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10 Short Tutorials on Aspects of Ageing

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An independent academic psychologist, based in England, who has written extensively on different areas of psychology with an emphasis on the critical stance towards traditional ideas.

A complete listing of his writings at http://kmbpsychology.jottit.com.

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1. OLDER ADULTS AND COSMETIC SURGERY

Older adults who have cosmetic surgery are often accused of "denying ageing" and of attempting to "stay young". Cosmetic surgery is seen as an "ageist practice" and the personification of anti-ageing ideas [1] that seek to hide the physical fact of "natural ageing" (eg: Gilleard and Higgs 2000).

Garnham (2012) disagreed: "Not only is this interpretation mobilised in popular discourse as a form of social critique targeting those who elect to have cosmetic surgery, but it also emerges in academic scholarship as an oppressive discourse limiting understandings of older subjectivities" (p38). She felt that older adults who have cosmetic surgery are "designing 'older' rather than denying ageing". A desire for a look of "indeterminate age" or "agelessness" that can be controlled by the individual (eg: Jones 2004).

Today "taking care of the body has become synonymous with taking care of the self" (Garnham 2012). The self is something that the individual is seen as constructing in society based on discourses (ideas) available at that time and place rather than something that is given. Thus the self (and the body) is a "project" like other "lifestyle projects" (eg: DIY renovation of the house). The self or body project takes place in the West in the context of consumer capitalism, and, in particular, "shopping choices" (and identity) [2] [3].

Garnham (2012) explored the "shopping choice" of cosmetic surgery in interviews with eleven 66-75 year-olds who had undergone cosmetic surgery in Australia. One interviewee, "Charlotte", summarises the desire to look better not younger - "I didn't want to look younger than people that are younger than me, I just wanted to look still like me, but I wanted to get rid of - and it did disappear - the droopy, the lines, the area that has been refreshed" (Garnham 2012 p43).

Garnham (2012) summed up: "Creative self expression through the aesthetic fashioning of the materiality of the body thus enables new corporeal forms that challenge

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[1] Anti-ageing ideas are based on the "renovation, rejuvenation, reversal, refresh, reposition, and restoration" of the body (Garnham 2012).

[2] Thus "body, clothes, speech, leisure pastimes, eating and drinking preferences, home, car, choice of holidays, etc are to be regarded as indicators of individuality of taste and sense of style of the owner/consumer" (Featherstone 2007 p81 quoted in Garnham 2012 p40).

[3] "Refusing to engage with consumption, or the refusal to choose, is constituted as a choice and as a choice it signifies something about the consumer - such as a lack of taste, style or status. Self-fashioning a 'lifestyle' within consumer culture therefore takes on an ethical dimension associated with virtues suspended in, what Featherstone, among others, refers to as the 'aestheticisation of everyday life'" (Garnham 2012 p40).

and exceed the boundaries of 'ageing'... [and] older people exercise ethical agency and creative resistance to navigate discourses and stylise a desirable mode of being" (pp44-45). To quote Rose (2007), "our somatic, corporeal neurochemical individuality has become opened up to choice, prudence, and responsibility, to experimentation, to contestation, and so to a politics of life itself" (quoted in Garnham 2012 p45).

ACTIVITY

- Find out how common cosmetic surgery is among over 60s. Are there official figures available? What are the most common procedures undergone or parts of the body changed? Does it vary between countries? What about gender differences? Are there ethnic differences?

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Rose, N (2007) The Politics of Life Itself: Biomedicine, Power and Subjectivity in the Twenty-First Century Princeton, NJ: Princeton University Press

2. OLDER CONSUMERS

A significant proportion of older adults have high levels of disposable income to spend [4], but they are the "invisible" majority as advertisers are not seeking to encourage their spending. If older adults are under-represented in advertising or advertising aimed at older consumers, "too many advertisements featuring older people are for a limited range of products and point towards an emphasis on incapacity in old age" (Yoon and Powell 2012).

