HUMAN DEVELOPMENT · STUDY GUIDE

Exam 7 Study Guide

This guide covers chapters 13 and 14, the last two chapters of the lifespan. You will see why bodies age, what the mind keeps and loses, and why some people flourish in their final decades. Then you will study death itself: how children come to understand it, how people meet their own dying, how care eases the end, how survivors grieve and how cultures give loss meaning. Work one chapter at a time. Read the "what to know" paragraphs, copy the tables out by hand, then try each worked case with the steps covered. Finish each chapter with its ten self-test items. The cram sheet at the end puts every term and name in one place.

WHAT THIS GUIDE COVERS

- Chapter 13 · programmed and damage theories of aging; the Hayflick limit and telomeres; free radicals and cross-linking; primary and secondary aging; sarcopenia, osteoporosis, reserve capacity, presbyopia and presbycusis; fluid and crystallized intelligence, memory types, wisdom and the positivity effect; dementia and Alzheimer disease; integrity vs. despair and the life review; disengagement, activity, continuity and socioemotional selectivity; successful aging and SOC.
- Chapter 14 · biological, clinical and brain death; the death system; irreversibility, universality, nonfunctionality and causality and Piaget's stages; Kübler-Ross's five stages and their limits; palliative care, hospice and total pain; living wills, proxies, DNR and POLST; bereavement, grief and mourning; Worden's tasks, the dual-process model and continuing bonds; complicated grief; death across cultures.

CHAPTER 13

Late Adulthood

Read it in full: **Chapter 13 in the textbook**. Practice it in the lab: **Why We Age** and **Cognitive Continuum**.

What to know

Late adulthood begins around 65 and can span three or four decades, so no single portrait of old age is true. **Senescence** is the gradual, universal decline in body function with time. Theories of

why it happens fall into two camps. **Programmed theories** say aging is built in, a genetic clock. **Damage (error) theories** say aging is accumulated wear the body cannot fully repair. The modern answer is that both act together.

The best-known programmed idea is the **Hayflick limit**. In the 1960s Leonard Hayflick showed that normal human cells divide only about **40 to 60 times** and then stop (replicative senescence). The clock is the **telomere**, a cap of repeated DNA on each chromosome end that shortens with every division. The **endocrine theory** points to a hormonal clock (menopause is its clearest sign); the **immunological theory** points to a preset waning of immune defense, raising infection and cancer risk. Cells that divide without limit are tumor cells that escaped the brake.

The oldest damage idea is wear and tear. The most influential modern one is Denham Harman's **free-radical theory**: reactive oxygen molecules from normal metabolism damage DNA, proteins and membranes faster than repair keeps up. **Cross-linking** describes sugars bonding to proteins (glycation) and stiffening tissues, contributing to stiff arteries and clouded lenses.

Primary aging is universal, intrinsic and unavoidable: gray hair, slower reflexes, a stiffening lens. **Secondary aging** comes from disease, disuse, environment and lifestyle, such as heart disease after decades of smoking. Much of what people blame on "just getting old" is secondary aging: often preventable and sometimes reversible. Skin thins and bruises. **Sarcopenia** (muscle loss) and **osteoporosis** (severe bone loss, especially in women after menopause) raise the risk of falls and fractures. Arteries stiffen and maximum heart rate falls. Underneath is a loss of **reserve capacity**, the spare margin each organ keeps for stress.

The senses dim in typical ways. **Presbyopia** (loss of near focus) brings reading glasses; later the lens can cloud (**cataract**) and the retina and optic nerve grow vulnerable (macular degeneration, glaucoma). **Presbycusis** takes high frequencies first, so consonants blur and noisy rooms are hard. Taste and smell fade, which can blunt appetite, and declines in touch and balance add to fall risk. Sarcopenia responds to resistance training at any age: use it or lose it is physiology.

Fluid intelligence (speed, working memory, novel problems) slowly declines from early adulthood; **crystallized intelligence** (vocabulary, knowledge, know-how) holds or grows. In memory, **episodic** memory for recent events and working memory slip most, while **semantic**

(general knowledge) and **procedural** memory (how to ride a bike) are well preserved. Normal aging means slower search, such as tip-of-the-tongue moments. **Wisdom**, expert judgment about the practical, uncertain problems of living, was studied by Paul Baltes as the pragmatics of life; it is not automatic with age but becomes more common. Older adults show a **positivity effect** and steadier moods.

