As described in many of the earlier chapters in this volume, it is clear that a variety of mental processes decline with age. In chapter 1, Park argues that declines in speed of processing, working memory function, and inhibitory processes likely are fundamental mechanisms that account for poorer memory function in late adulthood. Despite a wealth of laboratory evidence that these cognitive resources decline with age and are critically important in understanding performance on cognitive tasks, surprisingly little is known about their importance for function in everyday life. Interest in theory-driven applied research, however, is growing (Park, 1992). In this chapter, we examine the meaning of normal, age-related cognitive deficits for everyday life, drawing on work that has utilized what is known about age changes in basic cognitive processes to understand real-world problems of aging.

The global nature of the decline in speed of processing and working memory that occurs with age might lead one to expect that older adults would have substantial difficulties in managing the affairs of everyday life or maintaining a good level of performance on the job. There is considerable evidence, however, that older adults function well in many domains of everyday life, and that the cognitive declines of the considerable magnitude documented in the laboratory do not impact everyday domains of behavior as negatively as one might expect. The reasons for this are complex and not entirely understood, but will be a focus of discussion in this chapter.

Two important aspects of the aging cognitive system have been identified that likely play an important role in maintaining demanding cognitive behaviors in the everyday environment despite substantial declines in processing resource. The first is that there is considerable evidence knowl

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edge is maintained across the lifespan or even continues to grow with age (see Park, chapter 1 in this volume). Thus, much of what has been learned throughout older adults’ lives is preserved. This preserved learning provides older adults with access to an extensive knowledge base that can be useful in solving problems and addressing the needs of everyday life, thereby mitigating or compensating for declines in basic mechanisms of cognitive function. A second important element in maintaining performance of complex cognitive tasks in everyday life is the fact that frequent and familiar behaviors become automatized; that is, they require little cognitive resource or effort to perform. Jacoby (1991) developed a process dissociation procedure that allows separation of the effortful, resource-based components of memory from the effects of familiarity that control automatic cognitive processes. Automatic processes are cognitive processes that occur with no conscious awareness or effort and may be due to familiarity, practice, or the specific qualities of the stimulus being processed. Jacoby, Jennings, and Hay (1996) demonstrated that although the effortful component of memory declines with age, the familiarity-based, automatic component is age invariant. This finding suggests that in highly familiar situations where familiarity and automaticity contribute significantly to performance, older adults will be relatively unimpaired. However, in situations that demand controlled processing and mental effort, the age-related declines in processing resources will be of great importance and older adults will evidence impairment in their behavior.

Although everyday situations may superficially appear to be cognitively demanding, they often are based more on automatic processing than effortful processing. For example, consider an older woman who lives in the suburbs of a large city like Boston and has subscribed to the Boston Symphony for 20 years. She does not hesitate to drive into Boston to see the symphony on a Sunday afternoon. Automatic processes and acquired knowledge play a large role in her route selection and in finding her way. She simply knows how to get to the symphony with little thought and she easily negotiates complex traffic interchanges due to their high familiarity. Little controlled processing is required on her part to arrive at the destination, park the car, and find her way to the concert hall. Contrast this with another older woman who has flown into the same Boston suburb for a weekend to see friends who are busy on Sunday afternoon. She also would like to go to the symphony. For her, the task of driving to the symphony through Boston traffic is one that requires considerable engagement of processing resources and has a very small familiarity component. Age-related declines in cognitive function would play an important role in the everyday behavior of driving to the symphony in this second situation, but not the first. Driving to the symphony for the out-of-town guest would have a high working memory load in terms of keeping the directions in mind. Speeded processing also would be important in making rapid decisions about exit selection off the freeway and in deciding how to negotiate traffic circles in moving traffic. Acquired knowledge and familiarity would not contribute
much to this drive. There are few elderly adults who would attempt the second drive described (as well as many younger adults who also would be daunted), based on the likely correct perception that the processing demands of driving in Boston exceed their level of cognitive resource.

In the remainder of this chapter, we will consider the impact of cognitive aging on three domains of everyday behavior that are important to older adults. We will assess the impact of cognitive aging on health behaviors, driving competence, and function in the workplace. In each case, we will examine how declines in cognitive function may be offset by the experience and knowledge that the older adult possesses.