Advertisers struggle to engage with older consumers because they are not a homogeneous group, nor is it clear at what age an individual enters that category (eg: 50 or 65 years old). Sudbury and Simcock (2009) suggested using self-perceived age for the demarcation rather than chronological age, and from the responses of 650 50-79 year-olds in the UK the researchers distinguished five identities of older consumers for advertisers:

i) Solitary sceptics - least healthy and active, negative about consumerism, limited family contact.

ii) Bargain-hunting belongers - least affluent, close to family and friends, highly price conscious.

iii) Self-assured sociables - healthy and energetic, sociable, cautious consumers with limited interest in material goals.

iv) Positive pioneers - reasonably affluent and healthy, relatively materialistic, and concerned about how others see them.

v) Cautious comfortables - not attracted by materialism nor price-conscious, not especially sociable, healthy generally.

Celebrity advertising is part of the process of presenting a brand as aspirational, and it is commonly used across the board. But it is hardly used with older consumers. Yoon and Powell (2012) presented the case study of a campaign in the UK using celebrity advertising - Marks and Spencer's (M&S) and the older model Twiggy (from 2005 onwards). The success of the campaign was called the "Twiggy Effect" by the popular media as one blouse worn by her in 2006, for example, "sold more in one week than any other product in the history of M&S" (quoted in Yoon and Powell 2012). The use of Twiggy

[4] For example, 50-64 year-olds spend more per head on cars, foreign holidays, and recreation and culture than any other age group in the UK (Sudbury and Simcock 2009).

represented the aspiration to look good whatever a person's age. Yoon and Powell (2012) noted: "Her appropriateness in the campaign for M&S comes not from her presentation of self as perfection, but rather through a sense of authenticity derived in part through the way in which she positively positions herself within the arena of consumption, using goods creatively and playfully, not only providing the entertainment value of the visuals but concomitantly generating an immediate point of identification with consumers around her age group" (p1330).

Among "baby boomers" (born after 1945) who were teenagers and in the 1960s, Twiggy was there as a mini-skirted young model, and now appears with them in later life. There is an identification by viewers with her - "consumers of the baby-boomer generation will identify, consciously or unconsciously, with the ageing process as it is manifested through the figure of Twiggy herself. The era of The Beatles, Carnaby Street and mini-skirts represents a shared past between the celebrity and the consumer..." (Yoon and Powell 2012 p1331).

DISCUSSION QUESTIONS

1. Why are advertisers not interested in older consumers?

2. How to define and segment older consumers for advertisers?

3. Why is celebrity advertising popular generally?

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Yoon, H & Powell, H (2012) Older consumers and celebrity advertising Ageing and Society 32, 1319-1336

3. IMAGES OF ACTIVE AGEING

The view on ageing has changed in recent years. "Older people are no longer viewed as dependants and recipients of a paternalistic welfare system but have been reframed as consumers and participants of welfare who not only make active choices but shape the welfare agenda" (Martin 2011 p52). Key within this change is "active ageing", formalised by the World Health Organisation (WHO 2002). Health promotion and education are an important part of it.

But two contradictory sets of images have emerged with active ageing. The positive images of "possibilities and opportunities of later life, the good life here and now, and the pleasurable pursuits and consequences associated with body maintenance regimes, such as diet and exercise. These images portray health, vitality and activity and convey an ageless and timeless social world" (Martin 2011 p53). At the same time, the negative images "associated with perceptions of heightened risks to health, bodily vulnerabilities and dependence associated with growing older" (Martin 2011 p53).

Martin (2011) explored these contradictions using visual images of older adults and in-depth interviews in south-east England. Over 300 images aimed at over 50s were collected from health promotion leaflets and materials available in the community. During the interviews with 50-96 year-olds in 2003-4, the participants reported what they saw in the images (ie: the meaning to them).

Two key themes emerged from the analysis:

(i) "Active ageing" - positive images of being active, including through paid and unpaid work, and of opportunities in later life. Men were more likely to be depicted as active (eg: swinging a golf club) than women.

(ii) "Health, risk and dependency - negative images of health and everyday risks, and reminders of bodily decline (eg: use of mobility aids). Images associated with food and diet, depression, and memory loss were more likely to feature women than men.

Martin (2011) concluded about the health promotion images: "Gender, ageing and the body were moreover intertwined within these visual images, with the images of active and passive embodiment mapping onto wider dualisms including men (active/doing) and women (passive/motionless); young and old bodies; and public and private space" (pp65-66).