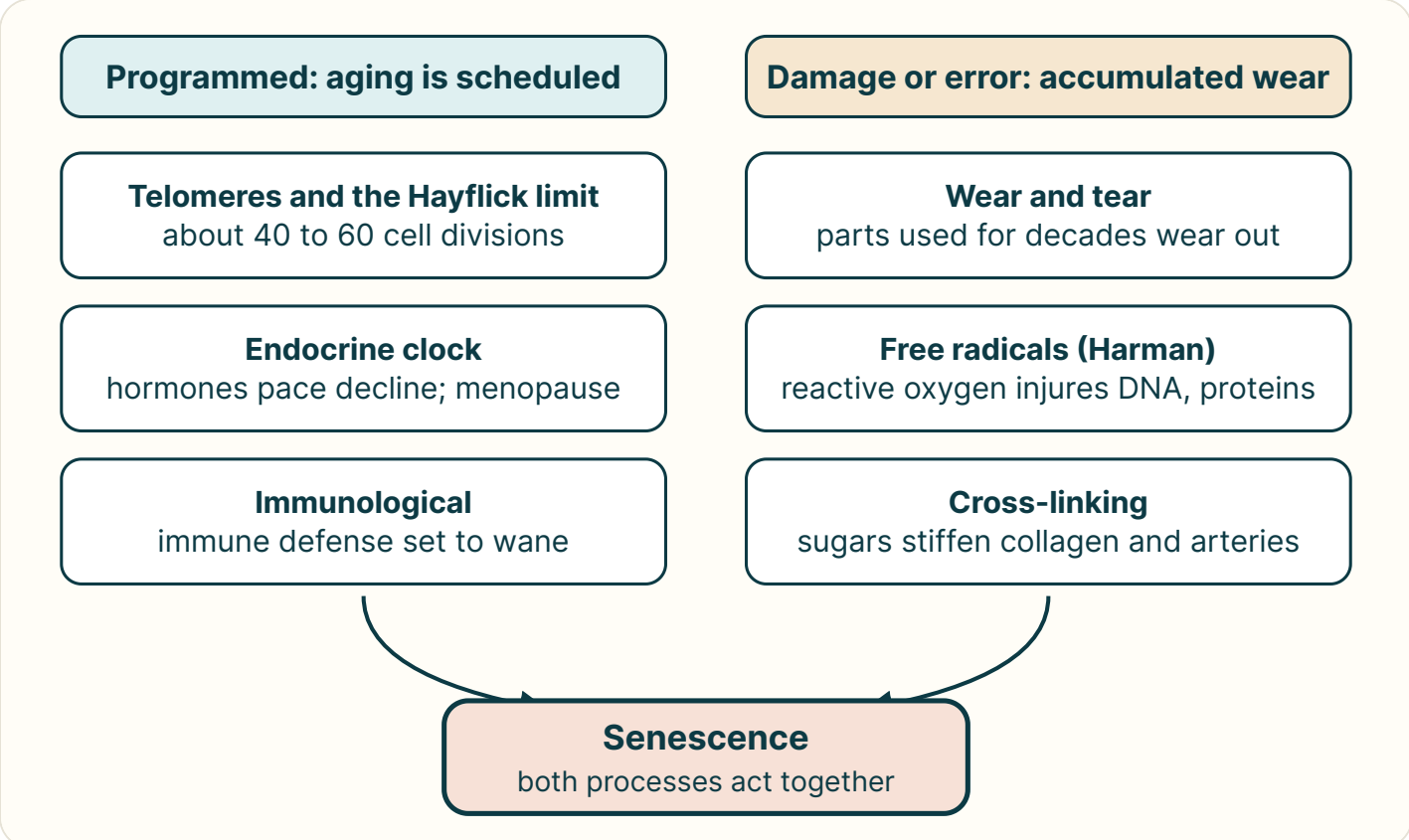
Dementia is an acquired, progressive decline in two or more cognitive domains, severe enough to impair daily life. It is not normal aging; most people who reach their eighties never develop it. **Alzheimer disease** causes roughly two-thirds of cases. Its hallmarks are **beta-amyloid plaques** between neurons and **tau tangles** inside them, beginning in the **hippocampus and entorhinal cortex**, so recent memory goes first. The course runs from early (recent memory, word-finding) to middle (language, orientation, daily activities) to late (near-total dependence). Age is the biggest risk factor; family history, the APOE-e4 gene and cardiovascular risks add to it.

