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Presidential Letter: A Review of 2018

Herbert Gingold, PhD¹

Dear Colleagues:

I am very excited about our latest volume of the *New York State Psychologist*. Following a recent tradition, a division, The Adult Development and Aging Division, has taken responsibility for it this year. The editors, Drs. Shibani Ray-Mazumder and Julia Penn Shaw have shepherded it through conception to the final, impressive, product. The articles, which celebrate resilience, are particularly important at a time when an increasing proportion of our population is aging. I would like to congratulate the contributors who have worked hard on their articles. There are two memorials of NYSPA members who have died recently that celebrate their considerable activity and accomplishments.

The theme of this volume, resiliency in aging, is particularly appropriate as NYSPA, as an outgrowth of former state psychological associations, is approaching its centenary year. Like many seniors, it is facing new challenges with diminished resources. Yet, its mission remains as important, or more so, as it was when it was formed. NYSPA functions as a wise elder for the psychological community in New York State. We are the oldest psychological organization in the state (one of oldest in the nation) and have a special standing with the legislature and other forces in the state. NYSPA alone speaks for psychologists with our experienced Legislative Committee and our excellent lobbyists. As I write this, legislation proposed by NYSPA on Continuing Education was just signed by the governor.

The year 2018 has been a difficult one both for the NYSPA and for me personally. When I resumed the presidency in June, it was with the primary goal of facilitating a needed NYSPA-focused review to address long neglected structural problems and

tensions within the organization. In addition, I also knew we were facing ineluctable challenges from outside; including irreversible changes in health care delivery, and social changes impacting the very means by which we have, in the past, recruited and maintained viable membership levels.

Despite the problems we are facing as a nation, as a profession and as an organization, I remain hopeful. I will describe my reasons for this optimism. As a subject it seems particularly appropriate to discuss in a journal devoted to resilience.

Internal Challenges

Leadership. For the first time since I became involved in the leadership in NYSPA, there is a new spirit of cooperation growing within the leadership and a recognition that many of our traditional ways and fixed opinions were not serving the organization well. Lack of openness and transparency, a national problem, leads to distrust and suspicion. Responsiveness to our membership has increased setting a new tone. NYSPA's leaders do not shirk from answering hard questions. Plans are afoot to institutionalize these changes.

Internal Communications. Happily, there is a growing sensitivity to tone and nuance in communications these days. We are in an era that is newly sensitive to bullying and micro-aggressions. Unfortunately this is undercut by the lack of subtlety in digital communications. People are often unaware of how emails and texts are interpreted, often out of context or when the writer makes assumptions that are not shared by the recipient. We as psychologists are particularly suited to dealing with this problem,

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as sensitivity to the use of language is a critical skill in the consulting room. In recent years, I have noticed in NYSPA a growing attempt for members to be more sensitive and patient with each other. If only this could happen on a national scale.

Structural problems. NYSPA's digital systems have evolved chaotically. As new programs were added they were stuck in to the basic system through a network of tricks and workarounds. The result has been a system tremendously susceptible to malfunctions. What we need is professional institutional software in which all functions are integrated and consistent. This is a project lined up for next year.

Outside Challenges

Health care delivery changes. As all members are aware, the context in which psychotherapy services are being delivered and reimbursed is changing rapidly and with increasing speed. When we are puzzled, angry and frightened by these developments many of us blame the messenger, or even NYSPA, for "not doing something about it." What members are learning is that if we unite and support each other with trust, warmth and sound advice, we can sometimes attenuate the worst effects. So, support your state organization financially and by volunteering to help in whatever battles are winnable. One of the great advantages of the NYSPA Listserv is that it is often a source

of real and generous support and advice (and even humor). That along with our extraordinary lobbying efforts are among the treasures of NYSPA.

New members. New and early career psychologists are joining NYSPA but not yet in the numbers needed to sustain us. Many of our new members are becoming active and taking leadership positions at all levels. This is a very positive development and it is a trend we need to encourage. NYSPA plans to reach out to more colleges and universities and training institutions to make students aware of how important this organization is for their future.

Culture change. Lastly, there are drastic changes in society that psychologists are supremely poised to address. We still have the ear of the public and popular psychological articles continue to be well received. New specialties, new techniques and new diagnostic challenges are facing us. This promises a productive and exciting future. As an example, I am getting calls from an increased numbers of young people who have realized that they have no idea how to be in personal relationships because their social lives have been largely lived online. Helping these people find the capacity for intimacy is one of the most stimulating challenges in my practice.

As NYSPA prepares for its second century, let us all come together and celebrate the accomplishments of the first one while practicing resilience. Thank you for your trust in me.

Welcome from the Co-Editors



Julia Penn Shaw, EdD

It has been my pleasure to work with Dr. Shibani Ray-Mazumder as co-editor of the 2018 *NYS Psychologist*, the flagship publication of the New York State Psychological Association. This has been an opportunity, as members of the Division of Adult Development and Aging, to focus on a topic close to our professional and personal interests: Aging and Resilience. Many members of our division contributed, including those who served as reviewers. I would like to give special recognition to Dr. Tobi Abramson, for her astute suggestions as a reviewer, and to Tricia Currie-Knight, our professional editor.

The range of articles selected for this journal is rich and diverse, considering aging and resilience from many perspectives. Most contributors have decades of practice as licensed psychologists or academics, integrating their seasoned personal experiences with theoretical models in service to particular groups of elders. The articles fall into two broad categories; those which focus on conceptual frameworks with a background of experience with elders; and those which emerge from direct experience in clinical settings, grounded in sound theoretical research, closing with reflections from Dr. June Blum, a practicing psychotherapist at the age of 98.

One aspect of this work that I particularly enjoyed was getting to know colleagues as authors. I have already known them as leaders in New York State Psychologist Association, with four having served as President of NYSPA: Herb Gingold, Roy Aranda, Richard Juman, and Sharon Brennan. In addition, five contributors served as President of the NYSPA Division on Adult Development and Aging: Shibani Ray-Mazumder, Tobi Abramson,

Julie Shaw, Ruth Mutzner, and, many years ago, June Blum (our nonagenarian).

The commitment of this group, whose work focuses on recognizing and supporting aging populations, has made this journal rich in detail and nuance. Although written for an international audience, it also serves as a sharing among friends of professional and personal experiences related to 'aging and resilience'.

We hope you enjoy this selection. As this journal has come together, I have enjoyed gaining fresh insights into aging and resilience, and also a deeper relationships with my NYSPA colleagues.

Julia Penn Shaw, EdD

Associate Professor, Human Development
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*Shibani Ray-Mazumder, ScD,
PhD*

The theme of resilience in aging is timely given that Baby Boomers are living longer than their parents and grandparents but are more likely to face health, psychological, and financial challenges. By the year 2030, Baby Boomers will make up 20%

of the U.S. population (Institute on Aging, 2018). Baby Boomers are less healthy than their parent generation, with up to 91% dealing with chronic illness such as obesity, diabetes, and hypertension (Institute on Aging, 2018; King, Matheson, & Chirina, 2013). Their age cohort is also more likely to suffer depression, particularly among females (Pratt & Brady, 2014). One third of them are more likely to live alone or, among 85+-year-olds, live in a nursing home (Institute on Aging, 2018). In 2010, 10% of 65+-year-olds were living in poverty (Institute on Aging, 2018). Despite these and other

life challenges, there are still older individuals who remain resilient by maintaining their sense of purpose and managing their aging experience positively.

Resilience is best defined as “an outcome of successful adaptation to adversity” (Zautra, Hall, & Murray, 2010). This 2018 *NYS Psychologist* journal provides a wide range of articles addressing resilience within the context of aging. For example, Dr. Abramson and Ms. Schmidt provide theoretical frameworks of psychological resilience and how they may be utilized in clinical practice. Dr. Shaw describes the epitome of resilience in the older years to be in finding wisdom. Dr. Mutzner points to the importance of a caregiving environment to develop resilience by elders in nursing homes. Dr. Juman writes of the problem of overmedication of institutionalized populations that create barriers to resilience. Dr. Ray-Mazumder identifies factors that differentiate resilient individuals from their non-resilient counterparts within the lens of gender. Resilience among specific groups is discussed by Ms. Siegel in the care of the elderly Holocaust survivors and by Dr. Aranda focusing on socio-cultural issues of the aging Hispanic population.

Dr. Gingold brings in a personal perspective reflecting on the resilience of the therapist in facing the possibility of dying and how this impacts the therapeutic alliance when disclosing to the patient.

“In Memoriam” pays tribute to two giants of the New York State Psychological Association (NYSPA) who passed away recently and who were the epitome of resilience. Drs. Sharon Brennan and Frank Goldberg were wonderful examples of keeping purpose and living in the moment of their lives while serving for the greater good.

The final article brings us to Dr. June Blum who is an example of living resilience and who has been

a longstanding heralded member of the NYSPA. Dr. Blum was interviewed by Dr. Shaw on many elements of what she considers to be important in a life worth living. A particular theme of resilience that arises from this interview is Dr. Blum’s encouragement to use the elder years as a time to accept and value who a person is rather than to base their interests and values on what others expect of them.

I have enjoyed working with my co-editor, Dr. Julie Shaw, on this compilation of articles for the 2018 *NYS Psychologist*. Thanks to the Adult and Aging Division for providing resources and funds to help with editing the journal. Thanks to NYSPA Central Office for providing help and resources with the publication process. Thanks to Dr. Nomita Sonty for her donating the cover photo that symbolizes true resilience over a hard terrain. Thanks to my fellow colleagues for their hard work and commitment to making this edition of the journal truly wonderful.

Shibani Ray-Mazumder, ScD, PhD

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Tobi Abramson



Pamela Braverman Schmidt

Cultivating & Fostering Resiliency and Human Happiness in Clinical Practice with Older Adults

Tobi Abramson, PhD¹ & Pamela Braverman Schmidt, MEd, LMHC²

A resilience framework acknowledges the role of deficits, but emphasizes assets and strengths. The ability to adapt positively and rebound after adversity is highly desirable and is a positive attribute for well-being. Older adults are capable of sustained resilience regardless of socioeconomic background, literacy, experience, and health status. How individuals face adversities, deal with stressors, and regain their sense of self involves a combination of personal strengths, protective processes, and social resources. This paper defines resilience, reviews concepts and frameworks of psychological resilience, presents propositions regarding the nature of resilience, and outlines clinical practices utilized when working therapeutically to cultivate resiliency as a catalyst for positive change and foster happiness with older clients. The first section of the paper focuses on definitions of resilience based on psychological research. The second section focuses on three theories of resilience: (1) Fredrickson's Broaden-and-Build Theory of Positive Emotions; (2) Baltes' Life Span Development Theory; and (3) Cowen and Work's Strengths Perspective. The final section frames the nature of resilience: (1) the role of positive emotions; (2) characteristics of resilient individuals; (3) antecedents of happiness and the savoring of experience; (4) pragmatics of self-care; and (5) clinical strategies to promote resilience. Resilience is examined as an attribute of positive human development and its response as a psychosocial process to negative life events. As we confront the increasing proportion of older adults needing support and intervention when facing life's challenges, utilizing knowledge-based resilience research assists clinicians in promoting well-being.

Keywords: resilience, happiness, older adults, clinical practice

Construct of Resilience

The term *adversity* is defined as risk involving negative life circumstances, whereas resilience is a response to the experience of adversity that helps one to restore balance. There are two key constructs central to understanding resiliency. Resilience as a construct can be identified as a personality trait; a stable attribute and resource that enables bouncing back from the experience of adverse events (Jacelon, 1997; Wagnild, 2003). Resilience, thus, can be seen as a protective strength in the face of adversity (Gooding, Hurst, Johnson, & TARRIER, 2012; Nygren, et al., 2005; Wells, 2010). Resilience has also been thought to be part of a cluster of traits (Trivedi, Bosworth, & Jackson, 2011) including optimism, extraversion, and conscientiousness. However, this view of resiliency, as an individualized personality trait, underestimates the impact of an individual's interactions with external situational factors (Leipold & Greve, 2009; Ungar, 2011).

The second construct identifies resilience as a behavioral process involving the assessment of vulnerability and the development of *protective factors* that might *modify* the negative effects of adverse circumstances (Luthar, Cicchetti, & Becker, 2000). Protective factors include positive social supports, sense of optimism, self-efficacy, intentionality, and level of engagement. Increasing the number of protective influences has been linked with a greater likelihood of positive outcomes in

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adapting to life's worst stressors (Leipold & Greve, 2009). Relatedly, as a process, resilience is defined as positive adaptation to adversity, or "bouncing back" from a stressful event (Hardy,

Concato, & Gill, 2004; Jopp & Rott, 2006; Luthar et al., 2000; Hildon, Smith, Netuveli, & Blane, 2008; Windle, 2010). The process includes the development of coping mechanisms such as rebounding, recovering and reintegrating (Earvolino-Ramirez, 2007). Resilience is viewed as a psychodynamic process impacted by situational factors. However, this perspective does not consider resilience as a motivational force within each person providing the opportunities to attain personal growth and self-transcendence (Richardson, 2002).

Theoretical Models of Resilience

Resilience can be explained through three theoretical models: (1) Fredrickson's Broaden-and-Build Theory of Positive Emotions (1998); (2) Baltes' Life Span Developmental Theory (1987); and (3) Cowen and Work's Strengths Perspective (1988). The Broaden-and-Build Theory of Positive Emotions suggests that the cultivation of positive emotions increases an individual's resources for survival. Through broadened awareness, new emotional resources are cultivated, making the difference between positive emotional survival or succumbing to various threats (Frederickson, 1998). An individual's access to a repertoire of positive thoughts and actions dismantles negative emotions and actions. Positive emotions (joy, gratitude, interest, hope, inspiration, love, and serenity) broaden one's awareness and are factors in building enduring psychological resources that enhance emotional well-being and resilience.