Health

The domain of health behavior and cognitive aging is relatively unexplored. Older adults frequently must make complex health decisions and follow elaborate drug and treatment regimens that require a considerable amount of higher order cognitive processes. With the increased tendency to hospitalize only the most critically ill patients and also to discharge them as soon as possible, older adults frequently are expected to use complicated medical devices at home that require considerable training and expertise to use (Bogner, 1999). Declining cognitive resources likely play an important role in the older patient’s ability to use medical equipment, take medications, and perform necessary steps to regulate an illness (Park, 1999). At the same time, it also is important to recognize that older adults have considerable experience with illness and health decisions and that their expertise and knowledge, particularly about chronic disorders that they have had for some time, may buffer them from the impact of declining cognitive resources in processing and managing information about their medical conditions.

Perhaps the most fundamental issue in understanding the medical behaviors of older patients is determining how much information they comprehend and what are the optimal methods for presenting this information. Considerable evidence from our laboratory has suggested that older adults have difficulty with comprehension. Morrell, Park, and Poon (1989, 1990) offered evidence that when presented with an array of prescription labels, older adults had more difficulty than younger adults in developing and remembering an accurate medication-taking plan. In other works, we examined how effectively older adults understood the information hospitals are required to present to patients about the development of advanced directives and living wills, as mandated by the 1990 Patient Self-Determination Act. Park, Eaton, Larson, and Palmer (1994) found that hospital administrators reported that the biggest perceived problem with implementing the law was the apparent difficulty patients had in comprehending the materials presented. In a later study, Zwahr, Park, Eaton, and Larson (1997) presented middle-aged and older adults with three versions of materials used by actual hospitals to explain living wills and advanced directives and
how to go about completing them. They noted that middle-aged adults understood more than older adults and that the best predictors of comprehension were working memory function and verbal ability. The types of materials employed ranged from simple pictorial representations of the law to pages of complex documents. However, format and complexity of information had no effect on how much information patients acquired, regardless of age. In general, the literature suggests that there is evidence that normal older adults do have more trouble comprehending and remembering medical information than younger adults. There is interesting work to be done to explore whether older adults would show similar impairments when acquiring new information about medical conditions with which they are familiar, as they might even show superiority to young adults if they have well-elaborated knowledge structures about these conditions.

One critically important medical issue associated with cognitive aging is whether normal older adults are disadvantaged in making important medical decisions that require significant amounts of comprehension, memory, and judgment. (For information on the decision-making capacities of cognitively compromised older adults, see Marson & Harrell, 1999.) In general, the sparse literature available suggests that the limited cognitive capacity of normal older adults does affect the processes used to make medical decisions. However, the literature also shows that the types of decisions made about medical conditions do not differ for younger and older adults. Meyer, Russo, and Talbot (1995) and Zwahr, Park, and Shifren (1999) both reported evidence that cognitive factors affected the decisions made by older women when presented with medical scenarios. Meyer et al. (1995) found that when older and younger women had to make decisions about breast cancer treatment based on information presented to them, they made similar decisions about what treatment option to select (e.g., mastectomy, lumpectomy). The older women, however, made their decisions faster, requested less information to make the decision, and offered less complete rationales for their decisions than younger women. These findings are compatible with the notion that older adults recognize the limits on their information processing capacity and thus choose to examine less information. Their tendency toward rapid decision making compared to younger adults may be related to willingness to rely on physician suggestions in the face of limited cognitive resources (Cassileth, Zupkis, Sutton-Smith, & March, 1980), as well as knowledge of past medical experiences when information seeking did not prove to be too useful (Park, 1999).

Zwahr et al. (1999) reported similar findings when they studied the quality of decisions made by women who read lengthy materials regarding the pros and cons of estrogen replacement therapy for menopausal symptoms. Participants were then asked to make decisions about whether estrogen replacement therapy should be taken for menopausal symptoms. Older women perceived fewer options regarding choices about the therapy, made fewer comparisons among options, and exhibited less sophisticated reasoning as the basis for their decisions than did younger women. Path analy-
ses indicated that cognitive variables predicted the age-related variance in both the number of options perceived and the number of comparative statements made in the decision process. Detailed discussions of adults’ decision-making processes about medical events and diagnoses are included in Yates and Patalano (1999) and Zwahr (1999).