Erikson's eighth stage is **integrity vs. despair**. Integrity is accepting the one life actually lived, with its choices, losses and limits, as meaningful and one's own. Despair is bitterness, regret and the fear that time has run out. The virtue is **wisdom**. Robert Butler's **life review** is the natural turn toward reminiscence in later life, an active way a life gets integrated; clinicians use it as **reminiscence therapy**. Integrity is not the absence of regret; it folds regrets into a life one can still accept.

Disengagement theory (Cumming and Henry, 1961) claimed older adults and society mutually withdraw; evidence turned against it. **Activity theory** (Havighurst) says staying active and replacing lost roles sustains well-being. **Continuity theory** says people age best by carrying forward long-standing patterns. Laura Carstensen's **socioemotional selectivity theory** says shrinking time horizons shift priorities toward emotionally meaningful goals and close people, so networks become smaller but deeper. The **convoy model** (Kahn and Antonucci) describes the lasting inner circle. Rowe and Kahn define **successful aging** as avoiding disease and disability, maintaining high physical and cognitive function and staying engaged; critics say this can exclude people with chronic illness who still report well-being. Baltes's **selective optimization with compensation**, illustrated by the pianist Arthur Rubinstein, describes adapting to loss.

LOCK THESE IN

- Programmed theories: telomeres and the Hayflick limit (about 40 to 60 divisions), endocrine, immunological.
- Damage theories: wear and tear, free radicals (Harman), cross-linking. Both camps act together.
- Primary aging is universal; secondary aging comes from disease, disuse and lifestyle and is often preventable.
- Sarcopenia and osteoporosis drive falls and fractures; reserve capacity shrinks.
- Presbyopia: near focus. Presbycusis: high frequencies first.
- Crystallized holds, fluid slows. Episodic memory slips; semantic and procedural are preserved.
- Dementia is not normal aging. Alzheimer: about two-thirds of cases; plaques and tangles; starts in the hippocampus.
- Integrity vs. despair, virtue wisdom. Socioemotional selectivity: smaller but deeper networks. Disengagement is largely rejected.



Why we age: two families of theory. Programmed theories describe a built-in schedule, while damage theories describe wear the body cannot fully repair. Senescence comes from both at once.

Key terms and comparisons

Term	What it means	Example
Hayflick limit	Normal cells divide a finite number of times	About 40 to 60 divisions
Telomere	Protective cap that shortens each division	The cell's counter
Free-radical theory	Reactive oxygen injures cells	Harman
Cross-linking	Sugars bond to proteins and stiffen tissue	Stiff arteries, cataracts
Reserve capacity	Spare margin for stress	Pneumonia hits harder at 85
Episodic memory	Memory for recent events	Slips most with age
Procedural memory	How to do things	Riding a bike; well preserved
Positivity effect	More attention to positive information	Lets small frictions go
Life review	Meaning-making reminiscence (Butler)	Basis of reminiscence therapy
Convoy model	Lasting inner circle of close ties	Kahn and Antonucci

Theories of aging

Theory	Camp	Core idea
Telomere and Hayflick limit	Programmed	Cells divide a set number of times
Endocrine	Programmed	A hormonal clock paces decline
Immunological	Programmed	Immune defense set to wane
Free-radical (oxidative)	Damage	Reactive oxygen accumulates and injures
Cross-linking	Damage	Sugars stiffen tissue

Normal aging or dementia?

Feature	Normal aging	Dementia
Forgetting	Misplaces keys; recalls later	Forgets whole events
Words	Occasional tip-of-the-tongue	Frequent; wrong words
Daily life	Stays independent	Impaired: missed bills, getting lost
Course	Stable year to year	Progressive
Insight	Aware of lapses	Often unaware

Social theories of aging

Theory	Core claim	Standing today
Disengagement	Mutual withdrawal of person and society	Largely rejected
Activity	Stay active; replace lost roles	Well supported
Continuity	Keep long-standing patterns	Supported
Socioemotional selectivity	Short horizons favor close, meaningful ties	Strongly supported

Worked cases

WORKED CASE 1 · NORMAL FORGETTING OR DEMENTIA?

Two 78-year-olds. Ruth sometimes cannot find her keys and blanks on a neighbor's name, which comes back an hour later; she manages her bills and drives. Hal has forgotten whole family visits, got lost on his usual route to the store and has missed several bills, but insists nothing is wrong. Sort them.