Baltes' Life-Span Developmental Theory posits that development continues throughout one's life and is influenced by environmental context. To the extent that it is appropriate to think in terms of plasticity, individuals are capable of cultivating pathways to happiness in response to life's adversities. Through reserve capacity, individuals use inner resources for responding effectively to challenging conditions. Through resiliency, individuals have the capacity for successful adaptation and recovery

in response to stressful life events. The potential for optimization is present throughout the lifespan.

Cowen and Work's Strengths Perspective theorizes that the cultivation of strengths, resilience, and growth as promotive factors offer substantial potential benefits in facing severe distress. By acknowledging the individual's unique worldview and integrating skill building and competence enhancing strategies, healthy adjustment trajectories are facilitated. This is a psychodynamic and fluid process necessary for healthy development.

Psychological Well-Being and the Antecedents of Happiness

Happiness is highly valued in today's world and a worthwhile pursuit as it provides us with experiences of pleasure and meaning (Ben-Shahar, 2012). It is inextricably linked to well-being and considered an essential part of living a meaningful and engaged life, directly contributing to the happiness of others as well.

Focusing more on the positive aspects of life, including personal strengths and social connections, enhances personal flourishing. Everyone can optimize well-being by incorporating proven practices into daily routines to increase levels of satisfaction and meaning. Seligman posits that happiness derives from three key elements for purposeful living: positive emotion, engagement, and meaning (Seligman, 2011).

A happy person enjoys *positive emotions* while perceiving life as purposeful (Ben-Shahar, 2012). Positive emotions function as exemplars of flourishing, or optimal well-being (Fredrickson, 2001) and include joy, contentment, love, and comfort. Positive emotions serve as indicators that one is not being distressed by negative emotions such as anger, despair, guilt, and anxiety. Clinical work can engage clients in utilizing strategies to regulate responses and gain insight when facing life's stressors.

The second element, *engagement*, cultivates one's virtues and strengths through flow, a heightened

state of awareness in which a person performing an activity is fully immersed with an energized focus.

The third element of happiness, *meaning*, is the purpose and satisfaction of life in serving something much larger than oneself (Seligman, 2002). Acts of altruism serve as transcendent experiences, allowing greater heights of character strength and value-driven behaviors. Acts of compassion may seem simple, but the consequences create an enduring sense of meaning.

Characteristics of Resilient Individuals

When resiliency is looked at in relation to personality traits several interesting relationships emerge. Resilient individuals have been found to score lower on the personality trait of neuroticism, which includes negative emotions, anxiety, insecurity, and weak coping skills (Hulya, 2016). Hulya (2016) also found a positive relationship between resilience and the personality traits of extroversion, openness to experience, agreeableness, and conscientiousness. Those individuals who have high levels of positive emotions have been found to have a wide range of tools on which to draw particularly when encountering stressful or adverse situations. In fact resilience may be strengthened through these adverse experiences (Fredrickson, 2001). Possessing positive emotions seems to promote flexibility in thinking and problem solving (Fredrickson & Branigan, 2005) and enable adaptive coping (Folkman & Moskowitz, 2004). Resilient individuals seem to utilize active rather than passive coping skills, minimize the appraisal of threat and create positive statements about oneself, and seek support from others (Southwick & Charney, 2012).

Pragmatics of Self-Care

Self-care is an essential component of cultivating and fostering resilience and happiness for both the older adult and for those who work with this population. Pragmatics of self-care is a broad construct that encompasses the practice of health and well-being to decrease stress. Conceptually, concepts such as learning how to leverage one's strengths, develop self-compassion, assessing one's intention, utilizing a strengths-based approach to

life review, expressing gratitude, reframing the narrative, and practicing mindfulness are essential in self-care and in the cultivation of resilience.

(1) *Leverage One's Strengths*: Strengths are built-in capacities for thoughts and behaviors that align with one's personal values. Identifying strengths helps accomplish goals and increases positive meaning in life. Strengths most closely linked to happiness include: gratitude, hope, vitality, curiosity, and love. (2) *Self-Compassion* is recognizing that discomfort is part of the universal human experience. Caring for ourselves increases resilience and helps one be more caring to others, thereby, lessening personal disconnection and isolation (Neff, 2011). (3) *Power of Intention* indicates that intentions are personal action motivational tools that cultivate change in one's life. This is done with an attitude of self-compassion for positive growth and change which are beneficial to everyone. (4) *Strengths-Based Life Review* is a review of past experiences, and, particularly, the resurgence of unresolved conflicts, illuminated by identifying strengths and capacities that can be reintegrated into a greater meaning in life. (5) *Expressions of Gratitude* improve psychological health and reduce toxic emotions, effectively increasing happiness, and reducing depression. (6) *Reframing the Personal Narrative* is a technique of cognitive reframing involving transforming specific negative *events* into more positive ones to improve the interpretation of one's life. (7) *Mindfulness Practice*, a nonjudgmental state, is achieved by focusing one's awareness on the present moment, while calmly acknowledging and accepting one's feelings, thoughts, and bodily sensations. It is important to consider how useful these self-care strategies are and can be incorporated into clinical settings when working with an older person.

Clinical Practices for Cultivating Resilience and Fostering Human Happiness

When designing and implementing interventions and programs to promote resilience and foster happiness in clinical settings the clinician needs to promote self-care, be present with their client, shifting the focus from *doing to being*. Utilizing tools that help the older adult through personal discovery enhances inner strengths and coping skills, become

empowered and, thereby, fostering their happiness and resilience. Seligman's positive psychological perspective provides a frame and guiding principles for psychologists to utilize with older adult clients in clinical settings.

(a) *Cultivate optimism and hope.* Teaching older clients to 'savor the good' is a technique that stimulates the brain, helping the client to cultivate optimism and more personal fulfillment. Research suggests that there may be a substantial genetic effect on optimism. By consciously challenging negative talk through cognitive behavior therapy techniques, optimism can be cultivated.

(b) *Reframing the Narrative, Cognitive Flexibility, and Cognitive Reappraisal.* Developing resilience requires cognitive flexibility to allow a client to draw on optimism, hope, and positive emotions. Reframing the narrative is an emotion-regulation strategy that increases the brain's ability to form new and robust neural pathways, thus, leading one to be able to experience positive emotions. Reinterpreting a negative situation by adopting a positive perspective is important in facilitating the client finding the 'silver lining.' By altering the perceived value and meaningfulness of the event changes the value the client places on the stressor. The client benefits from practicing this re-interpretative behavior as practice leads to the experience of positive emotions and ability to be happier. This practice of persistence in facing obstacles becomes easier as the brain encodes new patterns through repetition. An example of cognitive reappraisal would be: Appraisal: "*Life is horrible and unfair*"; Reappraisal: "*If I lived through that, I can face anything.*" In seeking to develop cognitive flexibility utilizing cognitive behavioral therapy, dialectical behavior therapy or problem-solving strategies can be useful in reframing the narrative and developing these cognitive reappraisal skills.

(c) *Practicing mindfulness.* Teaching older clients how to practice mindfulness, bringing their full attention to the moment is important, in developing resilience. One mindfulness technique utilizes the skills in the acronym RAIN, a 4-step process for using mindfulness meditation that can be used during stressful and difficult times (Wolf,

& Serpa, 2015). Wolf and Serpa (2015) define the components of RAIN as: **R**ecognizing what is happening by focusing on whatever thoughts, emotions, feelings or sensations are presently arising. You can ask the client to identify what is happening within their body at the moment; **A**llow life to be just as it is, allowing whatever thoughts, emotions, feelings or sensations one discovers to be present; **I**nvestigating one's inner experience with kindness and directing more focused attention to one's present experience can be assessed with questions such as, "*What most wants my attention*" or "*How am I experiencing this event internally, within my body?*" and **N**on-identification changing one's physical manifestation of the emotion with an awareness of self-compassion. This allows for the person to experience the event without letting it define who they are and involves changing phrases from, "*I am really anxious*" to "*There is a lot of anxiety in this situation.*" This can first be practiced in clinical sessions, but the older client can practice these techniques, independently, outside of the clinical sessions.

(d) *Expressing gratitude.* Developing and expressing gratitude improves one's self-concept and well-being. This can be done by having the older adult declare, write, or speak a thought focusing on how they want to align their life and be present in their world. The older person can be encouraged to write a letter of compassion to oneself; write a letter of appreciation to a significant person in their life; or telling a loved one how important they are. Regardless of one's communication abilities, older adults can practice these strategies to retrain the brain to be more positive. Ben-Shahar (2009) suggests writing a gratitude journal daily. In a therapeutic session, the client can practice generating 3 things they are grateful for each day. As homework, the older client can be asked to do this nightly before bed. If there are literacy or physical challenges, encouraging a client to verbally express appreciation and gratitude brings deeper connection. A gratitude journal allows the client to address distorted and irrational beliefs, while promoting meaning, appreciation of life, and ultimately psychological growth; all key factors in developing resiliency. There is an underlying physiologic change that occurs when one practices

gratitude. The hypothalamus (essential for regulating stress) and the ventral tegmental area of the brain (reward circuitry site) that produces the sensation of pleasure is activated in one's practice of gratitude (Zahn, et al., 2009).

In sum, the phenomenon of resilience is an attribute of positive human development. Developing resilience is based on interactive psychosocial processes and responses to stressors and negative life events. Tools in building resilience involve broadening mindsets to lead to personal flourishing. Psychologists can utilize a variety of clinical tools in helping older adult clients cultivate resilience, flourish, and live meaningful, happier lives.

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Differential Aging, Resiliency, and “Wising Up”

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Some of us age better than others. Some “wear out” while others “age well.” Do we all have the opportunity, however, to “wise up” with age? Is “wising up” perhaps the adult version of “growing up” that we sought to achieve in earlier years? While many aspects of aging are out of our control, wising up is a choice. It involves personal attributes beyond the state of health or well-being: Having good judgment in one’s life is a good thing, but it becomes wisdom when it extends to, and impacts, others. Wisdom has different sizes, and sometimes even small insights can make a lasting difference in the lives of others. Extending oneself into the realm of one’s challenge and mystery transforms us, and the psychological changes we experience as a result impact not only how we live our lives, but also how we influence others.

Keywords: aging well, wearing out, wising up

Introduction

We are all aware that with age comes greater variation in both the appearance and the reality of wellness. Some age well, and others wear out. Some age advantageously. They may age in place or in a place of comfort (Lee & Waite, 2017), have good health (Rhodes et al., 1999; Penedo & Dahn, 2005; Wurm, Tomasik, & Tesch-Römer, 2010), have control of many aspects of their lives (Steverink, Westerhof, Bode, & Dittmann-Kohli, 2001), have meaningful social connections (Guiney, Machado, & Knight, 2017), be grateful (Liao & Weng, 2018), and therefore feel resilient (Weststrate & Glück, 2017; Crystal, Shea, & Reyes, 2016). They may move

toward the goal of integration and wholeness, and perhaps even “gerotranscendence” (Erikson, 1997; Tornstam, 1997).

Others age with aggravation. Their lives have been burdened by scarce resources or limited mobility (Cain, Wallace, & Ponce, 2017); loneliness, social isolation, and poor health (Holt-Lunstad, 2017; Böger & Huxhold, 2018; Penhale & Kingston, 1995); chronic stress and financial distress (Miller, Chen, & Parker, 2011; Brown et al., 2016); and a limited outlook on possibilities for change (Bellingtier, Neupert, & Kotter-Grühn, 2015; Douglass, 1983).

Of course, these patterns are not all in one direction or the other. Happiness lights up the lives of those in pain, sorrow, or misfortune. Loneliness, grief, and strife happen to even those of us who are “lucky.” We can see, however, that the impacts of stress are greater on those who experience chronic isolation, distress, and ill health as their daily realities: They not only age quickly but also “wear out” sooner. How do elders in these two trajectories show resiliency?

Aging Well . . .

We hear versions of “70 is the new 50” or “60 is the new 40,” depending in part on the age of the speaker (Chopik & Giasson, 2017). What does this mean? It means that those who have access to personal life resources to keep their bodies, minds, and environments healthy can “age well” and, enviably, look and act younger than their years (Chopik & Giasson, 2017). Who among us does not

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want to age well? For aging well is living well. It is the healthy life, the happy life, the bountiful life that enables us to give back and to give forward.

Financially secure adults select from a smorgasbord of ways to address the stresses of aging, including psychological (psychotherapy, counseling), educational (upward mobility through education, life-long learning), spiritual (spiritual guides and alternative spiritual paths), medical solutions and procedures (from cancer suppression to spine surgery), social (volunteering for worthy causes, community centers for 55+ adults), physical (diets and medications), politics (supporting one's belief system), and planning meaningful legacies. Many of these options not only alleviate problems with the body but also address concerns of the spirit.

There are reasons that those who appear younger than their ages look smarter, happier, more content, and wiser. One might assume that because of their knowledge of the world, they have made good choices for their health, with their social connections, and with their finances (Chopik & Giasson, 2017). If, in addition, there is evidence that they have invested in a life that benefits others as well as themselves, then perhaps we aspire to age as they have aged—with grace. Some of our models for aging well may be individuals we know. Other models, for a lifespan developmentalist like myself, are also provided by theorists who outline steps toward elder maturity that make sense, and actually help us to understand aging processes better.