Thus far, we have largely considered the role that declines in controlled, effortful processes have on medical decisions. As mentioned above, it likely is important to recognize that older adults may be expert consumers of medical care and that some aspects of their health behaviors may be so highly practiced that they become automatic; that is, they require little effort or awareness to complete. One area where the controlled-automatic distinction may be of particular importance is in the area of medication adherence (Park, 1999; Park et al., 1999). Medication adherence is a behavior that has a substantial cognitive component, particularly when an individual is taking a complex medication regimen of four or more medications, as many older adults do. In order to adhere accurately to a complicated regimen, an older adult has to comprehend instructions on each medication, use working memory to integrate those instructions into a daily plan, use long-term memory to remember what the plan is, and, finally, engage prospective memory to remember to take the medication (Park, 1992; Park & Jones, 1996; Park & Kidder, 1996). Park, Morrell, Frieske, and Kincaid (1992) presented evidence that very old adults did show deficits in medication adherence compared to adults age 60 to 77, and that these deficits were remedied by providing the very old with medication organizers and charts designed to relieve the working memory burden associated with taking medications. The medication adherence was recorded via micro-electronic monitors so that accurate data on medication usage was obtained.

One surprising aspect of this work was that adults age 60 to 77 made almost no errors in their medication-taking behaviors, despite the fact that they were experiencing substantial age-related decline in cognitive function. The finding that older adults do not make many medication errors also was reported by Morrell, Park, Kidder, and Martin (1997). They found that, in a sample of hypertensive adults age 35 to 75, older adults from 65 to 75 years old made fewer errors than any other age group.

In a recent study, Park et al. (1999) reported a similar finding: adults age 60 to 75 with rheumatoid arthritis made the fewest medication errors of any age group. Forty-seven percent of the older adults, all of whom were taking four or more medications, made no errors at all with their medications over a 1-month period. Middle-aged adults made the most errors, despite strong evidence for markedly superior cognitive function in the middle-aged subjects. The use of individual difference measures that assessed not only cognitive function, but also socioemotional status and contextual variables, revealed that the best predictor of medication errors was self-report of a busy, highly engaged lifestyle. Such a lifestyle rarely characterized older adults. Moreover, older adults frequently had been taking medications for many years so that medication adherence behaviors were
routine and highly familiar to them. Thus, the apparent high cognitive investment that medication adherence would seem to require was offset by highly practiced automatic behaviors, where the daily environment served as a cue for taking medications. In contrast, younger adults who led less habitual lives where context frequently was changing did not have the same environmental stimuli to serve as automatic cues for taking medications and, as a result, this group made more errors. One lesson to be learned from this pattern of findings is that even tasks that appear to be highly cognitive and resource driven, such as remembering to take medications, may operate very differently than one would expect in a real-world, everyday environment.

Driving

An everyday behavior of great importance to older adults is the ability to drive, as this plays a significant role in maintenance of the ability to live independently in contemporary society. Although older adults drive fewer miles than younger adults and overall are involved in fewer accidents, older adults are in the highest risk category when figures are based on number of accidents per mile driven. There has been frequent speculation in the literature on driving that some of the age-related increases in accident rates are due to decreased cognitive function in older adults (Arthur, Barrett, & Alexander, 1991; Staplin, Breton, Haimo, Farber, & Byrnes, 1986). However, few studies directly linked cognitive aging to driving errors. Because driving is a dynamic, contextual behavior where the cognitive requirements of the task can change in a matter of seconds, understanding the relationship of cognitive function to driving is challenging.

It also is important to recognize that, because driving is an expert, highly practiced behavior for most older adults, we must be cautious in concluding that observed declines in speed of processing or working memory function are necessarily the basis for their poorer driving records. Driving has many of the components of an effortless, automatic process under certain conditions. Many individuals have reported that they have no memory of the landmarks or the conditions under which they drove a familiar route, such as their daily drive to work, presumably because such a highly practiced task takes so little cognitive capacity. However, in a demanding traffic situation, we all have experienced as drivers a tendency to cease conversation, turn down the radio, or ask children to be quiet. This represents a shift to a controlled (effortful, resource-demanding) processing situation. Ackerman (1986, 1987) provided us with important data indicating that cognitive resource, as measured by high cognitive ability scores, is not important for automatized tasks but strongly predicts performance on controlled, effortful tasks. Because we know that cognitive ability scores decline with age, the Ackerman data suggest that older adults likely would be deficient in driving situations that require a high amount of controlled
processing. In support of this conjecture, Holland and Rabbitt (1992) cited a study conducted by Moore, Sedgely, and Sabey (1982) that indicated that elderly drivers had a disproportionate number of accidents at complex junctions, a finding congruent with a cognitive explanation of accident rate. Also in keeping with the cognitive hypothesis, Lerner, Morrison and Ratte (1990) reported that older adults tended to be more likely to be involved in multivehicle crashes than other drivers, except on interstates where they were more likely to be involved in single-car accidents. It may be that the requirement for speeded responding on interstates results in cognitively demanding situations for older drivers.