RESEARCH ACTIVITY

- Try a replication of Martin's (2011) study. Choose a sample of images from a particular source, and divide them into categories, or ask older adults to divide them up. What criteria are used? What themes emerge from this categorisation process? Is it a simple binary between positive and negative images?

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4. SUCCESSFUL AGEING AND OUTDOOR ADVENTURE EXPERIENCES

"Successful ageing" (Rowe and Kahn 1987) is a concept that has appeared in recent years and includes good physical and psychological health, and social relationships. "Underpinning successful ageing is the concept of individual responsibility for self-reliance and independence" (Boyes 2013) [5].

Villar (2012) distinguished two versions of successful ageing:

i) The achievement or maintenance of a certain state of physical and psychological health (ie: successful ageing as an outcome). Villar (2012) noted that "establishing supposedly universal and objective criteria for ageing well runs the risk of creating a two-tiered view of the elderly, since only certain privileged minorities might aspire to meet the standards of success, which remain out of reach for those who, for whatever reason (eg: presence of disabilities, social exclusion or very advanced age) are unable to meet these strict criteria" (p1090).

ii) The involvement in activities that aid adaptation to changes in ageing (ie: successful ageing as a process). This can allow for "the ageing paradox" ("the presence of subjective wellbeing in the face of objective difficulties or other socio-demographic or contextual risks that intuitively should predict unhappiness"; Mroczek and Kolarz 1998).

Villar (2012) proposed that generativity can play an important part in this version of successful ageing. Generativity refers to contributions to society through, for example, transmitting cultural values to future generations ("cultural generativity") or establishing bonds ("communal generativity") (Kotre 1995).

Liang and Luo (2012) highlighted four problems with successful ageing:

a) It is grounded in the illusion of agelessness - "old age is simply 'more of the same', a resemblance and/or an extension of youthfulness and middle-age values" (p328).

b) It emphasises the "busy ethic" (Ekerdt 1986) -

[5] "Health issues, financial pressure and unsuccessful ageing in late adulthood are often outside the control of the individual and may be consequential to employment misfortune and lifestyle decisions made earlier in life. Being help responsible could lead to further marginalisation" (Boyes 2013 p645).

"older people are not valued unless they are active or productive, either through contributing to the economy by being good consumers or through so-called 'civic engagement' (Minkler and Holstein 2008)" (p329).

c) It accords with consumer culture - successful ageing can be achieved by buying the products for it (eg: anti-ageing products).

d) It is based in Western values - independence, youthfulness, and productivity.

Liang and Luo (2012) proposed "harmonious ageing" as an alternative to successful ageing. "Successful ageing focuses on the individual, especially the maintenance of an active and busy body. In contrast, harmonious ageing stresses the complementary co-existence of body and mind, harmonious family and social relationships, and a balanced outlook that appreciates both opportunities and challenges in old age" (Liang and Luo 2012 p333).

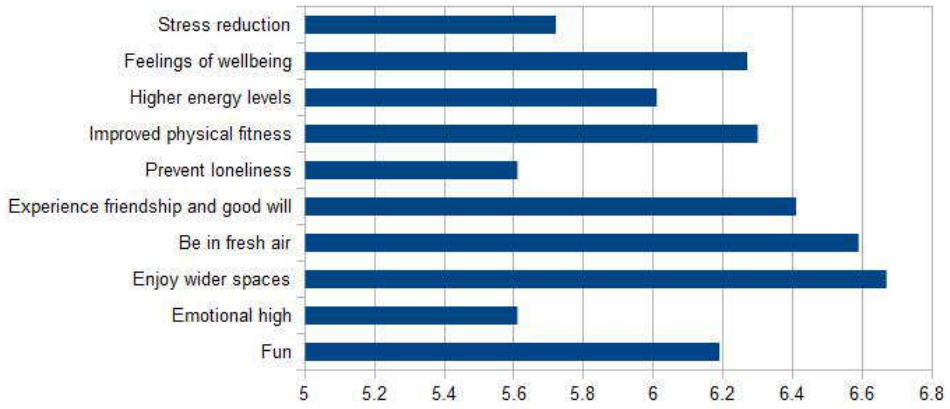
OUTDOOR ADVENTURE EXPERIENCES

Boyes (2013) explored "outdoor adventure experiences" as part of successful ageing. These include mountain climbing, hiking, and mountain biking. Such activities can benefit older adults in a number of ways:

- Physical - eg: muscle maintenance.
- Psychological - eg: positive emotions.
- Social - eg: friendship development.
- General - eg: independence.