. . . Versus Wearing Out

“Wearing out” is a phrase frequently used in discussions about cities and mechanical devices, but bodies and psyches wear out with age as well. Wearing out of the body impacts the spirit, and wearing down of the spirit impacts the body. The intersectionality of class and age play a huge part in the wearing down of bodies and spirits (Brandmaier, Ram, Wagner, & Gerstorf, 2017; Gerlach et al., 2017; Menkin et al., 2017; O'Brien et al., 2017). Impacts of poor diet (Clay et al., 2017), loneliness (Mason, Lyyra, Pulkkinen, & Kokko, 2017; Savolainen, Mason, Lyyra, Pulkkinen, & Kokko, 2017), high stress (Miller et al., 2011), poor education and

limited access to medical care (Crimmins, Kim, & Seeman, 2009), unhealthy or dangerous physical environments (Moorman, Stokes, & Morelock, 2016), and inadequate social support (Levy, 2017; Nguyen et al., 2017) all play a role. Genes, of course, play a role here as well, but are mitigated by economic and cultural factors.

Signs of aging are exacerbated by social class. Physical aspects of aging happen to all of us who live long enough, but for some with fewer opportunities, 60 can be like 80. Ravages of age are made worse by unfortunate fate(s) of inadequate living conditions, poverty, race, ethnic and gender minority status, mental or physical disability (Parry, 1980), and/or a lifetime of hard work and occupational instability. Life habits, many of which may be self-medication for hardships, also ravage both the body and the psyche: tobacco (U.S. Department of Health and Human Services, 2004), alcohol (Peters, Peters, Warner, Beckett, & Bulpitt, 2008), opiates (Peron, Gray, & Hanlon, 2011), and violence (Seeman & Crimmins, 2001). All elders experience age discrimination to some degree, but micro-aggressions increase with poverty, disability, and illiteracy, likely speeding up the process of wearing out (Brandmaier et al., 2017).

Wising Up

Perhaps “wising up” is the adult equivalent of “growing up” to a child—moving across age boundaries by successfully engaging in the roles and tasks of “the elder.” Just as growing up is a challenge faced by every child, no matter what their opportunities, so is “wising up.” No life is without challenges and sorrow, and indeed the path toward “wising up” includes milestones that demand courage, fidelity to an identity of worth, commitment to ideals, and social, intellectual, and emotional energy toward worthwhile goals (Camp, 1989; Brothers, Miche, Wahl, & Diehl, 2015).

Evidence for “wising up” comes to us from multiple academic disciplines, among which include sociology, developmental psychology, cognitive psychology, neuroscience, religious studies, and biology. What is wisdom? Why would we aspire to it? Research augments what we know about “wising up” as we age. Only two views on the growth of

wisdom are presented here, but they are suggestive of others. Erik and Joan Erikson and Elkhonon Goldberg contribute to the discussion of “wising up” from complementary viewpoints. From these perspectives, does it seem that resiliency and wising up are achievable for both those who age well and those who wear out?

Erik Erikson: A Psychosocial Perspective

Perhaps the best-known of the lifespan models for “wising up” is that of Erik (and Joan) Erikson (1997, 1980, 1998). Its popularity is warranted, I believe, for a number of reasons. It presents sensible milestones in the life trajectory that we recognize and speak of in everyday conversation. These milestones are framed through both positive and negative outcomes that make age-appropriate sense and provide guidelines for achieving psychological health and avoiding dysfunctional development: (1) more trust than distrust (infancy); (2) more autonomy than shame (toddlerhood); (3) more initiative than guilt (play age); (4) more industry than inferiority (school age); (5) more identity integration than identity diffusion (adolescence); (6) more intimacy than isolation (young adulthood); (7) more generativity than stagnation (later adulthood), (8) more integrity than despair (old age—65+), and (9) a movement toward gerotranscendence (old old age), which was added later. Each of these stages has a broader and deeper horizon, similar to Bronfenbrenner’s psychological ecology (1979) or Maslow’s hierarchy of needs (1968), until it includes the care of the earth and beyond from the position of a realistic and balanced individuated self. There is an understanding that one is always growing and that former views on life will be modified as one becomes more “integrated.” For example, one’s “basic trust” and “self-efficacy” begun in infancy evolves as one establishes adult intimate relationships or as one needs to rely on others in infirmity or old age. These may become points of engagement in psychotherapy with elders and sources of increased wisdom as past issues get resolved with current insights. As Joan Erikson (1997) notes: “It is important to remember that conflict and tension are sources of growth, strength, and commitment” (p. 106).

Looking at photos of Erik and Joan Erikson, attractive and apparently still healthy in their

90s, one assumes that they had more experience on the positive side of their life experience than the negative side, but it is helpful to remember that it was Erikson’s own extended moratorium toward adulthood and the need to find himself that led him to create the concept of “identity crisis” in young adulthood. The intellectual life of the Eriksons was still flourishing in later years, and Joan Erikson was 94 when she published *The Life Cycle Completed*, adding the ninth life stage to the Erikson model—influenced by Tornstam (1997)—called gerotranscendence. Does the Erikson model also apply to those whose lives are less fortunate than theirs?

Elkhonon Goldberg: A Neurological Perspective

Another interesting model for wising up with aging is offered by Elkhonon Goldberg in his book *The Wisdom Paradox: How Your Mind Can Grow Stronger as Your Brain Grows Older* (2005). It is not his last book (in his 70s, he is still actively teaching workshops and writing), but the one that gives a framework for aging with wisdom. A neuropsychologist and cognitive neuroscientist, he offers a model from a neurological perspective on the growth of neural patterns that become richer and more complex with age as a result of taking on challenges in life. This complex set of patterns for solving problems comes as a result of facing difficulties appropriate to one’s age and station in life, and being accountable for outcomes. Part of what we perceive as wisdom is the capacity to find paths to goals that others cannot imagine (either the path or the goal) and then cutting through a forest of doubt and difficulty to create that path and lead others. This is very different than being smart, which only requires that you store information, use it for your own benefit, and perhaps make it available to others.

Rigorous use of our thinking, judging, and problem-solving skills creates patterns in the brain that we can turn to even as, with age, the brain as a whole shrinks and some capacities become slower and more limited. We look to those who have exercised “thinking, judging and problem-solving” in the past (and, I would add, courage) to address problems now. We call them “wise.” Is this path

open to both those who age well and those who wear out?

Resiliency in the Face of Differential Aging

How does aging with resiliency fit with the differential paths toward aging? Is one path more likely to show resilience than another? Does resiliency appear in different forms with the different trajectories, or is there a common core to resiliency no matter where it appears?

As Goldberg suggests, wisdom is less a matter of “aging well” than of addressing life challenges and opportunities (McKenna, 2013; Kongsbakk & Rooney, 2016; Hays, 2017; Fox, 2002). Resiliency is born on a fidelity to a commitment to the self. The area of one’s wisdom is the area of one’s deep and meaningful experience, where emotional commitments connect to values and actions (Claxton, 2005). It relies on knowledge acquired from experience rather than formal education. Stanley Bergman (2018), in an article on “The Difference Between (Artificial) Intelligence and Wisdom,” writes, “The beauty of wisdom is that it is available to all. Wisdom doesn’t care what school you attended, and it doesn’t care about race, creed, or color. Wisdom is real and authentic, which is why no one ever speaks of ‘artificial wisdom.’”

Nor does anyone ever speak of “artificial resilience.” Resiliency in the face of adversity is a primary attribute of “being wise” (Goldberg, 2005). It is when circumstances are challenging that resilience is most evident, because perhaps only then is it clear that maintaining a difficult path takes effort. Perseverance in adversity appears to the observer to be “wisdom in action.” How does that man facing cancer continue to dedicate his service, with difficulty, to his profession? How does that aching arthritic woman with extreme personal financial hardship find a way to take care of her grandchildren? Resilience may be a personal attribute of another that we see only occasionally, when it is required.

Some of us have a fortunate life trajectory so that as we age, we are safe, secure, and in good health. For a person of high social status, strong social connections, and sufficient resources, resiliency

may not be evident: It may be disguised under the cloak of good habits born of a lifetime of effective actions. It may lead to maintaining that optimal environment as long as possible, and maintaining the identity and worldview that goes with that life, even if aspects of it fall away over time, such as loss of loved ones, social position, or financial means. What differentiates “aging well” from “wising up” is fortitude toward goals that the self invests in resilience in the face of challenge—fortitude that may not always show.

Some of us suffer from problems such as poverty, poor health, and lack of social support, many of which are brought on, or exacerbated, by broader cultural and financial inequities. For a person whose life trajectory has been fraught with socioeconomic, health, and social status stress, resiliency may also not be evident. It may be faithfully facing the future even knowing that some highly wished-for things will never happen. This resiliency may only be noticed by those whose lives are immediately touched by it—nevertheless, making a very strong impact.

A myth of growing up is that once we are adults, we have had sufficient mentoring to be self-regulated and self-monitoring and self-guiding. Strong extended families, deep roots in religion, a common core in education, civics education, and an upward-turning economy offering both stability and ever new opportunities were a part of our expected support as we aged. In so many cases, these supports for adult adjustments toward greater fulfillment in life have been weakened, and a life with weakened supports is a life with more tensions, more stresses, and unexpected outcomes. Wising up may be more difficult to achieve than in the past, but both of the “wising up” models suggest that we grow stronger by facing stresses and distresses in our lives (Reinders & Hays, 2018; Justes & Breidenstein, 2012).

Just as young people look for models for being “grown up,” we turn to people who are resilient as models for wisdom when our own difficulties arise. We might say, “If he can do it, so can I,” or, “If she can bear that challenge, surely I can handle this lesser problem.” Resiliency is a result of internal factors developed across a lifespan by handling

challenges of high stress with resolution, rather than capitulation. Awareness of “intersectional ageism”—the interaction of the various aspects of “wearing down”—may help us in individual interactions to be more sensitive to how outward appearances may mask signs of resiliency—effective coping with life issues by those who have “wised up” with age.

If becoming wiser with age involves the exercise of will and courage with resiliency, then both the path of “wearing out” and “aging well” may lead to personal wisdom (Shaw, 2010). It is personal spirit that enables us to “wise up” with age (Ramsay, 2012; Ramsey & Blieszner, 2016). Even those whose bodies and psyches are wearing out can face the challenges of their unique lives with fortitude and perseverance. Nelson Mandela, Mother Theresa, Mahatma Gandhi, and others showed resiliency to external challenges that discouraged those with less fortitude. The potential of aging with increased wisdom and grace is evident in those leaders. It is evident, as well, in our colleagues, friends, and family, sometimes in ways that surprise us.

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Resilience and the “Good-Enough” Environment in Late Adulthood: A Relational Perspective

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In periods of relative helplessness like infancy and late adulthood personal resilience is coextensive with environmental support. In keeping with Winnicott’s (1964) famous statement that without a caregiving relationship “there is no such thing as a baby...” (since physical and psychological survival of neonates is wholly dependent on others...), there seems to be no way to truly understand resilience in vulnerable seniors without also understanding the nature of available environmental support, i.e. the adequacy or inadequacy of care systems and care relationships. The literature on caregiving relationships in early life contains insights that are applicable to care relationships in late adulthood. Caregiver “sensitivity” (Ainsworth, 1967), “responsiveness” (Bowlby, 1999), and “attunement” (Winnicott, 1967) have been shown to facilitate health and adaptation in infancy, and may have similar benefits in senescence. Sociocultural factors like ageism and gerontophobia, however, and fiscal/institutional practices like high staffing ratios and rotating caregiver assignments, present obstacles for such “facilitating relationships” (Winnicott, 1965). Qualitative research, offering a window into the emotional significance of caregiver/care-recipient relationships, may be useful for understanding the needs of vulnerable seniors, and planning future adult care service models.

Keywords: resilience, helplessness, health, social interaction, caregiving, caregiving environment

Resilience in Social Context

Resilience, defined by the American Psychological Association as “the process of adapting well in the face of adversity” (Newman, 2002), is generally conceived of as an individual characteristic. Individual characteristics, however, are known to emerge in social contexts. The origins of adult resilience are traceable to self-regulatory capacities established through caregiver contact in infancy (Ozbay, Fitterling, Charney, & Southwick, 2008), and social engagements have been shown to interface with adaptation throughout life (Southwick et al., 2016).

The nuances of caregiving environments in early life have been closely studied, with considerable attention paid to the way specific aspects of infant-caregiver relationships affect mental and physical development, e.g., caregiver personality traits (Molfese et al., 2010; Kornienko, 2016), and nonverbal communication strategies between infants and caregivers (Fonagy, 2004; Winnicott, 1967; Mahler, Pine, & Bergman, 1975). Videographic investigations (Beebe, 2014) have tracked infant and caregiver reactions to one another through recorded facial expressions (smiles, frowns, grimaces, etc.), and scales have been developed to formally assess the quality of caregiver-infant interaction, e.g., the Ainsworth Maternal Sensitivity Scale (Ainsworth, 1963) and the Maternal Behavior Q-sort (Pederson, Moran, & Bento, 1999).

What, if any, relevance does this bountiful literature have for caregiving relationships in later life?