The cognitive components of driving that perhaps are most important include attention, speed of processing, and working memory capacity. With respect to attention, Ball and colleagues (Ball, Beard, Roenker, Miller, & Griggs, 1988) demonstrated convincingly that older adults have a more limited useful field of view; that is, they are less able to attend to information and targets on the periphery of the visual field. In a series of studies, they demonstrated that older adults with more limited useful fields of view are more likely to be involved in crashes. In fact, the strongest predictor of crash involvement was performance on useful field of view measures (Owsley, Ball, Sloane, Roenker, & Bruni, 1991). The two factors of mental status (as measured by the Mattis Organic Mental Status Syndrome Examination [MOMSSE]) and the size of the useful field of view together account for 20% of accident variance and 29% of the variance for intersection accidents. Recent reports stated that over the 3 years following initial assessment, older drivers with at least a 40% decrease in useful field of view (found in 56.9% of the sample) are 2.2 times more likely to be crash involved (Owsley et al., 1998).

Although useful field of view has been reported to be a good predictor of accident involvement, it is a multifaceted construct requiring further research to determine which elements affect driving ability. Useful field of view is determined by three different components: decreased ability to divide attention, decreased ability to ignore distractors (e.g., selective attention), and reduced processing speed (Ball, Roenker, & Bruni, 1990). On examination of the contribution of each of these three mechanisms to useful field of view, divided attention impairments were associated with a 2.3 times increase in crashes, while decreased speed of processing and selective attention were not related to crash involvement (Owsley et al., 1998). The contribution of each of these three components to accident risk may be further clarified by current work on training techniques in the laboratory that can increase the useful field of view (Ball et al., 1988; Roenker, Cissel, & Ball, 1997). Of potentially great applied interest, trials currently are under way to determine if increasing the field of view decreases accident rates, as one would expect.

There also is evidence that measures of only selective attention (requiring subjects to attend to only one of two targets presented simultaneously) are correlated with accident rates (Kahneman, Ben-Ishai, & Lotan,
Mihal and Barrett (1976) examined the relationship between auditory selective attention and accident data in younger and older drivers. They reported a stronger relationship for older drivers. Ranney and Pulling (1990) studied driving behavior of adults from age 30 to 83 on a driving course and reported lower driving performance and cognitive performance in the older adults, but did not find direct associations between the measures. They did note that although older drivers made more driving errors in decision speed, route selection, gap execution, vehicle control, and comprehension of instructions, the older drivers nevertheless performed as capably as the younger drivers in response to an emergency situation. It is fair to conclude that there appears to be a relationship between age, attentional variables, and driving function in some situations, but the exact conditions under which attentional variables are important remains unspecified.

The relationship of age-related declines in speed of processing to driving behavior also has been examined. Mihal and Barrett (1976) found that although simple and choice reaction times were not related to accidents in a simulator, complex reaction time had a modest relationship for the entire sample and a large correlation (.52) for the older adults. Ranney and Pulling (1989), however, found no association between simple reaction time or perceptual speed and driving performance. Finally, Olson and Sivak (1986) found that younger and older adults had equivalent perception-response times when they were required to notice and brake to an object in the road, using actual driving in an experimental vehicle to collect the data. In summary, the relationship of speed of processing deficits in older adults to driving function appears to be in question, requiring additional investigation.

The relationship of working memory to driving and aging has been studied using divided attention tasks. Working memory refers to the amount of cognitive resource available at a given moment to manipulate, retrieve, and store information (Baddeley, 1986, or see Park, chapter 1 in this volume). Due to age-related declines in working memory function (Park et al., 1996), older adults would appear to have fewer resources available to perform multiple operations that frequently are required when driving. However, there is considerable debate about whether older adults are disproportionately disadvantaged when performing two tasks at once (a divided attention situation). Hartley (1992) conducted a meta-analysis of all of the divided attention studies done with older adults. He stated that, although any simple conclusion probably is wrong, the “most plausible interpretation of the findings from dual-task studies is that younger and older adults do not differ in the ability to allocate attention across conditions” (p. 32).