Boyes (2013) performed in-depth interviews with six 63-80 year-olds and the programme director of a Third Age Adventures programme in New Zealand, and then used the information to develop a questionnaire for another eighty participants on the programme. Respondents reported more emotional and social benefits of the activities rather than the thrill and risk rated as important by younger adults in other studies (eg: Holyfield et al 2005) (figure 4.1).

Boyes (2013) summarised the findings: "The impact on these people's lives was notable. The activities were typically 'soft adventure' and the cohort confirmed that risk engagement was desirable but situations of over-extension were avoided. From the perspective of the individual, authenticity, embodiment and emotional engagement through fun, pleasure and excitement were sought. Uncertainty was accepted but not to the point of discomfort or threats to safety. Of similar importance



(Data from Boyes 2013 table 1 p655, table 2 p657, table 3 p658, table 4 p659, and table 5 p660)

Figure 4.1 - Mean scores (out of 7) for selected items.

were social and environmental experiences and learning. The inimitable combination of these elements produced a flavour of adventure that was unique. The participants were very happy participating in adventures and saw considerable personal and social benefits from engagement" (p661).

ACTIVITY

- Design (or find out about) adventure programmes in your area for older adults:

- Lasting one day.
- Lasting more than one day.
- For adults in their 50s and 60s who physically able.
- For adults who mildly physically disabled.
- For adults in their 70s with some physical limitations.

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5. ANTI-AGEING

The desire to stop, control or educe ageing has historically led to many and varied practices including alchemy, taking extracts from glands of various animals, and eating specific foods. "Anti-ageing" manifests itself today in "(1) commercial and clinical enterprises that offer anti-ageing products, regimens, and treatment and (2) research and development efforts of biogerontologists - scientists who study the biology of ageing" (Binstock and Fishman 2010 p472). Together the aim is to extend the lifespan (while downplaying negative aspects of ageing like physical deterioration) [6].

Binstock and Fishman (2010) distinguished three "anti-ageing paradigms" [7]:

i) Compression of morbidity - increase the disease- and disability-free period of life rather than the lifespan itself (though this can be extended) (eg: Fries 1980).

ii) Decelerated ageing - slowing the process of ageing and thereby increasing the lifespan (eg: Miller 2002).

iii) Arrested ageing - reversing the ageing process via rejuvenation (eg: de Grey and Rae 2007 [8]).

What is distinct today about anti-ageing is the view that ageing is, in effect, a disease that can be potentially cured like any other illness. Haber (2001-02) noted three factors that have led to this position - scientific discoveries related to slowing ageing, the ageing of "baby boomers" who grew up with youth-oriented popular cultures, and the general increase in numbers of older adults in the population. All of this takes place in the context of consumerism where any product or service can be sold or bought [9]. So why not "age-resisting technologies" (Binstock and Fishman 2010)?

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[6] Gruman (2003) referred to "prolongevity" - "a limbo reserved for impractical projects or eccentric whims not quite worthy of serious science or philosophical consideration" (quoted in Fishman et al 2008).

[7] A "weak" life extension view focuses on increasing the average lifespan from 80 to 100 years old, for example, with compressed morbidity, while the "strong" view imagines an average closer to 200 years old (Vincent et al 2008).

[8] Vincent (2008) was critical of this approach: "De Grey presents himself as the persecuted avant garde, the forefront of the new science excluded by the reactionary establishment. In rhetorical terms he, and many other anti-ageing activists construct themselves in a 'scientist as hero story' drawing parallels to past rejections of scientists and their ideas which have subsequently become publicly acclaimed" (pp332-333).

[9] The Internet has played a key role in reaching new consumers for the anti-ageing products and services offered by the increasing number of entrepreneurs in this area (Fishman et al 2008).

Vincent (2008) concluded that "the key response to the anti-ageing movement should not necessarily be to question its scientific validity and credentials. But rather to rid science as a whole of its ageist preconceptions, a difficult task when it is embedded in a wider ageist culture" (p338).