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Helplessness in Infancy and Late Adulthood

One characteristic that infants and very old people seem to share is physical helplessness: the inability to ambulate, feed, bathe, or toilet oneself without assistance from others. There are, to be sure, individuals who live long and complete lives without ever losing their capacity for independent mobility and self-care. There is, nonetheless, a gradient of functional impairment that tends to increase with chronological age. The National Health and Aging Trends Study (Freedman et al., 2013) reveals that two-thirds of American seniors over the age of 65 need assistance with one or more activities of daily living. The U.S. Census American Community Survey Report (He & Larsen, 2014) indicates the highest rates of physical and mental infirmity to coincide with the most advanced levels of age. Neugarten (1974) referred to the very latest stage of adulthood as “old-old” age. Laslett (1989) identified the same period as “the fourth age.”

The experience of helplessness in infancy is moderated through caregiver support. Psychoanalytic theorists (Kohut, 1971; Winnicott, 1953; Klein, 1921; Freud, 2001) have posited that infants feel symbiotic with caregivers in early life and that this experience supplants feelings of vulnerability with feelings of power (“omnipotence”). While such tenets are hard to verify, there is ample empirical evidence that the quality of infant-caregiver interaction profoundly affects the trajectory of biopsychosocial development. It seems reasonable to speculate that the quality of senior-caregiver interaction may also impact on health and well-being, “will-to-live” and resilience.

Research on Infant-Caregiver Interaction Variables: “Sensitivity,” “Responsiveness,” and “Attunement”

The terms *sensitivity*, *responsiveness*, and *attunement* seem to overlap in the literature on infant-caregiver interaction. The concept of caregiver “sensitivity,” introduced by Mary Ainsworth (1967), is defined as a caregiver’s “ability to perceive and accurately interpret the signals and communications implicit in an infant’s behavior, and given this understanding, to respond to them appropriately” (Ainsworth, Bell, & Stayton,

1974). The concept of caregiver “responsiveness,” originated by Bowlby (1999), is defined by Bornstein and Tamis-LeMonda (1997) as a caregiver’s “prompt, contingent, and appropriate” response to an infant’s communicated need or distress state. The term “attunement”, presaged in Winnicott’s (1967) discussion of “mirroring,” denotes a capacity for synchronous affect between infant and caregiver (Woltering, Lishak, Hodgson, Granic, & Zelazo, 2015), such synchrony serving to guide caregiver action to emergent needs. Common to these three terms is a caregiver’s ability to feel for, and feel with, an infant, to accurately interpret behavioral signals in relation to underlying needs, and to promptly and effectively respond so as to protect or, if necessary, restore physiological and psychological equilibrium.

Caregiver sensitivity has been favorably linked with structural and functional aspects of brain development (Belsky & De Haan, 2011), increased brain volume (Sethna et al., 2017), and childhood and adult temperament and social functioning (Leerkes, 2008; Stams & Juffer, 2002). Caregiver-infant attunement has been correlated with early linguistic competence (Bornstein, Tamis-LeMonda, & Haynes, 1999), secure attachment (Meins, 2013), and the development of emotional regulation and self-control skills (Feldman, Greenbaum, & Yirmiya, 1999; Tronick, 1989; Kopp, 1982; Woltering & Lewis, 2009; Gianino & Tronick, 1988). Maternal responsiveness has been correlated with early cognitive development (Beckwith & Cohen, 1976; Coates & Lewis, 1984; Freund, Bradley, & Caldwell, 1979; Ho, 1987) and positive social adjustment (Goldberg, Lojkasek, Gartner, & Corter, 1989; Ainsworth et al., 1974).

Conversely, the absence of contact with an emotionally available caregiver in infancy has been linked with such behaviors as apathy, lethargy, social ineptitude, and physiological wasting, a symptom cluster identified by Spitz (1945) as “anaclitic depression.” These observations were initially made of infants in foundling homes, whose physical needs (food, shelter, hygiene, etc.) were adequately met, but who were deprived of extended caregiver contact. Bowlby (1995), who studied homeless children in post-World War II Europe, coined the

term “maternal deprivation” to denote psychological harm accruing from inadequate emotional contact with a primary caregiver (regardless of whether or not children’s physical survival needs are met).

In ensuing discussion of caregiver interactions with older adults, the term sensitivity will be utilized.

The Caregiving Environment as a Relational Field

While the term *environment* is often used to refer to physical surroundings, in the literature on human development, the term *environment* typically denotes a social-relational field. Hartmann (1939) identified the “average expectable environment” as a setting that is “responsive to the child’s psychological needs.” Winnicott (1960) describes the “holding environment” as a nexus of physical and emotional support provided by a mother to an infant. Emphasizing that physical acts like feeding, diapering, and bathing have psychological significance, he states: “Processes which from the outside may seem to be purely physiological . . . belong to infant psychology and take place in a complex psychological field” (p. 588). He further asserts that empathy is implicit to maternal caregiving and that “holding . . . is a form of loving” (Winnicott, 1960, p. 592). Winnicott (1953) observed that early care relationships change over time to keep pace with changing maturational needs, a tendency referred to as “good-enough mothering.” “The good-enough mother . . . starts off with an almost complete adaptation to her infant’s needs,” Winnicott (1953) writes, “and as time proceeds adapts less and less” (p. 94), encouraging initiative and independence in the developing child.

Caregiving with older adults also takes place in “a complex psychological field.” The downward trajectory of functional abilities in later life engenders steadily increasing physical and psychological vulnerability, and steadily accelerating support needs. Effective caregiving relationships provide physical and psychological scaffolding in this delicate and often-unstable period.

Resilience and Social Connectedness Across the Life Span

The correlation between social connectedness and resilience has been demonstrated in numerous studies. Individuals with high levels of social support have been found to live longer (Eisenberger, 2018; Berkman & Syme, 1979; House, Landis, & Umberson, 1988; Holt-Lunstad, Smith, & Layton, 2010), have better mental health outcomes (Seeman, 1996), and have greater resistance to physical illness (Martire & Franks, 2014; Cornwall & Waite, 2009; Uchino, 2006) than socially isolated subjects. Research has also shown that emotional states associated with breaches of social connectedness (e.g., rejection and loneliness) activate the same physiological response systems that are activated in the face of physical danger, e.g., the amygdala, dorsal anterior cingulate, dorsal medial prefrontal cortex, and sympathetic nervous system (Southwick et al., 2016). Umberson and Montez (2010) write: “Humans are wired for social connection. Without social ties, distress emerges and health fails. In this sense, social connection seems to be a biological imperative.”

The course of adult life unfolds within a lattice of social relationships. Family and friends, co-workers, and romantic partnerships, frame and define human existence from cradle to hospice. Social support systems have a tendency to erode in later years. Friends and family members die or for other reasons drift beyond reach. Health and mobility challenges emerge, reducing out-of-home activity and making it difficult to replace lost relationships. At some point physical assistance is needed and professional care networks are engaged, with multiple agents serving diverse functions (nurses, social workers, direct-care aides). These relationships tend to be friendly though formal, and staff assignments shift regularly, limiting opportunities for dyadic attachment.

It is a paradox of later life that while social support is deeply needed, it is often hard to come by. This paradox is especially salient in the latest stages of elderhood, when base rates of physical and mental infirmity are high and communicative abilities may be compromised. In this period of life, professional caregivers are apt to have as much, if

not more, direct contact with seniors as friends and family members. This is particularly likely among seniors living in long-term care settings (nursing homes or assisted-living facilities), though it may also be the case with community-dwelling seniors. Nurses and direct-care staff (“aides”) have limited and circumscribed instrumental duties (e.g., they administer medications, measure blood pressure, change diapers, etc.); however, when ministering to otherwise socially isolated individuals, they become default representatives of the relational world. This function is not in their job description, nor do they get paid extra for it. It just happens.

Obstacles to Sensitive Caregiving With Older Adults: Sociocultural and Fiscal/Institutional Factors

Sociocultural Obstacles to Sensitive Caregiving with Older Adults: Ageism and Gerontophobia

Ageism (bigotry and discrimination against old people) and gerontophobia (fear of old age and/or old people) tend to be interconnected. In the circular fashion in which all bigotries emerge and propagate (i.e., fear induces bigotry; bigotry induces fear), fears about growing old spawn ageist stereotypes, and ageist stereotypes (accurate or inaccurate) fuel further anxiety about old age. Gerontophobic reactions are likely to be experienced most intensely around the latest stage of elderhood, the period identified by Laslett (1989) as “the fourth age.” Laslett characterized the fourth age as a period of “ignominy” and “decrepitude.” Gilleard and Higgs (2015) describe this stage as “the repository of all the feared and disdained aspects of age and agedness,” citing frailty, mental deterioration, loss of agency, loss of bladder and bowel control, and loss of self-care ability as vectors to social alienation (“othering”) and “social death” (defined by Wikipedia as “the condition of people not accepted as fully human by wider society”).

Multiple investigations have affirmed the prevalence of ageist stereotyping, bias, and discrimination in American culture (Nelson, 2016; Ng, Allore, Trentalange, Monin, & Levy, 2015; Rogers, Thrasher, Miao, Boscardin, & Smith, 2015). Professional caregivers, along with the general public, are routinely exposed to age-derogatory

messages in media and public discourse. It seems inevitable that these would in some way affect caregivers’ attitudes toward aged patients. A recent longitudinal study (Rogers et al., 2015) concluded that one out of five adults over the age of 50 experience age discrimination in American healthcare settings.

Fiscal/Institutional Obstacles to Sensitive Caregiving With Older Adults

In community as well as long-term care settings, fiscal priorities compete and sometimes conflict with quality-of-care goals. Rotating staff assignments, high resident-to-staff ratios, use of agency staff, and use of part-time rather than full-time staff, are all practices that limit opportunities for extended contact between seniors and caregivers, thereby limiting opportunities for relationship development. Minimum staffing requirements for nurses are mandated by state regulations, though no minimum standards are currently specified for direct-care workers in New York State.

Research on Caregiving Environments: “Person-Centered Care” and the “Culture Change Movement”

Multiple studies of caregiving environments have in recent years emerged from the “person-centered care” and “culture change” movement. These closely related perspectives are critical of traditional, medical-institutional care paradigms, emphasizing more flexible, individualistic, and relationship-oriented approaches. Included among the practices of person-centered care (Pioneer Network, 2018) are opportunities for patient/resident choice in domains of daily living (e.g., dining, bathing, recreating, etc.), opportunities for meaningful social and leisure engagement, consistent assignment of care staff, and high levels of care staff accessibility (which in long-term care settings means low resident-to-staff ratios).

Li and Porock (2014) published a review of 24 studies investigating clinical outcomes in settings identified as either “person-centered care” or “culture change” facilities. Though results from different studies were somewhat mixed, placement in culture change facilities was shown to have

beneficial effects on resident quality of life in multiple areas including experienced dignity, security, and autonomy. Lower depression scores on the Global Depression Scale were also noted in culture change facility subjects. Nine of the 24 studies in the review addressed the effects of person-centered care with dementia patients. Reductions in levels of agitation were demonstrated in dementia patients in person-centered care facilities, relative to traditional settings. Decreased psychotropic drug use was also noted among subjects in person-centered care settings.

Kim and Park (2017) published a meta-analytic study of the effects of person-centered care on dementia patients. Nineteen separate investigations were included in the meta-analysis, with a combined total of 3,985 research subjects. The results indicated that person-centered care settings reduced agitation, reduced depression, and improved quality of life for dementia patients.

Person-centered care advocates Kitwood and Bredin (1992) assert that the “personhood” of cognitively challenged individuals can only be expressed “within the context of a mutually recognizing, respecting, and trusting” caregiving relationship (Fazio, Pace, Flinner, & Kallmyer, 2018). This observation is reminiscent of a well-known Winnicott quote. Discussing infantile dependence, psychoanalyst Donald Winnicott (1964) famously said: “There is no such thing as a baby. . . . If you set out to describe a baby, you will find you are describing a baby and someone. . . . A baby cannot exist alone but is essentially part of a relationship” (p. 88).

Possible Directions for Future Research

While design characteristics vary from one study to another, the preponderance of existing research on caregiving environments is experimental or quasi-experimental in form (the latter distinguished from the former by the absence of randomized group assignment), using quantified “process” or “outcome” dependent measures. “Process” measures pertain to required services or interventions like restraints or levels of psychotropic medication. “Outcome” measures refer to clinical symptom indices, like frequency and severity of pressure ulcers, or scores

on mood or “life satisfaction” rating scales (Castle, 2008). Much of this research has been executed by nurses and public-health-sector professionals.

There seems to be a paucity of qualitative investigations in this area, i.e., studies that focus on the personal meaning and emotional impact of caregiver/care-recipient exchanges. For example: Do seniors feel comforted or distressed during and immediately following care? Worthwhile or abject? Understood or misunderstood? What are seniors’ thoughts and feelings while waiting for requested physical assistance? While waiting five minutes? Fifteen minutes? Thirty minutes? How do specific aspects of caregiving transactions affect care-recipients’ experience (e.g., caregiver warmth, empathy, vocal tone, etc.)? Such information could add texture and dimension to conclusions derived from quantitative research and have useful applications in such areas as staff selection, evaluation, and training. Cognitively impaired seniors, of course, might not be able to provide such feedback; however, videographic studies, comparable to Beebe’s (2014) microanalytical investigations of infants and caregivers, could be utilized to track emotional responses to caregivers among subjects unable to self-report.

