, and dangerous intersections are just a few of the other kinds of environmental obstacles that sentence older adults to stay home rather than be full participants in their neighborhoods and communities.These issues will be explored further in Chapter 15.

WHY DOES THE BODY AGE?

Before looking at the biological changes that accompany the aging process, it is important to explore why scientists believe biological aging occurs. If the cause of aging can be scientifically determined, can the process be stopped? Would it be desirable to significantly lengthen people's lives? These are some social questions that derive from the interest in knowing why the human body ages. The biological questions center more on ways to slow the process of aging. This includes minimizing the development of disease and improving the quality of life for older adults as their bodies grow older. The scientific community does not agree on what initiates the biological aging process, but the primary theories currently espoused fall into three categories: genetic programming, cross-linked cells and free radicals, and changes in the immunological system. These categories do not exhaust all current theories of aging but represent the major areas of scientific inquiry under serious scrutiny. See Figure 2.1 for a brief discussion of extreme caloric restriction as an approach to lengthening the life span.

Genetic Programming

Proponents of the "wear-and-tear" theory of aging suggest that the body simply wears out, reflecting a preprogrammed process determined by genetic makeup. Under this theory, the human body has a maximum life span, and major physiological systems deteriorate at a relatively set rate (McDonald, 2014). Cells are programmed with a finite number of divisions, the process that creates new cells and replaces damaged cells (Saltsman, 2011). This deterioration is hastened by environmental and lifestyle factors but is genetically predetermined. The development of age-related diseases, such as glaucoma, Alzheimer's disease, and late-onset diabetes, may be determined by genetic markers. Genetic markers for certain diseases would explain why certain conditions

Could the secret to living longer be as simple as just eating less—a lot less? Restricting caloric intake by as much as 50% has long been proposed as a way to extend life, although it has only been tested on primates other than humans. Recent research at the University of Wisconsin-Madison and the National Institute on Aging found that "chronic caloric restriction" in rhesus monkeys (who show patterns of biological aging similar to those of humans) showed significant health benefits. One rhesus monkey that began a 30% reduction in calories consumed at age 16 has lived to be 43 years old, the human equivalent of 130 years. Lab specimens on the restricted diet also showed reductions in cancer, cardiovascular disease, and insulin resistance as compared to the control group. Extreme caloric restriction translates into reducing caloric intake to between 700 and 1100 calories per day, compared to the recommended 2000 calories per day. The most beneficial results were seen when the lab specimens were middle-aged or older when they began the diet and fed a plant-based diet minus meat and refined sugar (Mattison et al., 2017).

Besides physicians' obvious concerns about inadequate nutrition for maintaining bone and muscle health, nutritionists warn that such a low-calorie diet would also threaten an individual's emotional well-being. Who want to live to be a 100 years old, if it means such severe restrictions on something as pleasurable as eating?

FIGURE 2.1 Can Extreme Calorie Restriction Help You Live Longer?

run in families. There is strong evidence that longevity (without disease) runs in families by a combination of sheer genetic luck and healthy living. However, the genetic programming theory of aging is not universally accepted as the only explanation of the biological changes associated with aging.

Cross-Links and Free Radicals

Cellular biologists propose that aging begins with adverse reactions within the structure of cells and molecules, but those changes are not necessarily initiated by a genetic program. According to this theory, molecules in the body develop cross-links within themselves and with other molecules that create subtle changes in the physical and chemical functioning of the cell (Aldwin & Gilmer, 2004: McDonald, 2014; Meiner, 2015a). Cells accumulate collagen, a gelatinous substance present in connective tissues, which reduces the elasticity of tissue. The accumulation occurs because the body is not efficient in recognizing and eliminating cross-linked cells. This accumulation is observable in cartilage, blood vessel, and skin cells (Meiner, 2015a). Cartilage becomes less flexible, leading to the joint stiffness associated with aging; blood vessels harden, and skin wrinkles.

Another molecular-level explanation for aging is the free radical theory (McDonald, 2014; Saltsman, 2011). Free radicals are unstable oxygen molecules produced when cells metabolize oxygen. These molecules attach to proteins in the body, impairing the functioning of healthy cells. The damage to the body occurs when cross-links and free radicals accumulate, damaging cellular structures. Free radicals are believed to impair the body's ability to fight cancer, repair skin cell damage, and prevent low-density fat cells from clinging to artery walls. Adding antioxidants to multivitamins represents an effort to stabilize free radicals and thus slow the process of cell damage and promote healing. Antioxidants include many color intense vegetables such as squash, carrots, pumpkins, Brussels sprouts, spinach, and kale and fruits such as strawberries and cantaloupe. These fruits and vegetables are important to a balanced diet for all age groups, regardless of their antioxidant qualities.