Increasing the lifespan raises existential issues which include questions like: "What is old age? What is the purpose of life, and its different stages? Is life always preferable to death - is immortality desirable?" (Vincent et al 2008 p292).

DEBATE

- This house believes that extending human life can only be beneficial.

OR

- This house believes that the "finitude of human life is a blessing" [10].

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Vincent, J, A et al (2008) The anti-ageing enterprise: Science, knowledge, expertise, rhetoric and values Journal of Aging Studies 22, 291-294

[10] Leon Kass (2001), chair of the US President's Council on Bioethics (2001-5) quoted in Binstock and Fishman 2010.

6. STATISTICAL EXERCISES

Selwyn, N et al (2003) Older adults' use of information and communications technology in everyday life Ageing and Society 23, 561-582

A household survey in the west of England and south Wales about use of information and communications technology (ICT) was completed by 1001 adults over 20 years of age.

1. The response rate was 75%. How many questionnaires were sent out?

2. The age distribution of the respondents = 352 x 60 years plus, 319 x 41-60 years, and 330 x 21-40 years. What are the percentages of the total sample for each age group? Draw a pie-chart to show the age distribution of the sample.

3. Selwyn et al concentrated on the over 60s age group. What percentage of the questionnaires sent out responded in this age group?

4. The respondents over 60 were 154 men and 198 women, and 328 White and 24 non-White. What are the ratios of male to female respondents, and White to non-White respondents?

5. The mean age of the respondents over 60 was 72.3 years (with a standard deviation of 7.97 years). Assuming a normal distribution, what is the age range of two standard deviations, and what proportion of the group does that age range cover?

6. Using the data in table 6.1, what are the numbers of users and non-users of computers for men and women? Using the chi-square test, is there a significant difference between the number of male and female users?

GENDER	USERS (%)	NON-USERS (%)	SAMPLE SIZE
Male	32	68	154
Female	15	85	198

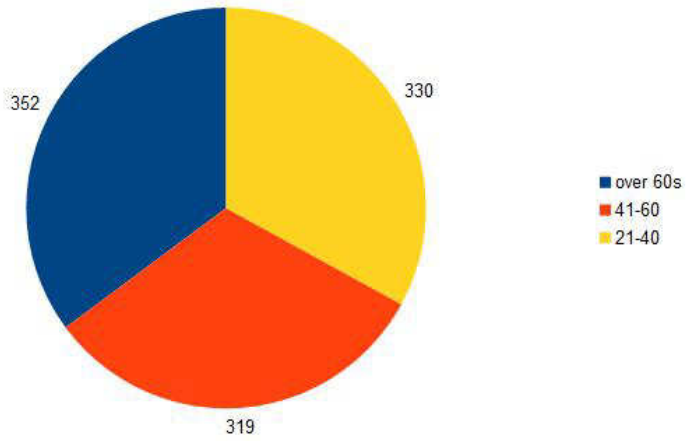
(Source: Selwyn et al 2003 table 7 p574)

Table 6.1 - Users and non-users of computers based on gender.

Answers to Selwyn et al (2003)

1. 1335.

2. Over 60s = 35.2%; 41-60 = 31.9%; 21-40 = 32.9%.



3. 26.4%.

4. 1 male: 1.3 female; 1 non-White: 13.7 White.

5. Age range = 56.4 to 88.2 years; covers approximately 95% of group.

6. 49 male users and 105 non-users; 30 female users and 168 non-users. $X^2 = 13.77$ (df = 1) ($p<0.001$). There are significantly more male computer users than female.

7. SANDWICHED-IN GENERATION

McIlvane et al (2007) explored the well-being of the "sandwiched-in" generation - adults with living parent(s), and with child(ren) of their own in the Detroit area of the USA. Psychological well-being was measured by the Center for Epidemiological Studies Depression Scale (CES-D) (Radloff 1977), which has twenty items on mood in the last week. Each item is scored from 0 ("rarely/none of the time") to 3 ("most or all of the time"). The scores range, thus, from 0-60, where a higher score is associated with more depressive symptoms.

Of the sample of 796 30-64 year-olds, 505 were "sandwiched-in" (parents and children), 104 had living parent(s) but no children of their own (parents only), and 187 had only child(ren) of their own (children only).