Summary and Concluding Comments

Resilience is a complex construct involving personal resources, innate and learned, as well as interpersonal support. Social connectedness is a reality at every stage of human development, though perhaps most conspicuously during infancy and late adulthood, when physical survival is almost entirely contingent on interpersonal care. It is generally understood that caregiving acts, while instrumental, are also relational, and that the experience of being cared for has meaning as well as utility. Care is a message as well as a medium, an attitude as well as an overt act. The experience of care is distinct. We know what it feels like to care and be cared for by another. This experience may overlap with but is not the same as the experience of being physically handled. Research has shown the quality of care relationships in early life to have a significant impact on development, with sensitive, responsive, and emotionally attuned caregiving styles linked with indices of health and

successful adjustment. The absence of contact with an emotionally available caregiver, conversely, has been linked with apathy, lethargy, and physiological wasting — even when physical support needs have been met (Bowlby, 1995).

It is a paradox of later life that while meaningful social engagement is deeply needed, it is often hard to come by. In the face of physical and mental infirmities, mobility challenges, financial and housing transitions, and death and illness among friends and family members, the most vulnerable seniors often become the most isolated. Professional care staff (e.g. nurses and nurses' aides...) frequently become surrogate social figures for such individuals. These contacts, however, tend to be brief and task-oriented. Professional care staff, furthermore, trained in technical procedures and basic etiquette for interacting with patients, receive little training in handling their own emotional reactions. Care staff may without realizing relate to seniors as if they were their parents or their children. It is not unusual for care staff to address senior clients as "mama" or "pop". Certain clients seem to appreciate this epithet. Others don't. Ageism and gerontophobia are prevalent in western culture, and are likely to find their way into caregivers' attitudes and responses to seniors. Seniors may remind caregivers of their own advancing age and mortality, causing them to become aloof, or perhaps compensatively cloying.

Qualitative research, exploring the nuances of adult care relationships, may provide useful frames of reference for planning, funding, and implementing future adult care service models. It would make sense for psychologists to play a part in such research, which would in essence investigate the relational needs of vulnerable seniors, the extent to which existing care systems meet or fail to meet them, and the impact of these variables on geriatric mental health. It would also make sense for psychologists to have a role in training and supervising adult care staff. It is unrealistic to expect care staff to be consistently "in sync" with vulnerable seniors without the benefit of specialized training and supervision. Psychologists on interdisciplinary training teams could help care staff understand and humanely respond to seniors' emotional as well as physical support needs.

Psychologists on interdisciplinary training teams could also help care staff recognize and effectively manage their own emotional responses to older patients.

Epilogue

For about two weeks in my first year of graduate school, I worked as an aide in a nursing home. I had no prior experience and no real training other than a set of simple instructions provided by an on-site nursing supervisor. I have no idea of whether or not it was legal for them to start workers out like that. I was instructed to sponge-bathe residents and change their diapers. "Wipe their backsides up toward the back and their frontsides up toward the front," my supervisor said. I remember how "otherworldly" it felt reaching over people I'd just met and untying their diapers. I remember how very pale and translucent their skin was. I remember feeling nauseated by the smell of excrement. I remember my efforts to maintain an air of cheerful professionalism despite an urge to scream. I believe I tended to seven people the first day. Before leaving the facility, I checked in with my supervisor. She said I'd done "OK," adding, however, that I needed to "pick up speed." Within about a week I'd adjusted to the body contact and the foul smells. I was getting to know my patients and beginning to feel comfortable in the direct care role. As I recall by the end of the week I was taking care of nine patients in a shift. My supervisor complained that I was too slow and doing too much talking. I recall her exact words: "You're not being paid to listen to their life stories," she said. I decided not to return to the job. The next time I set foot in a nursing home was about eight years later. By that time, I was a licensed psychologist, in fact being paid to listen to patients' life stories.

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Over-Medication as a Barrier to Resilience in Older Adults

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Overmedication can be a barrier to resilience in older adults in post-acute care. Too many medications, many of which may no longer be necessary, impact successful aging. A patient in post-acute care is challenged to confront difficult physical rehabilitation while also addressing existential questions such as ‘who am I now, in the face of this?’ The work of the patient with the help of the therapist to address these challenges is made harder by prescriptions for a cocktail of major and minor tranquilizers, opioid-based pain medications and sleeping pills that may no longer be advisable.

When Shakespeare wrote of the “slings and arrows of outrageous fortune,” he was obviously thinking about Hamlet, not the 78-year-old who just entered your psychotherapy office. But, although there are many exceptions, older patients are more likely to be confronted by a variety of challenges that tend to spare other age groups. Aging often brings unique issues, including the existential issue of impending death, in addition to deterioration in important physical and cognitive realms, the loss of peers, pain, and a diminution of one’s sphere of functioning (Weiss & Bass, 2002). Unfortunately, too frequently these patients are asked to face the trials and tribulations that can come with aging from an even more disadvantageous position—that of being oversaturated with antipsychotics, benzodiazepines, opioids, and a host of other medications that have significant sedating properties (Peron, Gray, & Hanlon, 2011; Ried, Johnson, & Gettman, 1998; Pollock & Mulsant, 1995). It’s a situation that can parallel the dilemmas posed by working with younger patients who are misusing drugs or alcohol, except in this case the drugs are prescribed by the patients’ primary care providers. Too many

medications, and obviously unnecessary ones, chip away at the resilience that is a key indicator of successful aging.

In the work that I do in what is now known as “post-acute care”—skilled nursing facilities, assisted living facilities, and subacute rehabilitation centers—all patients are grappling with loss. By definition, they have lost some measure of their physical health—if they hadn’t they wouldn’t be in post-acute care. On short-term rehabilitation units, patients who have recently experienced a stroke, a broken hip, or another traumatic event are quite literally fighting for their lives—fighting to return to the lives they were living in the community prior to the event. The challenge in front of them is to do the work of rehabilitation—physical, occupational, and speech therapy—to regain a level of functioning that will allow them to return to their homes.

Waking up that first morning on the rehabilitation unit, being told that it’s time to go to the gym, a common reaction goes something like this: “You must be joking! Do you know what I’ve just been through? I had surgery two days ago, and since then it’s been nothing but sleep deprivation, bad food, and pain. I need a couple of days to settle in before I get down to work.” At that point the (hopefully) empathic rehabilitation therapist will explain that for every day that the patient doesn’t attend their prescribed rehabilitation session, their chances of going home drop significantly. That gets most patients out of bed, but not all. And who are the patients whose refusal to adhere to their treatment plan may eventually cause them to fail to meet their goals and return home? It’s those who are too depressed, too anxious, too paranoid,

too unmotivated, or too confused to succeed at the assignment they've been handed, and so they become our patients. On subacute rehabilitation units, the psychologist is often a critical factor in helping a patient mobilize the resources needed to put forth their best efforts in the gym and, eventually, return home after a successful rehabilitation.

The rehab unit managers in the best facilities understand that in order for psychological services to be most effective, they need to be accessed as soon as the patient demonstrates one of the "red flags" of potential rehabilitation failure: the depression, apathy, refusal, combativeness, confusion, and anxiety that are among the key predictors of eventual trouble. The psychologist will work with the patient, the family, the nursing staff, and the rehabilitation staff to do whatever is needed to get the patient through their treatment and back home. A good track record of rehabilitation outcomes has become a crucial barometer of facility success—with its reputation in the community, its relationship with referring hospitals, and its financial viability all heavily influenced by its ability to admit high-acuity patients and return them to the community. So the work that psychologists do on these units is critical to facility success, as well as fascinating from a clinical standpoint.

Unfortunately, in many cases patients are being asked to engage in the fight of their lives with one hand tied behind their back, because they will often arrive at the gym with a cocktail of major and minor tranquilizers, opioid-based pain medications, and sleeping pills in their systems. I don't know about you, but when I hit the gym the only thing I want on board is my morning coffee and maybe a little protein powder. How does it happen that these vulnerable patients are being asked to perform the Herculean task of rehabilitation following a stroke or a broken hip while burdened by the sedating effects of multiple medications? Well, it's not a sadistic scheme designed to throw numerous obstacles in their way—it's evidence-based medicine.

Many patients in the post-acute setting are in pain, including the acute post-surgical pain that is found on rehab units. Opioids are obviously evidence-based for pain, so despite the fact that they

are not the best treatment for either long- or short-term pain, they are frequently prescribed to this population. Many patients on the rehab unit are experiencing significant anxiety—how could they not be? They are worried about whether they will be able to return to their homes and their previous lives, as opposed to being admitted to long-term care. Benzodiazepines are obviously evidence-based for anxiety, so they are commonly used. If there is difficulty sleeping—as a result of pain or anxiety or depression or all three—here comes another benzodiazepine, or maybe Ambien, both evidence-based for sleep disturbance. Finally, if at any point in their hospitalization an infection occurs, causing a delirium, here comes an antipsychotic. Unfortunately, antipsychotics are often kept on board long after the infection and the resulting delirium have passed.

While each of these medications may be, in a vacuum, appropriately prescribed, the cumulative effect of them is severe, and it contributes to the failure of rehabilitation and eventual placement in long-term care for many patients.

Unfortunately, a very similar paradigm operates on the long-term care units.

Short-term rehabilitation patients who, for whatever reason, aren't able to return to the community because of an unsuccessful rehabilitation experience are going to feel the "double whammy" of post-acute care: being placed in long-term care after rehabilitation instead of returning home. These patients will experience it like this: "It was bad enough breaking my hip, having surgery, dealing with all of this pain, doing all of that work in rehab, but now you're telling me that I'm not going to go home, like you said I would, ever? I have to spend the rest of my life in a nursing home?" All of that helps explain why we work so hard to ensure that subacute rehabilitation is successful, and highlights the agony that patients experience when it's not. These patients join other long-term care patients, now called "residents," who are all confronted by similar losses and challenges. In addition to the loss of health status that precipitated the admission to long-term care, these patients have now lost their home and the furniture, artwork, photographs,

knick-knacks, and other memories that it took them a lifetime to curate. They've lost, for the most part, the connection to their communities, religious groups, hobbies, and other interests that helped define them as unique individuals. They have lost their pets—an underrated agony for many residents.

So the most important challenge that residents in long-term care are confronted by is really an existential challenge that can be framed like this: "What is my role in the world now? Do I even have one? A couple of months ago I was the matriarch of my family, the person who everybody came to for kindness, wisdom, and advice, and my home was the place that everyone came for celebrations, rituals, and milestones. I defined myself in those terms, but that definition no longer works. So what is there to get me out of bed in the morning?"

So the work of psychologists with long-term care patients can be defined as existential psychotherapy, or identity-issues therapy, or viewed from a stage-of-life perspective. The trajectory of a resident admitted to long-term care usually goes one of two ways. For many, the admission is the beginning of a precipitous decline characterized by depression, apathy, cognitive slowing, isolation, and, eventually, death. For many others, though, and this is the work of psychotherapy, the admission signals the beginning of a new period in which the resident is able to "continue being who they are"—or even grow—despite the "slings and arrows" and the new environment. Sometimes I'll frame it like this: "How are you going to write this final chapter of your life?"

Residents who bring a resilient, determined approach to being placed in long-term care can overcome the losses they've experienced and confront the challenges they're facing to create very satisfactory final years. Such residents form deeply connected relationships with their caregivers and their fellow residents while also maintaining strong bonds with their visiting families and friends. They take an active role in the larger facility community by participating in the daily rhythms and activities in the building. They undertake projects that they were too busy for when they were running a household or holding a job, such as organizing their family photo albums or ("finally!") figuring out the

internet. The role of psychotherapy in this process can't be overestimated, and the often long-term treatment alliances that clinicians form with their patients are precious in the new reality of value-based reimbursement.

And yet here again, on the long-term care units, the important work that patients need to do in order to thrive is often made more difficult because of medications and their side effects. It is not usual for a nursing home resident to receive 20 or more medications each day, a situation bound to bring on negative interactions and side effects. There are now restrictions on the use of certain medications, such as antipsychotics and benzodiazepines, and now opioids are getting the attention they deserve, but there is still a long way to go.

Clearly, the patients treated in post-acute care have had a litany of challenges that the older people psychologists treat in the community have not yet experienced. But most people of "a certain age" can relate to the inexorable decline in health status that growing older can bring, and many have started to experience the physical and psychological burden of an accumulating regimen of medications.

In post-acute facilities, where the integrated care model is firmly established, psychologists are strong advocates for their patients. We work directly with patients' attending physicians and nursing staff to ensure, among other things, that the kind of non-pharmacologic interventions that psychologists provide are first-line treatments for mental health issues. In non-facility settings such as private practice, where frequent communication with patients' primary care providers is often difficult, it's critical that psychologists teach their patients how to advocate for themselves. When medications are prescribed to older people, there can be a tendency for them to stay on board indefinitely. As they accumulate, they exert a significantly deleterious impact on the patient's ability to continue to navigate life's challenges. Unlike psychotherapy, where "the only side effect is a better life," every medication has a risk/benefit algorithm, one that psychologists can help their patients analyze so as to improve their conversations with their prescribers.

Working with older patients in psychotherapy can be extremely rewarding and interesting; making sure that every patient is in the best possible position to do the work of treatment is part of the challenge.