STEP 1 · WHAT IS FORGOTTEN

Ruth loses details and recalls them later. Hal loses whole events.

STEP 2 · DAILY FUNCTION

Ruth stays independent. Hal's daily life is impaired.

STEP 3 · INSIGHT

Ruth notices her lapses. Hal is unaware.

ANSWER

Ruth shows normal age-related change. Hal's pattern deserves evaluation for dementia. The key test is whether forgetting impairs daily life.

WORKED CASE 2 · PRIMARY OR SECONDARY?

Mr. Ortiz, 80, has gray hair, needs reading glasses, has type 2 diabetes after years of inactivity, and weak legs that improve after three months of supervised strength training. Sort each.

STEP 1 · UNIVERSAL CHANGES

Gray hair and presbyopia are **primary aging**.

STEP 2 · LIFESTYLE-LINKED DISEASE

Type 2 diabetes after inactivity is **secondary aging**.

STEP 3 · THE LEGS

Improvement with training shows much of the weakness was disuse, so secondary and reversible.

ANSWER

A large share of what looks like primary aging is secondary aging in disguise.

WORKED CASE 3 · A SMALLER CIRCLE

After retiring, Beatrice, 82, sees fewer acquaintances but spends more time with two close friends and her grandchildren. Her son worries she is withdrawing. Use the chapter to respond.

STEP 1 · CHECK DISENGAGEMENT

Disengagement theory would call this natural withdrawal, but it is largely rejected.

STEP 2 · APPLY SOCIOEMOTIONAL SELECTIVITY

With a shorter felt time horizon, Beatrice is choosing emotionally meaningful ties: smaller but deeper.

STEP 3 · CHECK WELL-BEING

If she is content and engaged with the people who matter, this is active selection, a sign of health.

ANSWER

Connection, not the number of contacts, predicts a good old age.

TRAPS PEOPLE FALL INTO

- **Picking one theory of aging.** Programmed and damage processes work together.
- **Calling telomere shortening a damage theory.** It is programmed: the cell counts its divisions.

- **Blaming every decline on age.** Much of it is secondary aging and can be prevented or reversed.
- **Thinking dementia is normal aging.** Most people in their eighties never develop it.
- **Judging dementia by how often someone forgets.** The test is what is forgotten and whether daily life is impaired.
- **Equating integrity with having no regrets.** Integrity folds regrets into a life one can still accept.
- **Reading a smaller network as loneliness.** Socioemotional selectivity says older adults are choosier, not lonelier.
- **Treating Rowe and Kahn as the only way to age well.** Critics note it can exclude people with chronic illness; SOC describes adapting to loss.

Chapter 13 self-test · ten items

1. Telomere shortening belongs to which family of aging theory?

A. Damage
B. Programmed
C. Psychosocial
D. Disengagement

B. Programmed Cells count their divisions on their telomeres, a built-in clock.

2. About how many times can a normal human cell divide?

A. 5 to 10
B. 100 to 200
C. 40 to 60
D. Without limit

C. 40 to 60 That finite number is the Hayflick limit.

3. Who proposed the free-radical theory of aging?

A. Leonard Hayflick
B. Robert Butler
C. Laura Carstensen
D. Denham Harman

D. Denham Harman Reactive oxygen molecules accumulate and injure cells.

4. Which change is secondary rather than primary aging?

A. Heart disease after decades of smoking
B. Graying hair in the sixties
C. A lens that stiffens with age
D. Slower reflexes over the decades

A. Heart disease after decades of smoking Secondary aging comes from disease, disuse and lifestyle.

5. Presbycusis affects which sounds first?

A. Low frequencies
B. Loud sounds
C. Music only
D. High frequencies

D. High frequencies Consonants blur and noisy rooms become hard.

6. Which kind of memory is best preserved in late adulthood?

A. Episodic
B. Procedural
C. Working
D. Recent event

B. Procedural Procedural and semantic memory hold up; episodic and working memory slip.

7. Alzheimer damage begins in the

A. hippocampus and entorhinal cortex
B. occipital lobe and visual cortex
C. motor cortex and cerebellum
D. brainstem and spinal cord

A. hippocampus and entorhinal cortex That memory hub explains why recent memory goes first.

8. Erikson's virtue for integrity vs. despair is

A. care
B. fidelity
C. wisdom
D. hope

C. wisdom A favorable balance toward integrity yields wisdom.

9. Which theory of social aging is largely rejected?

A. Activity
B. Continuity
C. Socioemotional selectivity
D. Disengagement

D. Disengagement Withdrawal predicts worse well-being, not better.

10. Which is part of Rowe and Kahn's successful aging?

A. Withdrawing from earlier social roles
B. Avoiding all medication
C. Staying actively engaged with life
D. Living alone

C. Staying actively engaged with life They name avoiding disease, keeping function and staying engaged.

CHAPTER 14

Death, Dying and Bereavement

Read it in full: **Chapter 14 in the textbook**. Practice it in the lab: **Understanding Death** and **Grief Tasks And Types**.