Because of the particular concerns about aging and dual-task performance that occur in the context of driving, there actually are a number of studies on this topic. Ponds, Brouwer, and van Wolffelaar (1988) examined the ability to steer an automobile while performing a dot counting task. They reported the cost of dividing attention on steering was greater for older adults than younger adults. In a later study, they introduced a third
task that required participants to monitor events in their peripheral field, in addition to steering and dot counting. They viewed the steering and peripheral tasks as typical of driving, and the dot-counting task as similar to the attention required by an in-vehicle navigational system. The older adults were most disadvantaged compared to younger adults when both the peripheral and dot-counting tasks were added to the steering task. Crook, West, and Larrabee (1993) conducted a simulated driving study where computer keys acted as an accelerator and as a brake pedal for a traffic scene depicted on the computer monitor. The secondary task was information about weather and traffic that the participant was asked to remember. Crook et al. (1993) reported that costs of the dual-task situation were higher for older adults for lift time (removing finger from the key), but not travel time (moving finger over to the other key). Although these studies do suggest disproportionate costs of divided attention to older adults in simulated driving situations, more realistic situations are needed to determine whether older adults are at particular risk in driving conditions that require high amounts of multitasking.

Work

The nature of work in contemporary society has shifted. In the past, workers often retired because aging had left them incapable of physically managing their work due to arthritis, heart conditions, or other physical ailments. The picture has changed today. Older people are healthier than they have been in the past, and contemporary work relies more on the ability to process and manage information than on physical strength. Because of the growing age of our workforce and the frequent desire to remain in the labor force into late adulthood, understanding the impact of age-related changes in cognitive function in workplace performance is becoming a matter of some urgency. Despite the growing importance of this issue as our society and workforce ages, there is a surprising dearth of information on this topic.

This is particularly surprising because there is a well-documented relationship between cognitive ability and work performance. Even the lowest level jobs show a positive relationship between cognitive function and rated excellence on the job (Hunter & Hunter, 1984; Schmidt, Hunter, & Outerbridge, 1986). The decline of cognitive abilities in older adults, combined with the finding that low ability workers perform more poorly, suggests that one would expect to find a negative relationship between aging and work performance. Meta-analyses, however, consistently have failed to find such a relationship (Rhodes, 1983; Waldman & Avolio, 1986). In general, there is a preponderance of evidence suggesting that there is no relationship between age and job performance.

Park (1994) hypothesized that there are four possibilities that can account for this relationship. One is that older adults have jobs for which
they are highly experienced and that are characterized by maintenance functions. That is, older adults rarely encounter resource-demanding transition phases, described by Murphy (1989), where they must learn many new skills. As a result, age deficits in cognition are not very important in job performance. This hypothesis, in some ways, is an automatization hypothesis, since one of the reasons maintenance functions can be performed so effectively in the face of declining resources is the high familiarity component of such behaviors, which also are low in the effortful, controlled processing component. Salthouse, Hambrick, Lukas, and Dell (1996) reached a similar conclusion in their research on synthetic work time management situations. They suggested that older adults in the workforce may be less efficient than their younger colleagues, at least when beginning a job. Historically, the trend to remain in the same job throughout one’s entire career may have masked transition difficulties for older workers. The recent trend toward changing companies, and even professions, throughout one’s working years may reveal larger job performance deficits for older workers.

A second possibility is that experience protects against decline in the cognitive abilities used in the workplace. Meticulous work by Salthouse, Babcock, Mitchell, Skovronek, and Palmon (1990) on aging architects and by Salthouse (1984) on aging typists clearly shows that declines in component behaviors (such as spatial visualization in architects and interval to respond between key strokes in typists) do occur with age. In a laboratory-based training study that required participants to manage time among several simultaneous tasks, large age differences were maintained across a 2-hour performance interval (Salthouse et al., 1996). Thus, there is little evidence that practice protects against declines in the basic cognitive mechanisms underlying the work behavior.

A third possibility is that complex knowledge structures about a job increase with age and compensate for decline in basic cognitive abilities. A number of studies have shown that older workers in various professions have as much or more domain-specific knowledge about aspects of their job than younger workers (Baltes & Smith, 1990; Stumpf & Rabinowitz, 1981; Taylor, 1975), so there is some legitimacy to this hypothesis.