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Predictive Factors of Resilience in Aging

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This study identifies factors that differentiate resilient individuals from their non-resilient counterparts within the context of positive aging and gender. Perception of a positive aging experience in the presence of chronic stress was defined as resilient. Individuals who regarded their aging experience as negative in the presence of chronic stress were defined as non-resilient. Secondary analysis of the Psychosocial Leave-Behind Participant Lifestyle questionnaire (Health Retirement Study, 2004) data completed by 3,262 individuals in the United States yielded interesting findings. Males who were resilient were less likely to be lonely and had strong social support when compared to non-resilient males. Females who were resilient were more likely to have higher quality-of-life scores and good health compared to non-resilient females. Moderate to less optimism, within the presence of good social support, was also a significant predictive factor of resilience, particularly for females. Findings from this study may have important implications in promoting resilience to individuals in the United States as they face life challenges in their advancing years. Specifically, it broadens the understanding of what resources and factors are important for males and females who achieve positive aging. Also it considers whether optimism should be regarded on a spectrum rather than an all-or-none concept (often used in positive psychology) given that individuals with moderate to less optimism with proper protective factors can still experience resilience in aging.

Keywords: positive aging, resilience, gender, social support, health, optimism

With the graying of the Baby Boomer generation, it is expected the 65 or older population will go beyond doubling from 47.8 million in 2015 to 98 million by 2060 (U.S. Census Bureau, 2016) and make up 25% of the total U.S. population (U.S. Census Bureau, 2017). In 2017, women in the United States made up 55% of the 65+ years old group and 70% of the 85+ years old group (CIA World Factbook, 2018). Women and men experience aging differently (Rappaport, 2014; World Health Organization, 2007). Women tend to live an average of 6.5 years longer than men and usually tend to survive better in challenging conditions (Zarulli et al., 2018; Hays, Kaplan, Ganiats, Feeny, & Kind, 2007). Older women are more likely to live in poverty (40% have only Social Security as their main income), they receive 58% less retirement income, and they pay a higher amount out of pocket for health care as compared to older men (Rappaport, 2014; Weitz & Estes, 2001). In addition, women tend to report poorer quality of life (QOL), decreased life satisfaction, increased loneliness, and lower self-esteem at the same age as men (Pinquart & Sorenson, 2001). Men are more likely to remarry after losing a spouse or partner, while women are less likely to do so (Rappaport, 2014; World Health Organization, 2007; Pinquart, 2003; Lang, 2001).

Although there are studies on gender differences in chronic health conditions and physical disability (Regitz-Zagrosek, 2012; Crimmins, Kim, & Sole-Auro, 2010), there exists limited empirical research on biopsychosocial differences between males and females related to the aging experience (Brabender & Mihura, 2016; Kryspin-Exner, Lamplmayr, & Felhofer, 2011; Jeste, Depp, & Vahia, 2010).

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Since associations between biological, social, and psychological factors on age and gender become even more complex with age, there is an identified need to study these factors comprehensively from a multidimensional perspective (Kendig, Browning, Thomas, & Wells 2014; Kryspin-Exner, Lamplmayr, & Felnhofer, 2011; Jeste, Depp, & Vahia, 2010) across gender and also within gender groups.

Individuals who actively reframe their perceptions and reactions so that they can regard life as worthwhile even in the presence of chronic stress, adverse health, and life challenges are experiencing *positive aging* (Hill, 2005). Positive aging in this context can be regarded as a form of resilience. *Resilience* is defined as an outcome of successful adaptation to adversity (Zautra, Hall, & Murray, 2010; Sturgeon & Zautra, 2010). Individuals who are active in choosing their well-being despite the presence of stressful life challenges through the years are experiencing resilience in the form of positive aging

The purpose of this study is to distinguish characteristics between women who identify themselves as experiencing positive aging from those who are not and to do the same for men as well. This within-group analysis provides understanding of the resources used by resilient individuals who

have experienced similar environmental contexts defined by their gender. The interaction of these factors grows even more complex with the expansion of *gender* into a more fluid and less binary frame. This, however, is beyond the scope of this paper.

Conceptual Framework and Hypotheses

Research identifies active choice (Hill, 2005), self-efficacy, utilization of internal and external resources (Gergen & Gergen, 2005), and empowerment (O’Leary & Bhaju, 2006) as essential components identified with positive aging resilience. The conceptual framework created for this study (Figure 1) integrates the essential components of the positive aging models of Hill (2005) and Gergen and Gergen (2005) as well as the empowerment model of O’Leary and Bhaju (2006) within the context of gender and chronic stress.

Following this model (see figure 1), in response to chronic stress, the resilient individual makes active choices that are based on their self-efficacy and sense of control over their environment (Hill, 2005). These choices are influenced by the presence of external resources such as social networks and internal resources such as optimism (Gergen & Gergen, 2005). There may still be inherent differences in which resources are obtained or

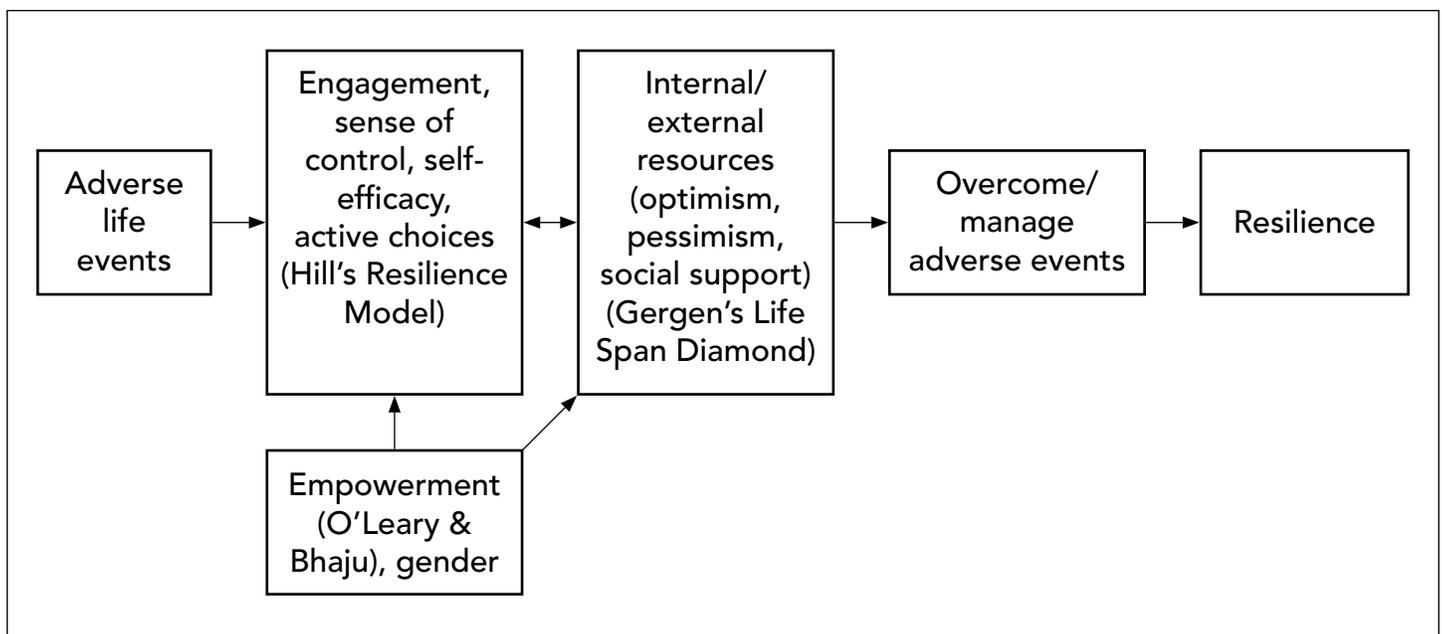


Figure 1. Conceptual framework for current study.

used depending on individual experiences. Women, particularly older women, are more likely to have accumulated a lifetime of negative issues related to their productivity and thus to their value within society (O’Leary & Bhaju, 2006; Gergen & Gergen, 2005). The impact of this experience may lead them to utilize different resources than men or other women when problem solving (O’Leary & Bhaju, 2006).

Based on previous literature, this study hypothesized that the factors of effective social support and absence of loneliness would be

predictors of resilience among females and the factors of optimism and sense of control would be predictors of resilience among males. Multiple regression and logistic regression were conducted to identify if indeed these factors were significant and in the direction as predicted for within each gender group.

Methods

This study utilized questionnaire data from 3,262 respondents who were randomly selected from 20,129 participants of the 2004 Health Retirement

Independent Variables	Instrument	Reliability (Cronbach’s Alpha)	Type	Scale	Range	Score Interpretation
Optimism	LOT-R (Scheier, Carver, & Bridges, 1994).	0.78	Self-report 3 item	Likert 6-point: SD (1) to SA (6)	3–18	Higher score, more optimistic
Loneliness	Loneliness Scale (Hughes, Waite, Hawkey, & Cacioppo, 2004)	0.82	Self-report 3 item	Likert 3-point: Often (1) to Hardly Ever (3)	3–9	Higher score, more lonely
Sense of Control	Midlife Developmental Inventory MIDUS (Prenda & Lachman, 2001; Lachman, & Weaver, 1997)	0.89	Self-report 2 item	Likert 2 point: SA (1) to SD (2)	2–4	Higher score, more sense of control
Social Support Index			Self-report 3 item	Likert 4-point: A lot (1) to Not at all (4)	1–12	Positive Social Support (2 S.D. from mean score)
Chronic Stress Index	Chronic Stress questionnaire (Bromberger & Matthews, 1996)	0.67	Self-report 8 item	Likert 4-point: Did not happen (1) to Very Up- setting (4)	1–32	Low Stress (1 S.D. from mean score); Moderate Stress (2 S.D. from mean score); Extreme Stress (3 S.D. from mean score)
Dependent Variables	Instrument	Reliability (Cronbach’s Alpha)	Type	Scale	Range	Score Interpretation
Rating of Aging (RA)			Self-report 1 item	Likert 5-point: Very Negative (1) to Very Posi- tive (5)	1–5	Higher the score, more positive aging
Quality of Life (QOL)	CASPI-19 (Hyde, Wiggins, Higgs, & Blane, 2003).	0.7	Self-report 19 item	Likert 4-point: Often (1) to Never (4)	1–76	Higher values, better quality of life

Study (Clarke, Fisher, House, Smith, & Weir, 2008). These individuals were asked to complete the 2004 Health Retirement Study Psychosocial Leave-Behind Participant Lifestyle questionnaire (PLBQ) after their home interview. This questionnaire was voluntary and self-administered and contained questions on psychosocial issues including rating of aging experience. A non-response adjustment weight was factored into the psychosocial data to control for any differences that may have existed between respondents and non-respondents (Clarke, Fisher, House, Smith, & Weir, 2008). Variables were selected (see table 1) based on their relevance to the integrated conceptual model previously described (O'Leary and Bhaju 2006; Hill, 2005; Gergen & Gergen, 2005). Demographic data including race, gender, age, marital status, education, and income were available by matching core HRS data with the PLBQ respondents.

Data Analyses

Descriptive analyses looked at frequency and mean distributions of age, gender, race, education, socioeconomic status, marital status, health, chronic stress, as well as the key independent variables and dependent variable. ANOVA and Students T test was used to identify any significant associations ($p < .05$) between the independent variables of optimism, loneliness, life satisfaction, perceived sense of control, and chronic stress.

Multiple regression identified the relative contribution of social support, absence of loneliness, optimism, sense of control, health, and chronic stress to the variance of the Rating of Aging (RA) experience across females and males. RA was considered on a continuous spectrum from a score of 1 (negative non-resilient aging) to a score of 5 (positive resilient aging). Logistic regression was conducted to determine the relative strength of these variables toward the prediction of the positive (resilient) and negative (non-resilient) aging experience within female and male groups.

Demographics

Data was available on 3,262 individuals who were randomly selected (76.8% response rate) to complete the Psychosocial Leave Behind

Questionnaire (PLBQ) of the 2004 U.S. Health Retirement Study. Seventy-nine percent (79%) of the sample were White, 17% were Black, and 44% were males. Sixty-six percent (66%) indicated being married at the time of completing the questionnaire (2004), while 3% indicated never being married. The mean age of the respondents was 67 + 9 years ($n = 2048$) and the mean years of education was 12 + 3 years ($n = 3201$).

Results

Distribution of Rating of Aging, Chronic Stress, and Health Variables

Fifty-five percent (55%) of individuals rated their aging as positive as compared to 11% who indicated a negative rating. Thirty-four percent (34%) were neutral. The mean rating of aging experience was 3.6 + .92 with a range of 1 to 5. Thirty-eight percent (38%) of individuals indicated that they experienced chronic stress ($n = 3,178$). Health getting in the way of activities was an important factor for 43% of the sample who responded to this question ($n = 3,170$).

Bivariate Analysis

Bivariate analysis identified significant association with rating of aging and optimism, absence of loneliness, social support, sense of control, chronic stress, quality of life, and health. These variables were included in the regression models.

Multiple Regression

The multiple regression models determining variance for rating of aging (RA) were statistically significant for females and males ($p < .001$). Chronic stress played an important role in its contribution to the variance of RA among females (5%) and doubled in its contribution to RA variance among males (10%). Positive social support was an important factor contributing to RA among males but not among females. Optimism was a significant contributor toward RA for both females and males but not in the expected positive direction. Its negative direction implies that individuals with moderate to less optimism were more likely to rate their aging as positive. One explanation to this finding is that overall the population tended to be moderately optimistic (47%) as compared to highly

optimistic (10%), and so this finding may have been more due to a population characteristic. However, it is important to note that not everyone who was moderately optimistic rated their aging as positive (mean positive aging rating 3.5, SD 0.8), nor did individuals who described themselves as highly

optimistic (mean positive aging rating 2.5, SD 1.2). However, moderately optimistic individuals who had rated their aging as positive were three times more likely to feel a high sense of control, have good social support, and also be healthier than the general population (see Table 2).