What to know

Biological death is the permanent end of the processes that sustain life. **Clinical death** is when the heart stops and breathing ceases; for a brief window it can sometimes be reversed by resuscitation. **Brain death** is the irreversible loss of all brain activity, including the brainstem; no intervention can restore the person, even if a machine keeps the heart pumping. Ventilators created the need for this distinction. Death is also social: Robert Kastenbaum's **death system** is the web of people (funeral directors, clergy, coroners), places, times, objects and symbols through which a culture manages mortality.

Children build the concept of death in pieces. Speece and Brent (1984) named three core components: **irreversibility** (the dead do not come back), **universality** (everything that lives dies, including me) and **nonfunctionality** (all body functions stop). Later work added **causality** (death has physical causes), which most textbooks include though its status is debated. Most children assemble all four between about **5 and 7**.

The sequence tracks Piaget. A **preoperational** child (about 2 to 7) may see death as reversible, like sleep or a trip, and may think a wish or bad deed caused it. A **concrete operational** child (about 7 to 11) grasps all four components. In **formal operations**, adolescents can reflect abstractly, yet the **personal fable** can blunt felt vulnerability. Plain, honest words ("Grandpa died; his body stopped working and he won't come back") fit young children better than "went to sleep."

In 1969 Elisabeth Kübler-Ross published **On Death and Dying**, drawn from interviews with terminally ill patients. Her five stages, **DABDA**, are denial, anger, bargaining, depression and acceptance. She brought dying out of the shadows and helped popularize the hospice and death-awareness movements. But the stages are not a fixed or universal sequence: people skip, repeat and blend them, and support for a lockstep order is weak. Used **descriptively**, the model normalizes feelings; used **prescriptively**, it wrongly judges how someone should die. The study of death is **thanatology**.

Palliative care is comfort-focused care for anyone with a serious illness, relieving pain, breathlessness, nausea and distress, and it can run alongside curative treatment at any stage. **Hospice** is palliative care near the end of life, typically when a physician estimates **six months or less** and the goal shifts fully to comfort; it usually happens where the patient lives, with a team of nurses, aides, social workers, chaplains and volunteers. Dame **Cicely Saunders** founded St Christopher's Hospice in London in **1967** around the idea of **total pain**: physical, emotional, social and spiritual. Hospice aims neither to hasten nor to postpone death.

Advance directives record wishes ahead of time. A **living will** states which treatments a person does or does not want. A **durable power of attorney for health care** (health-care proxy) names who decides if the person cannot. A **DNR order** tells clinicians not to attempt CPR, and **POLST**-type forms turn a seriously ill person's wishes into portable medical orders. These spare families guesswork and protect a person's values.