Finally, a fourth reason that the relationship between age and job performance may be null is that older adults increasingly use environmental supports to compensate for declining cognition (Park, 1994). There is evidence that older adults consult with younger colleagues, collaborate extensively, and gravitate toward positions that require knowledge and judgment while moving away from positions that have high cognitive resource requirements. (For example, a position as a university administrator, which is typical for older academics, requires more judgment and less intensive processing resource compared to that of a bench scientist, which is more typical of younger academics. Similar analogies exist in the legal and corporate world.)

Tacit knowledge of a job is a type of procedural knowledge that is
useful for solving everyday problems associated with a job, but that usually is not explicitly verbalized in job training. There is evidence that tacit knowledge of a job may also be relatively preserved with age and may serve as a determinant of job success with age. A recent study of 200 bank managers by Colonia-Willner (1998) found that tacit knowledge (as measured by the Tacit Knowledge Inventory for Managers [TKIM]) decreased less with age than did psychometric reasoning ability (as measured by Raven's Advanced Progressive Matrices and the Verbal Reasoning subtest of the Differential Aptitude Test [DAT]). Age, Raven's performance, and DAT performance failed to predict managerial skill as assessed by job performance ratings, salary, and management span (a count of the number of personnel supervised, both directly and indirectly). However, tacit, job-related knowledge in dealing with others did appear to be related to managerial skill. Because tacit knowledge is relatively preserved with age, and experts appear to possess more of it than nonexperts, perhaps tacit knowledge mitigates the relationship between age and expected declines in job performance.

The data on aging, work, and cognition point to the fact that, although basic declines in cognitive function would appear to be critical obstacles to performing a demanding job, the environmental supports, elaborated knowledge structures, tacit knowledge, and experiences of older workers may serve as compensatory mechanisms in familiar, everyday environments.

A final important issue with respect to the aging workforce is how able and willing older workers will learn and use new technology. Given the rapid pace of technology changes in the workplace, this has become a critically important issue. There is evidence that older workers are perceived more negatively and thus have less potential for development (Rosen & Jerdee, 1976), and that they are less likely to be selected for continuing job training (Fossum, Arvey, Paradise, & Robbins, 1986; Lee & Clemons, 1985).

Evidence has suggested that older workers do perform computer entry tasks more slowly and that cognitive abilities underlie the performance difference (Czaja & Sharit, 1998; Czaja, Sharit, Nair, & Rubert, 1998). Other research has indicated that older adults acquire computer skills more slowly than younger adults (Elias, Elias, Robbins, & Gage, 1987; Kelley & Charness, 1995; Zandri & Charness, 1989). There also is evidence that age-related differences in acquisition ability of computer tasks are controlled by measures of speed and working memory (Echt, Morrell, & Park, 1998; Morrell, Park, Mayhorn, & Kelley, in press), and perhaps spatial ability (Kelley & Charness, 1995). Although these studies consistently have demonstrated learning advantages and better performance on the part of younger adults for important technical workplace skills, the studies also consistently have indicated that older adults do learn and perform with a high degree of accuracy. Because it is clear that continuous and gradual cognitive decline begins in early adulthood (see Park, chapter 1 in this volume), it is important that, as workers age, they keep abreast of changes in technology and job requirements. A middle-aged worker who updates skills in a continu-
uous and gradual fashion will not have to make large adaptations to learn new workplace functions. An older worker, however, who perhaps has never used a computer and suddenly is required to learn many new functions simultaneously as a new job requirement would be much more disadvantaged than a middle-aged worker who had to learn only an updated version of a software package as a new job function. Data suggest that the failure to invest in training in middle-aged and older workers will severely disadvantage these sectors of the workforce.

Summary

An increasing understanding of age-related changes in the basic mechanisms of cognitive function has resulted in a growing understanding of the meaning of these changes for the function of older adults in their everyday environments. Although the declines in speed of processing and working memory that occur with age result in some decrements in performance in everyday behaviors, the decrements tend to be less pronounced than one might expect, or may not be evident at all. There is a wealth of evidence suggesting that older adults perform well when they are performing behaviors at which they are expert or when they are in familiar environments. The impact of cognitive deficits on everyday behaviors is most pronounced when older adults are in unfamiliar environments and must perform tasks that are novel to them.

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