Table 2 | Characteristics of Less Optimistic Individuals Who Were Resilient

	Less Optimistic About Future and Positive Rating of Aging (n = 183)	Overall Population (n = 3161)
Sense of Control: Low	3 (1.7%)	104 (3%)
Sense of Control: High	26 (14.7%)	146 (5%)
Social Support: Poor	18 (16%)	429 (23%)
Social Support: Good	38 (35%)	246 (13%)
Health Stops Me From Doing Things: Often	13 (8%)	387 (12%)
Health Stops Me From Doing Things: Never	92 (53%)	1025 (32%)

Factors Predictive of Resilience

The logistic regression model for predicting resilient positive aging had a prediction success of 89% among females and 92% among males (Table 3). Moderate to less optimism and good quality of life (QOL) including having good health were important predictors of positive aging among females when compared to females who perceived themselves to be negatively aging. Moderate to less optimism and decreased loneliness were significant predictors of positive aging among males when compared to non-resilient males who perceived their aging experience to be negative.

what characteristics differentiate resilient men and resilient women from their non-resilient counterparts within each of their gender groups. This takes into account the different environmental

Discussion

The graying of the Baby Boomer generation in the United States brings with it increased longevity, higher prevalence of chronic illness, and changing expectations of the experience of growing old. Some individuals seem to experience aging better than others and rate their aging as positive even in the face of life stressors. These individuals are considered to be *resilient*. Through the life cycle, there are different aging experiences due to biological, social, and economic factors across gender (Murtagh & Hubert, 2004; Pinquart, 2003; Pinquart & Sorenson, 2001; Lang, 2001; Weitz & Estes, 2001). The tendency in the literature is to compare males to females without acknowledging the different life context that each group experiences. This study takes an alternative approach by examining

Table 3 | Logistic Regression Predicting Positive and Negative Aging

	FEMALES Exp(B)	MALES Exp(B)
Race	1.2	1.0
Age	1.0	1.0
Education	1.1	1.1
Marital Status	0.7	0.8
<i>Functional Status</i>		
Chronic Stress	0.73	0.4
QOL	1.17***	1.1
Incl Health	2.0***	1.8
<i>External Factors</i>		
Positive Social Support	0.85	1.2
Loneliness	1.16	0.6**
<i>Internal Factors</i>		
Optimism	0.78***	0.8*
Sense of Control	1.0	1.2
Nagekerke's R ²	.43	.49
Chi-Sq Statistic	125.4*** (df=10)	36.9***(df=9)
Prediction Success	89%	92%
Positive Aging Prediction	98%	98%
Negative Aging Prediction	37%	42%
Note. Exp(B)=Odds Ratio. *p<.05, **p<.01, ***p<.005;		

context that males and females encounter as they go through their life. The purpose of this study was to try to understand what differentiates these resilient individuals from non-resilient individuals who find the experience to be more negative under similar circumstances.

The contributions of this study to the literature include the following: (a) addressing gaps in the literature by identifying protective factors that differentiated resilient from non-resilient individuals within each gender group, (b) examining the role of these factors within a multivariate context, and (c) providing cause to reexamine the role of optimism within the realm of positive aging.

The importance of the biopsychosocial factors contained in the integrated conceptual framework in regard to positive aging and resilience (O'Leary and Bhaju, 2006; Hill, 2005; Gergen & Gergen, 2005) was confirmed in this study. *Resilience* in this study was defined as rating the aging experience as positive even within the presence of chronic stress. Optimism, social support, loneliness, as well as quality of life and health were significant factors associated with rating of aging experience (RA) in the presence of chronic stress.

Based on the literature, the study hypothesized that positive social support and absence of loneliness would be predictors of resilience among females and that optimism and a good sense of control (defined as good QOL, and good health) would be predictors of resilience among males. However, findings were opposite the expected direction. Instead, positive social support and absence of loneliness were significant predictors of resilience among males. Good health and good quality of life were significant predictors of resilience among females. One simple explanation to these switched findings by gender may have to do with a tendency to converge roles with age (Sheldon, 2009; Gergen & Gergen, 2005). It is possible that men and women tend to alter their attitudes and behavior based on adaptation and survival needs brought on by aging and maturity (Sheldon, 2009; Gergen & Gergen, 2005). However, alternate explanations follow.

The importance that positive social support and absence of loneliness played among resilient men in this study is surprising because women are usually the ones who seek and develop social networks (Kendler, Myers, & Prescott, 2005). Males are usually the recipients rather than providers of social support and benefit from the social networks developed by their female spouse (Goodwin, 2005). Further exploration in the literature makes it apparent that loneliness or isolation indeed plays an important role for older men who either may have never developed or who became disconnected from social networks due to the loss of a female partner. This isolation places them at increased risk of anxiety and depression (Arber & Davidson, 2003). Men are also more likely to remarry than older women (Rappaport, 2014; World Health Organization, 2007; Pinquart, 2003; Lang, 2001) and are able to be once again be part of a new social network. Thus, resilient men are those who have positive social support and who are not as isolated and lonely as their non-resilient counterparts.

The importance of health and quality of life for women is apparent given that they are more likely to live longer and have poorer health (Rappaport, 2014; Murtagh & Hubert, 2004), which impacts their quality of life (Freedman, 2016; Pinquart & Sorenson, 2001). Women are disproportionately subject to being at higher risk of coronary disease, osteoporosis, dementia, and depression (Appelman, 2015; Murtagh & Hubert, 2004). Older women are more likely to have problems with cognition and instrumental activities of daily living (Hsu, 2005), and problems with engaging in meaningful activities (Hsu, 2005). Remaining healthy is an important predictor of resilience, as it enables females to have a sense of control over their personal and financial lives (Goodwin, 2005), which impacts their quality of life (Freedman, 2016).

Another finding identifies moderate to less optimism as a significant predictor of resilience for both females and males. This finding may be a product of the higher prevalence of moderate optimism within the population. But it also creates an important opportunity to revisit the concept of "learned optimism" that is present in positive psychology (Seligman, 2006). Seligman

and Csikszentmihalyi, (2000) emphasize that happiness is a state of mind that can be achieved by learning to apply it in different situations. They encourage building strengths and developing optimism instead of focusing on negative attitudes or behaviors (Seligman & Csikszentmihaly, 2000).

This study brought into focus that optimism can be viewed at different levels such as low, moderate, and high rather than be limited to an all-or-none phenomenon. In this study, moderately optimistic individuals were found to still experience positive aging. They were found to have a higher sense of control and good social support and were healthier than the overall population. These findings make us reconsider whether optimism should be viewed more on a spectrum, ranging from low, moderate, to high, as compared to an all-or-none approach. So why is it important to differentiate levels of optimism? Studies confirm that individuals with optimism live longer (Kato, Zweig, Barzilai, & Atzmon, 2012), are healthier (Achat, Kawachi, Spiro, DeMolles, & Sparrow, 2000; Kubzansky, Sparrow, Vokonas, & Kawachi, 2001) and have a general sense of well-being (Carver, Scheier, & Segerstrom, 2010). However, sometimes these glowing hopes of optimism can result in creating unrealistic expectations that may not be the most adaptive response for individuals who face life challenges. Instead, they may lead to self-blame and emotional distress when patients succumb to illness and other unfortunate life circumstances (Holland & Lewis, 2001). Treating optimism as an all-or-none concept can result in self-doubt and self-blame among those who find difficulty in thinking positively through all circumstances (Holland & Lewis, 2001). These emotions create inner tension that can itself be a source of stress (Aspinwall & Tedeschi, 2010).

Findings of this study encourage establishing realistic expectations with elderly psychotherapy clients and then supporting them by building inner and external resources as a better way to promote resilience. Factors such as social support, sense of control, and good health can support moderately optimistic individuals toward achieving resilience.

Limitations of This Study

The 2004 PLBQ database was rich in its information on psychological and social factors particularly related to the question of rating the aging experience. Respondents were self-selected based on their willingness to complete the questionnaire and thus were not necessarily generalizable to the whole HRS population. However, when comparing the norms of the population to the standardized populations, it appears that respondents were close to the mean values on all measures except in the case of optimism, where the norms tended toward the low to moderate end. In addition, the data was limited to cis-gender identities.

Clinical Implications of the Current Study

Identifying factors that promote resilience and quality of life within the female and male environmental context can give us more ideas of how to help individuals better their aging experience. This knowledge becomes increasingly imperative for clinical work and policy development as we work to understand the social and personal implications of longevity.

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An Integrated Model of Trauma and Resilience in Aging Holocaust Survivors: Psychological Needs and Implications for Social Services

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Holocaust survivors, individuals who lived through Nazi systematic extermination and persecution during World War II, represent an aging cohort in need of trauma-informed social services. Previous studies have found conflicting results about the mental and physical health profiles of holocaust survivors (e.g. Ohana, Golander, & Barak, 2014; Raposo, Mackenzie, Henriksen, & Afifi, 2014; Zeidner & Aharoni-David, 2014). A recent focus on resiliency has generated an increase in articles on the competencies that enable holocaust survivors to age successfully (Ohana et al., 2014; Shrira, Palgi, Ben-Ezra, & Shmotkin, 2010). This review of the literature from 2010 to the present aims to present an updated, comprehensive overview of prior research to establish consensus about the needs of holocaust survivors. Overall findings indicate that resilience and emotional distress can simultaneously interact with the aging process. In general, holocaust survivors experience more emotional distress than age-matched controls (Raposo et al., 2014) and some display resilience (Ohana et al., 2014). Currently, most social service and elder care providers are not adequately prepared to meet the needs of aging holocaust survivors (Fossion, Leys, Kempnaers, Braun, Verbanck, & Linkowski, 2013). Implications for practice are discussed with recommendations for future research.

Keywords: Holocaust survivors, social services, aging, trauma and resilience, long-term care

Aging populations face unique risks and challenges to their mental and physical health. Individuals over 65 years expend about three times on personal healthcare than working age

adults (Lassman, Hartman, Washington, Andrews, & Catlin, 2014). For older adults with a trauma history, aging is accompanied by an added dimension of ascribing meaning to past adversity (Gershon, Sudheimer, Tirouvanziam, Williams, & O'Hara, 2013). Holocaust survivors represent a large-scale population of individuals who experienced adversity in early life and are now dealing with the effects in old age. Although researchers spanning multiple disciplines including psychology, social work, neuroscience, and medicine have studied holocaust survivors, there is little consensus about holocaust survivors' vulnerabilities and strengths (e.g. Ohana, et al., 2014; Raposo, et al., 2014; Zeidner et al., 2014).

Holocaust survivors, as defined in this paper, are individuals who faced systematic oppression and persecution by Nazi's or their collaborators between 1933 and 1945 (United States Holocaust Memorial Museum). As the decades since the holocaust have progressed, survivor's needs have changed. In 2010 the youngest survivors turned 65, which is the American retirement age for individuals born before 1943 (United States Social Security Administration). As they age, holocaust survivors' distinct trauma backgrounds create a complex psychological interplay with physical health and social service needs (Conference on Jewish Material Claims Against Germany, 2012; Fossion et al., 2013).

Although population estimates of living holocaust survivors vary considerably, demographic studies are useful in determining population needs and allocating resources. Worldwide estimates from

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2011 established the number of living holocaust survivors at approximately 570,000 individuals (Conference on Jewish Material Claims Against Germany, 2012). According to a UJA-Federation of New York population survey (2012), there were approximately 73,000 holocaust survivors in the New York metropolitan area in 2012. The survey projected that by 2025, this number would decrease to under 25,000. As such, the next decade is a crucial time for conducting research on the needs of this aging population and connecting them with appropriate resources. This population has been further subdivided based on level of trauma exposure. Remaining survivors of Nazi death camps tend to be older than their counterparts who were hiding throughout the war. Understanding the makeup of the holocaust survivor population is crucial for providing appropriate care in the final stages of their lives. The purpose of this review of the literature from 2010-present is to identify coping styles and disparities among elderly holocaust survivors with implications for social service provision and psychotherapeutic intervention.

Trauma and aging

Although most of the literature on the effects of trauma focuses on child and youth populations, there is growing recognition that trauma in childhood can have ramifications into late adulthood (e.g. Raposo, et al., 2014; Shrira et al., 2010). A review article by Maschi, Baer, Morrissey, & Moreno (2013) found increased rates of post-traumatic stress symptoms in older adults who experienced childhood trauma compared to those who did not. Particularly, these trauma survivors presented with reexperiencing and avoidance symptoms, causing them to react to present stressors as if the trauma was currently occurring. Raposo et al., (2014) found that individuals age 65 and older with a history of adverse childhood experiences were more likely to report having an anxiety, depressive, or personality disorder in the past year. Because of the long-lasting effects of trauma, aging populations should be included in studies of trauma exposure to determine the trajectory of resilience and mental health outcomes.

There is a complicated interaction between PTSD and dementia among older adults who experienced trauma in childhood (Sperling, Kreil,

& Biermann, 2011). The lingering effects of PTSD in late adulthood differ from those during other life stages (Lapp, Agbokou, & Ferreri, 2011). A review of the literature on the effects of PTSD on cognitive performance in old age found that individuals with PTSD performed worse on cognitive tasks than individuals without the disorder (Schuitevoerder et al., 2013). When dementia is considered in addition to the normal aging process, there are significant implications for individuals with a trauma history. A national sample of United States veterans found that PTSD is a significant risk factor for developing dementia (Mawanda, Wallace, McCoy, & Abrams, 2017). Research with other populations has also demonstrated a relationship between PTSD and later cognitive impairment (e.g. Burri, Maercker, Krammer, & Simmen-Janevska, 2013; Wang et al., 2016). While holocaust survivors as a whole are not at increased risk for developing dementia (Ravona-Springer, Beerli, & Goldbourt, 2011), survivors with PTSD demonstrate cognitive impairments at a greater rate than their peers without PTSD (Golier et al., 2002; Schuitevoerder et al., 2013). For those survivors with PTSD, dementia risk should be considered in the context of their aging process.