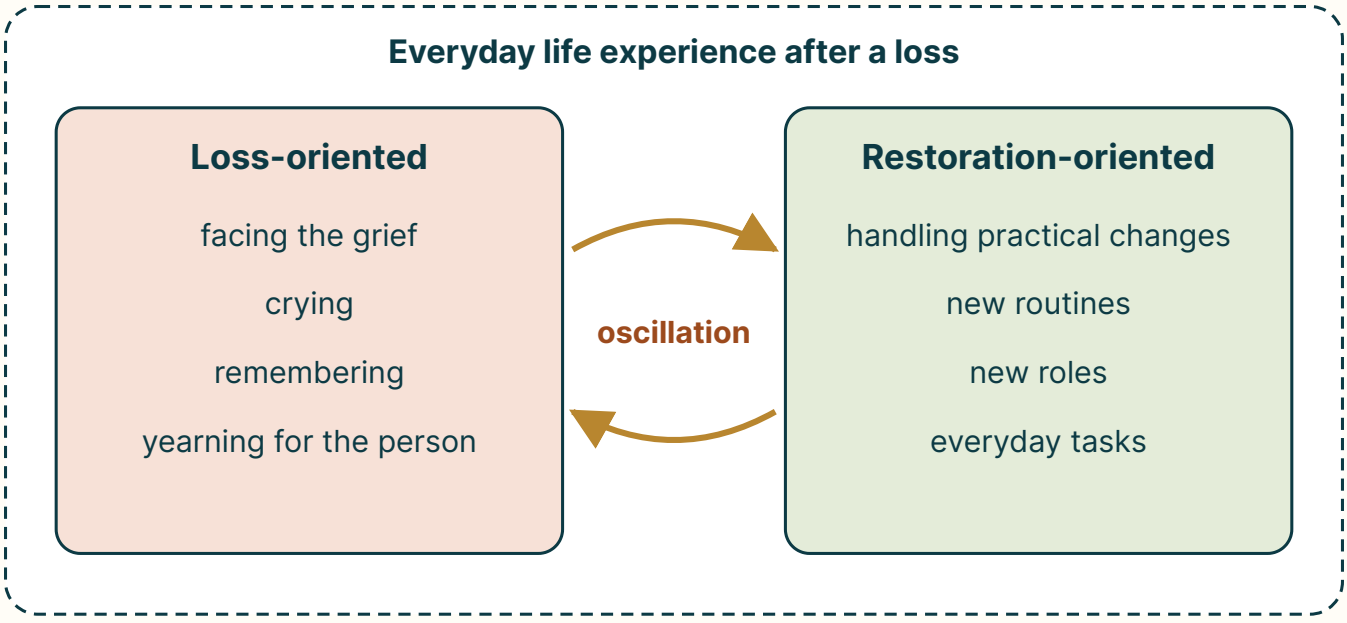
Bereavement is the fact of loss. **Grief** is the inner response: sorrow, longing, guilt, anger, fatigue, even physical ache. **Mourning** is the outward, culturally shaped expression, such as sitting shiva or holding a wake. J. William Worden's **four tasks of mourning** are to accept the reality of the loss, process the pain, adjust to a world without the person and find an enduring connection while moving forward. Stroebe and Schut's **dual-process model** describes oscillation between **loss-oriented** and **restoration-oriented** coping, both needed. The **continuing bonds** perspective says healthy grief usually keeps a transformed connection rather than "letting go."

For most people, acute grief softens over months. In a minority it stays intense and disabling for a year or more, with unrelenting yearning and an inability to accept the death or re-engage. This **complicated grief** is now recognized as **prolonged grief disorder** and responds to specific treatment. Grief comes in waves tied to reminders and preserves self-worth; major depression is more pervasive and marked by worthlessness.

The biology of dying is universal, but its meaning is cultural. Cultures can be death-accepting, death-defying or death-denying. In Jewish practice, burial is prompt and mourners observe **shiva**, seven days of receiving visitors. Islamic tradition also favors swift burial with a defined mourning period and prayers. Hindu practice generally calls for cremation and the **antyeshti** rites, reflecting belief in reincarnation. Many Buddhist traditions frame death through impermanence, with meditation and merit-making. In Mexico's **Día de los Muertos**, families build altars (ofrendas) and welcome the dead over 1 to 2 November, children on 1 November and adults on 2 November. Cultural humility means asking what a death means to this person and family.

LOCK THESE IN

- Clinical death can sometimes be reversed; brain death (all brain and brainstem activity) cannot.
- Kastenbaum's death system: people, places, times, objects, symbols.
- Four components: irreversibility, universality, nonfunctionality, causality; mastered about ages 5 to 7.
- Preoperational children see death as reversible; concrete operational children grasp all four.
- Kübler-Ross (1969): denial, anger, bargaining, depression, acceptance. Describe, do not prescribe.
- Palliative care at any stage, even with cure-focused treatment; hospice near the end (about 6 months), comfort only.
- Saunders, St Christopher's, 1967, total pain. Living will says what; proxy says who; DNR and POLST are orders.
- Bereavement, grief, mourning. Worden's four tasks; dual-process oscillation; continuing bonds; prolonged grief lasts a year or more.



Healthy grieving swings between the two; both are needed (Stroebe and Schut).

Stroebe and Schut's dual-process model. Healthy grieving moves back and forth between facing the loss and rebuilding daily life. Neither side alone is enough.