The data collected in 1992-93 in a regionally representative household survey ("Survey of Social Relations"), which recruited a stratified probability sample of 1702 individuals aged 8-93 years.

The parents only group had significantly less depressive symptoms than the other two groups (mean: 8.8 vs 10.5 and 10.5). The significance level was 1% using the ANCOVA statistical test.

EXERCISES

1. Psychometric questionnaires like the CES-D have established validity and reliability. What do the following terms mean, and how would you establish them for the CES-D?

- Concurrent validity
- Test-retest reliability
- Predictive validity

2. What type of scoring scale does the CES-D use? What is an advantage and a disadvantage of such a scale?

3. What does significant at 1% mean? What is the ANCOVA test?

4. What is a stratified probability sample? What is an advantage and a disadvantage of using it?

5. What is the dependent variable (DV) in this study? What is the independent variable (IV) (or technically the quasi-independent variable)? Why is technically a quasi-independent variable? What type of design is being used?

ANSWERS

1. Concurrent validity - correlation of scores with another valid measure of the same behaviour (eg: another questionnaire about depression). Test-retest reliability - correlation of scores by same person on same test at two different points in time. Predictive validity - degree to which the test scores predict future behaviour (eg: taking anti-depressants).

2. Likert scale.

3. Likelihood of this difference between the groups being due to chance is 1 in 100. ANCOVA = analysis of co-variance.

4. The population is divided into strata (eg: based on age) and a certain number of individuals are sampled from each stratum.

5. DV = score on CES-D. IV = group (parents only, children only, or parents and children). IV is quasi because individuals cannot be randomly allocated to any of the groups. The design is thus quasi-experimental.

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8. PERCEPTION OF APPEARANCE OF OLDER ADULTS

- Perform a replication of Rexbye and Povlsen (2007)

(Rexbye, H & Povlsen, J (2007) Visual signs of ageing: What are we looking at? International Journal of Ageing and Later Life 2, 1, 61-83 (freely available at http://www.ep.liu.se/ej/ijal/)

- How the appearance of older adults is perceived by younger individuals?

- Facial and full length photographs of older individuals who can choose what to wear and where to be photographed.

- Younger participants estimate the age of individuals in the photographs and describe them.

- This combines quantitative or qualitative analysis. Estimates of age can be compared to actual age (quantitative), and descriptions of individuals can be recorded and analysed for language used and patterns.

9. ETHICAL AND PHILOSOPHICAL ISSUES AND DEMENTIA

Dementia raises a number of philosophical issues, particularly as the disease gets worse for the sufferer (Hughes 2013).

1. Citizenship and social death - "Some people with dementia are positioned as socially dead [11] because of the impoverished nature of social interactions" (Hughes 2013). Brannelly (2011) referred to "social disregard" where sufferers are marginalised by others, and "social disregard" where the individual's rights as a citizen are emphasised. One manifestation of this idea is the question of "therapeutic lying" (Tuckett 2011) (ie: lying to the sufferers in their best interests, for example).

DISCUSSION POINT - Is it right to lie to dementia sufferers about their condition or treatment? How does this vary from medical professionals lying to sufferers of other terminal illness?

2. Capacity and consent - The autonomy of the individual is challenged by memory loss leading to problems with understanding decisions (capacity) and the ability to make them (consent). The main option is "surrogate decision-making" (ie: the decisions are made on behalf of the individual by another person).

Using two end-of-life clinical vignettes, Jox et al (2012) compared the decisions made by family surrogates and "professional guardians" (eg: volunteers with guardianship organisations) in Germany. The former (first-degree relatives) were more likely to make decisions based on their own preferences, though they did take account of the patient's age, wellbeing, and suffering. Professional guardians were more concern with correct procedure and legal aspects.

ACTIVITY - In England and Wales, the Mental Capacity Act is the legal framework for situations of lack of capacity. What are the main points of the Act in relation to dementia sufferers?

3. Expression of sexuality - In a care home, residents may want to express their sexuality or refuse the advances of others. These scenarios produce conflicts in

[11] This is "when people are considered unworthy of social participation and deemed to be dead when they are alive" (Brannelly 2011 p662).

the principles of respect for autonomy, beneficence [12], non-maleficence [13], and justice (eg: Mahieu and Gastmans 2012).