Key terms and comparisons

Term	What it means	Example
Clinical death	Heart and breathing stop; may be reversible	Revived by CPR
Brain death	Irreversible loss of all brain activity	Ventilator keeps the heart going
Death system	Cultural web around death (Kastenbaum)	Clergy, cemeteries, memorial days
Thanatology	The study of death and dying	Kübler-Ross's field
Total pain	Physical, emotional, social, spiritual suffering	Saunders
Living will	Which treatments one wants	No ventilator if no hope of recovery
Health-care proxy	Who decides if one cannot	Durable power of attorney
Anticipatory grief	Grief before a death	Mourning an expected loss
Continuing bonds	Ongoing, transformed connection	Feeling a parent's presence at a wedding
Prolonged grief disorder	Disabling grief a year or more	Complicated grief

The concept of death by stage

Age and Piaget stage	Typical grasp	Still missing
Infant, sensorimotor (0 to 2)	Senses separation and absence	No concept of death
Preschool, preoperational (2 to 7)	Reversible, like sleep; a wish may have caused it	All four components
School age, concrete (7 to 11)	Final, universal, functions stop, physical causes	Abstract framing
Adolescence, formal (11+)	Abstract, philosophical reflection	Personal fable may blunt vulnerability

Care at the end of life

Term	What it is	Key point
Palliative care	Comfort care for serious illness	Any stage; can go with curative care
Hospice	Palliative care near the end	Comfort only; often about 6 months prognosis
Living will	Written treatment wishes	What you want done
Health-care proxy	Named decision-maker	Who decides
DNR and POLST	Medical orders	Portable orders clinicians must follow

Normal and complicated grief

Feature	Normal grief	Complicated (prolonged) grief
Course	Eases over months	Intense and disabling a year or more
Pattern	Waves tied to reminders	Constant yearning
Engagement	Gradually resumes life	Withdrawn
Acceptance	Slowly accepts the death	Persistent disbelief

Worked cases

WORKED CASE 1 · TALKING WITH A YOUNG CHILD

Four-year-old Mia's grandfather has died. Her aunt says, "Grandpa went to sleep." Mia now refuses to nap. Explain and suggest better words.

STEP 1 · PLACE MIA

At four she is **preoperational**: concrete and literal, and she may see death as reversible.

STEP 2 · FIND THE PROBLEM

"Went to sleep" taught her that sleep and death are linked, so naps feel dangerous.

STEP 3 · NAME WHAT SHE LACKS

Irreversibility and nonfunctionality are not yet secure.

STEP 4 · BETTER WORDS

"Grandpa died. His body stopped working, and he won't come back. Sleeping is different; your body keeps working when you sleep."

CHECK IT

Children handle plain truth better than adults expect.

WORKED CASE 2 · PALLIATIVE OR HOSPICE?

Mrs. Adeyemi is receiving chemotherapy for cancer with a good chance of remission, and a team helps with her nausea and pain. Mr. Lind has advanced heart failure; his doctor estimates a few months, and he has chosen to stop disease-directed treatment and focus on comfort at home. Name each type of care.

STEP 1 · MRS. ADEYEMI

Comfort care alongside curative treatment is **palliative care**.

STEP 2 · MR. LIND

Comfort-only care near the end of life, at home, is **hospice**.

STEP 3 · THE RULE

All hospice is palliative, but not all palliative care is hospice. Palliative is not giving up.

WORKED CASE 3 · READING A FAMILY'S GRIEF

Eight months after her husband's death, Joan cries when she hears his favorite song but also has started a garden club and handles the finances he used to manage. She still talks to his photo each morning. Her daughter thinks Joan is "not letting go." Respond using the chapter.

STEP 1 · THE DUAL-PROCESS MODEL

Crying at the song is loss-oriented coping; the club and the finances are restoration-oriented. She oscillates, which is healthy.

STEP 2 · CONTINUING BONDS

Talking to his photo is a transformed, ongoing connection, not a problem.

STEP 3 · CHECK FOR COMPLICATED GRIEF

Her grief comes in waves and she is re-engaging with life, so it does not look like prolonged grief disorder.

ANSWER

There is no timetable and no required letting go.