ACTIVITY - If you were a staff member at a care home, and two individuals with varying degrees of dementia started an apparently consensual sexual relationship, how would you react? What issues need to be considered? What role does the social prejudice about sexuality in the elderly play in such decisions?

4. Feeding - The use of tube feeding (artificial nutrition and hydration) for advanced sufferers who can no longer feed themselves.

5. Self and identity - A reductionist view would be that the self is a product of the physical brain, and the deterioration of the brain is a loss of the self. A philosophical view reflects on the nature of selfhood and the idea that "we are more than just our brains" (Hughes 2013). On the other hand, "the link between personhood and cognition, or loss of self and loss of memory, might mean that these notions of personhood and self are less than useful in dementia and should be replaced by talk of how people with dementia can still build a life-world through their interactions and creative engagements" (Hughes 2013 p286) (eg: Millett 2011).

DISCUSSION POINT - What is the self? Is there a point at which an individual can be physically alive but without a self?

6. Technological developments - Technological developments have the potential to improve the lives of older adults generally, as well as dementia sufferers. But their use raises ethical issues. For example, devices to keep track of individuals all the time may invade privacy or deepen the isolation of users home alone (Sorell and Draper 2013), while robots that perform all the basic needs of individuals raise the issue of "whether the technology allows people still to be regarded as social beings who can respond reciprocally to human interaction" (Hughes 2013 p285).

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[12] Weighing the benefits with the risks and costs (http://www.alzheimer-europe.org/Ethics/Definitions-and-approaches/The-four-common-bioethical-principles/Beneficence-and-non-maleficence; accessed 18/07/13).

[13] Avoiding causing harm (http://www.alzheimer-europe.org/Ethics/Definitions-and-approaches/The-four-common-bioethical-principles/Beneficence-and-non-maleficence; accessed 18/07/13).

7. End-of-life and advanced directives - Increasingly individuals are leaving instructions about what others should do when the individuals are unable to make their own decisions. These advanced directives can be made years beforehand in some cases. "At the end of life, we may have to trust the judgements of others when it comes to interpreting our advance directives, but that just points towards the requirement that those who make decisions for others should exhibit the appropriate virtues" (Hughes 2013 p286).

DISCUSSION POINT - Is an advanced directive by the individual themselves always better than a situation where relatives have to make an end-of-life decision? Are there situations where advanced directives may not be a good thing?

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10. AGEING AND COGNITION

To understand how intelligence and cognitive abilities change over the lifespan, the simple way is to compare a group of older adults (eg: 80 year-olds) with younger individuals (eg: 20 year-olds). But such a comparison is not like-for-like because there are historical events, or aspects of the physical and social environment which affect one group and not the other. For example, differences in the level of education between the groups. This is known as the "cohort effect" [14].

However, Salthouse (2013) provided evidence of differences within cohorts that were as large as differences between cohorts. He quoted data collected by the Virginia Cognitive Aging Project in the USA. This involved the same sixteen tests of five cognitive abilities given to the same individuals every year between 2001 and 2011 (within-cohort group) (all born in the same year), and to a cross-section of different ages at one point in time (between-cohort group) (figure 10.1).

(Based on Salthouse 2013 figure 1 p125)

Figure 10.1 - Between- and within-cohort designs.

Salthouse (1991) warned against the assumption that individuals within the same birth cohort are similar: "It is unlikely that individuals will be meaningfully grouped with respect to common experiences when they are classified according to arbitrary temporal boundaries... not all experiences are presumed to be relevant, and there is no assurance that individuals

[14] Generally, cognitive test scores have been found to improve with each subsequent cohort/generation, even testing individuals at the same age. For example, a thirty year-old in 1950 will have lower scores than a thirty year-old in 1980. This is called the "Flynn Effect" (Flynn 1984).

classified together on the basis of year of birth all share the critical experiences... [and] ...because the impact of experiences may not be uniform among individuals born within specified temporal intervals, relying upon birth year to define cohorts also leads to the problem of possible differential effects of critical experiences among individuals treated as equivalent" (p 117; quoted in Salthouse 2013 p129).

Salthouse (2013) felt generally that: "Disentangling potential determinants of age-related cognitive change is challenging because there is still limited understanding of what is responsible for the relations between age and cognitive functioning" (p129).

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