TRAPS PEOPLE FALL INTO

- **Treating clinical death and brain death as the same.** Clinical death may be reversible; brain death is not.
- **Assuming toddlers understand death is final.** Preoperational children often see it as reversible.
- **Using "went to sleep" with a young child.** Literal minds may fear sleep or wait for a return.
- **Using Kübler-Ross as a checklist.** The stages describe common feelings; they are not a required order.
- **Thinking palliative care means giving up.** It can run alongside curative treatment.
- **Confusing a living will with a proxy.** A living will says what; a proxy says who.
- **Expecting grief to end in "letting go."** Continuing bonds are normal and healthy.
- **Judging another culture's mourning as wrong.** Rituals differ widely; ask what the death means to this family.

Chapter 14 self-test · ten items

1. Which statement about brain death is correct?

A. No intervention can reverse it
B. It can be reversed by prompt CPR
C. It means only the heart has stopped
D. It requires breathing to continue alone

A. No intervention can reverse it Brain death is irreversible loss of all brain and brainstem activity.

2. Kastenbaum's death system refers to

A. the order of Kübler-Ross's five stages
B. a culture's web of roles, places and symbols
C. the body's failing organ systems
D. a hospital's resuscitation team

B. a culture's web of roles, places and symbols It is how a society manages mortality.

3. "Everything that lives eventually dies, including me" is

A. irreversibility
B. nonfunctionality
C. universality
D. causality

C. universality Universality is that all living things die.

4. Most children grasp all four death components by about ages

A. 2 to 3
B. 5 to 7
C. 10 to 12
D. 14 to 16

B. 5 to 7 The pieces come together as concrete operations approach.

5. Which is the correct order of Kübler-Ross's stages?

A. Denial, anger, bargaining, depression, acceptance
B. Anger, denial, depression, bargaining, acceptance
C. Denial, bargaining, anger, acceptance, depression
D. Shock, anger, guilt, depression, acceptance

A. Denial, anger, bargaining, depression, acceptance DABDA, though people do not move through them in lockstep.

6. Which care can accompany curative treatment?

A. Hospice only
B. A DNR order
C. Brain-death testing
D. Palliative care

D. Palliative care Palliative care relieves suffering at any stage.

7. Who founded the modern hospice movement?

A. Elisabeth Kübler-Ross
B. Robert Kastenbaum
C. Cicely Saunders
D. J. William Worden

C. Cicely Saunders She opened St Christopher's Hospice in London in 1967.

8. A document naming who will make medical decisions is a

A. living will
B. health-care proxy
C. death system
D. POLST medical order form

B. health-care proxy A proxy names who decides; a living will states what is wanted.

9. The outward, culturally shaped expression of grief is

A. mourning
B. bereavement
C. thanatology
D. anticipatory grief

A. mourning Bereavement is the fact; grief the inner response; mourning the outward expression.

10. Grief that stays intense and disabling for a year or more is

A. normal, uncomplicated grief
B. anticipatory grief
C. acceptance
D. prolonged grief disorder

D. prolonged grief disorder Complicated grief is recognized as prolonged grief disorder and responds to treatment.

ONE PAGE

Cram sheet

Everything from chapters 13 and 14 in one place. Cover the right column and see if you can rebuild each row.

Numbers and names

Item	Value or name	Note
Hayflick limit	About 40 to 60 divisions	Telomeres are the clock
Free-radical theory	Denham Harman	Damage camp
Alzheimer share	About two-thirds of dementia	Plaques and tangles
Disengagement theory	Cumming and Henry, 1961	Largely rejected
Socioemotional selectivity	Laura Carstensen	Smaller, deeper networks
Successful aging	Rowe and Kahn	Health, function, engagement
Death components	Speece and Brent, 1984	Mastered about 5 to 7
On Death and Dying	Kübler-Ross, 1969	DABDA
St Christopher's Hospice	Cicely Saunders, 1967	Total pain
Hospice prognosis	About 6 months or less	Comfort only
Prolonged grief	A year or more	Treatable
Día de los Muertos	1 to 2 November	Children Nov 1, adults Nov 2

Rules that are not numbers

Topic	The rule
Aging theories	Programmed and damage processes act together.
Primary vs. secondary	Universal change vs. disease, disuse and lifestyle; much decline is secondary.
Memory	Episodic and working memory slip; semantic and procedural hold.
Dementia	Not normal aging; the test is impaired daily function.
Eighth stage	Integrity vs. despair; virtue wisdom; life review.
Kübler-Ross	Describe, do not prescribe.
Directives	Living will says what; proxy says who; DNR and POLST are orders.
Grief	Worden's tasks; dual-process oscillation; continuing bonds.
Culture	Ask what a death means to this person and family.

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