In addition to the relationship between trauma and mental health, childhood trauma exposure impacts physical health outcomes in older adulthood. Holocaust survivors are differentially impacted during the recovery process following serious medical illness associated with aging (Mizrahi, Lubart, Heymann, & Leibovitz, 2017). Population based studies of older adults have found an increased mortality rate among individuals suffering a hip fracture (Panula et al., 2011). When holocaust survivor identity was taken into account, the risk of sustaining a hip fracture escalated to three times that of the general Jewish population (Mizrahi et al., 2017). Moreover, holocaust survivors who were in rehab following a hip fracture scored lower on an assessment of functional independence. These differences may be due to nutritional and sunlight deprivation that holocaust survivors experienced during their critical growth period (Mizrahi et al., 2017). The comparative worse outcomes for holocaust survivors in rehab after a hip fracture should be considered to provide these patients with optimal care and the greatest chances

of improvement. This finding has repercussions for social service agencies that provide post-rehab services and medical professionals to ensure successful recovery.

Concurrence of emotional distress and resilience

Despite the emphasis on adverse mental and physical health outcomes among aging holocaust survivors, multiple studies have developed a more nuanced perspective. Although holocaust survivors must contend with the additional dimension of complex developmental trauma during aging, they display resiliency in multiple areas. Ohana et al., (2014) examined the relationship between resilience and psychache, or emotional distress, in holocaust survivors. Their results indicate that psychache can co-occur with a unidimensional measure of resilience, meaning that a person can simultaneously experience elevated levels of distress and lead a productive life. The conclusion that psychache can coexist with resilience has been supported by multiple studies with holocaust survivors (Fossion, et al., 2013; Ohana et al., 2014). Fossion et al., (2013) studied a multi-dimensional resilience construct in a sample of holocaust survivors. They found that holocaust survivors with deficits in two resilience areas (planned future and perception of self) who had experienced multiple lifetime traumas were more likely to experience current symptoms of anxiety and depression. Nonetheless, these survivors still maintained competencies across four other resilience domains, highlighting the simultaneous experience of resilience and distress. Resilience was found to mediate the relationship between trauma exposure and development of anxiety and depression for holocaust survivors who experienced at least one additional trauma in their lifetime.

Further evidence from studies on the relationship between psychopathology in holocaust survivors and their children provides support for a resilience model. Fridman, Bakermans-Kranenburg, Sagi-Schwartz, and Van Ijzendoorn (2011), conducted a longitudinal study with a group of first generation female holocaust survivors and their daughters. Participants completed measures assessing broad domains of physical, mental, and cognitive functioning. Results indicated holocaust

survivors are generally able to cope with old age, but displayed more dissociative symptoms and lower levels of subjective wellbeing compared to same age controls. Daughters of holocaust survivors did not differ from the daughters of non-survivors in any area. This finding indicates holocaust survivors were able to rebuild their lives and prevent transmission of trauma to the next generation (Fridman et al., 2011).

Several studies have looked at potential moderators to determine what factors enable holocaust survivors to age successfully. Zeidner et al., (2014) compared survivors of Nazi death camps to those who spent the war years in hiding or ghettos. They failed to find a difference in subjective wellbeing in late life between survivors who were interned in death camps and those who were not. Notably, they found that individuals who lost a parent during the holocaust reported a greater sense of coherence, or ability to meaningfully construct one's reality, and subjective wellbeing. The authors also examined the mediating role of sense of coherence on subjective sense of wellbeing and psychopathology. Their finding suggests fostering a sense of coherence can be beneficial regardless of the type of trauma exposure experienced during the holocaust. Shrira et al., (2010) found that holocaust survivors did not differ from comparisons in their reports of post-holocaust cumulative adversity. This finding supports the idea that holocaust survivors are not predisposed to experience more adversity because of their prior trauma history. There was a moderating effect, however, of post-holocaust cumulative adversity on depression in old age, in that the relationship between post-holocaust cumulative adversity and depression was stronger for holocaust survivors than comparison groups. Holocaust survivors may have been forced to develop coping skills which enabled them to survive the holocaust and lead productive adult lives.

Positive and negative coping

Holocaust survivors, and other traumatized groups, employ multiple strategies to cope with the losses of old age. Kimron & Cohen (2012) studied coping styles in patients who were hospitalized for acute medical illnesses (e.g. fractures, infections, heart attacks). When assessing coping among the

hospitalized patients, holocaust survivors reported higher levels of distress and employed more emotion-focused coping strategies to manage the stresses of being hospitalized compared to age matched controls. Emotion-focused coping strategies included methods to control the distress through engaging with painful emotions or distraction without attempting to manage the problem. They also reported using fewer problem-focused and support-seeking coping, which have been implicated in reduced experience of emotional distress during a stressful encounter.

As people age, the degree to which they develop skills to cope with the realities of aging predicts their success. For holocaust survivors in particular, in addition to dealing with the normal losses of old age, they also must come to terms with their difficult past. Holocaust survivors may engage in reminiscence to integrate the holocaust trauma into their lives. O'Rourke et al., (2015) interviewed 269 holocaust survivors to understand the function of reminiscence. They asked holocaust survivors to recount memories and divided them based on the function. The memories fit within a tripartite model of reminiscence. They found reminiscence among holocaust survivors can serve a self-positive, self-negative, or prosocial function (O'Rourke et al., 2015). Understanding the purpose of reminiscence can allow caregivers to help holocaust survivors turn their memories into a productive experience. While this study provides preliminary information about the functions of reminiscence in holocaust survivors, it does not draw conclusions for social service providers or psychologists interacting with this population.

Implications for practice

Holocaust survivors are an aging population in need of trauma-sensitive treatment. Holocaust survivors utilize primary care health services more than others their age, leading to more frequent interactions with service providers (Iecovich & Carmel, 2010). Medical providers should routinely inquire about potential holocaust status among older populations to assess their needs, as holocaust survivors have increased rates of cancer (Sadetzki, et al., 2017) and higher morbidity rates from hip fractures (Mizrahi, et al., 2017). Although holocaust

survivors may have personal resiliencies that are linked to longevity (Sagi-Schwartz, Bakermans-Kranenburg, Linn, & Van IJzendoorn, 2013), longer life expectancy may be accompanied by greater emotional distress (Kimron & Cohen 2012; Ohana et al., 2014). Consequently, older holocaust survivors may benefit from mental health treatment and increased social support.

Because of the stressors facing elderly holocaust survivors, psychological treatment and family consultation are critical for providing trauma-informed care. One barrier to developing appropriate treatments for this population is the varied symptom presentation of holocaust survivors and their families (e.g. Fridman et al., 2011). From a developmental psychopathology perspective, holocaust survivors' struggles can be described by the principle of multifinality, or the idea that exposure to a similar event can produce divergent outcomes in people. Mental health providers should consider possible interactions of holocaust survivor status, later trauma, and history of mental illness to determine treatment options. Because holocaust survivors who faced multiple adversity also had increased rates of depression (Shrira et al., 2010), mental health assessment should include a detailed trauma history of events after the holocaust. Traditional therapeutic methods may not be successful (e.g. cognitive therapy) or even indicated (Suttenberg, 2015) with this population. Based on research findings and a need for creative treatments, a strengths-based approach may be helpful. Research indicates that, overall, survivors were able to continue their lives and display resiliency even in the face of extreme hardship. Moreover, reminiscence can serve an important function for holocaust survivors when it allows them to create a sense of coherence (Zeidner et al., 2014) and teach the next generation (O'Rourke et al., 2015). This finding suggests treatments for holocaust survivors should focus on building resiliency through creating meaning and an integrative narrative of one's life (Fossion et al., 2013).

Incorporating trauma-informed models into eldercare facilities is valuable, yet there are few practice guidelines (Ganzel, 2018; Kimron et al., 2012). Older adults in the final stages of life

are likely to experience additional traumas from hospitalizations and medical crises which may compound the effects of earlier traumas. The existing literature on trauma-informed care for end of life or hospice patients is sparse (Ganzel, 2018). Glicksman (2017) conducted a qualitative analysis of holocaust survivors' experience in long-term care facilities to determine whether they have a more difficult adjustment. As compared to same-age peers, holocaust survivors in long-term care reported having fewer family supports which was associated with differences in mental health. The transition to long-term care could be particularly difficult for holocaust survivors, as the loss of independence may remind them of earlier losses (Anderson, Fields, & Dobb, 2011). Along with the loss of independence, survivors in long-term care have more time to recall their traumatic past which may serve a self-negative function (O'Rourke et al., 2015). Although holocaust survivors demonstrate resilience throughout the lifespan, the effects of trauma may manifest in eldercare facilities.

Although trauma is common in the general population (Benjet et al., 2016), literature on its effects in aging samples is limited (Lapp et al., 2011). A survey of aged care managers responsible for nursing and related staff revealed that 50% of the sample considered their staff's knowledge of the impact of trauma in late-life to be lacking (Teshuva & Wells, 2017). During the initial intake process, nursing homes do not routinely ask about trauma history (Anderson, Fields, & Dobb, 2011). This omission could have negative consequences for holocaust survivors in long-term care. As holocaust survivors become less independent in later life, they may display strong discomfort upon receiving help. For example, Kimron and Cohen (2012) cite that evidence from clinical practice indicates that hospital procedures, showers, and a state of helplessness may trigger emotional reactions from holocaust survivors. Because many people in long-term care suffer from dementia, nursing staff should be trained to differentiate PTSD symptoms from similar problems that are characteristic of dementia. Although persecutory delusions are common among people with dementia (Hwang, Tsai, Yang, Liu, & Lirng, 1999), holocaust survivors may experience these delusions as reexperiencing

symptoms and believe that caretakers are Nazi collaborators. In a qualitative study of caregivers providing support to holocaust survivors, caregivers expressed understanding a client's background helps them provide appropriate services. They also reported the job is emotionally draining, as they need to extend themselves to gain trust and may be bearers of survivors' painful memories (Teshuva, Borowski, & Wells, 2017). If nursing home staff are not properly educated about the needs of trauma residents, they may inadvertently make the transition more difficult for this population.

Discussion

Holocaust survivors are dying at a rate of thousands per year, according to some counts, and nearly all of those who are still living utilize medical and psychosocial support (Conference on Jewish Material Claims Against Germany, 2012). Despite the overwhelming need for culturally sensitive treatment, many holocaust survivors are not afforded the respectful care they require. Because of the magnitude of the trauma experienced by holocaust survivors, social service agencies and mental health providers should be cognizant of this population to enable them to age gracefully.

Numerous studies have determined the distinct mental and physical health profiles of elderly holocaust survivors (Anderson, Fields, & Dobb, 2013; Fridman et al., 2011; Mizrahi et al., 2017; Prot, 2010). However, research is needed to develop interventions for successful coping with trauma in late adulthood. The first step in increasing access to trauma-informed care is developing criteria for staff competencies. Formal competencies to increase awareness and training standards for social service providers and clinicians working with aging holocaust survivors are lacking. While facilities and individuals have developed training programs and guides (e.g. Giberovitch, 2014; Holocaust Resource Project, Baycrest Centre), there are few empirically supported resources. A few studies to date have identified mediators, such as resilience, and moderators, such as exposure to trauma in adulthood (e.g. Fossion, et al., 2013). As holocaust survivors age, research on mediators and moderators is increasingly necessary to predict subsets of the population that will require more support.

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Resilience Among Aging Hispanics

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My rich experience serving as a psychotherapist for Hispanics across more than forty years has convinced me that, in spite of the significant challenges and hardships they may face, many Hispanics age with resilience, making use of personal, familial, community and cultural strengths. Further research is needed and many recommendations are offered.

Keywords: Hispanic elders, resilience among Hispanics

Hispanics have to deal with stressors related to immigration, assimilation, and a plethora of microaggressions, stereotypes, and discrimination that affect emotional well-being and health (Vega, Markides, Angel, & Torres-Gil, 2015). Hispanics have to contend with a multitude of risk factors—compared to the majority—that have long-term consequences for their health and thriving, particularly older Hispanics: lower income and socioeconomic status, living in unsafe neighborhoods, being uninsured or having lower levels of insurance, more limited educational opportunities and financial assistance, medical health care disparities, mental health care disparities, more work-related injuries, higher death rates from several medical conditions, limited or no access to social supports, difficulty getting to places and obtaining a driver's license, obtaining inadequate and rushed services due to a language barrier, being looked down upon, a lack of qualified Spanish-speaking interpreters, and sometimes-questionable legal status (Passel & D'Veira, 2009).

According to the U.S. Census Bureau (2018), the Hispanic population of the United States as of July 1, 2017, reached 58.9 million; it is estimated that by

2060 the Hispanic population will be 119 million; the United States has become the second largest country in the world with a Hispanic population; there are 1 million or more of the following Hispanic groups in the United States: Mexican, Puerto Rican, Cuban, Salvadoran, Dominican, Guatemalan, and Colombian; and the following states have a Hispanic population of 1 million or more Hispanic residents in 2017: Arizona, California, Colorado, Florida, Georgia, Illinois, New Jersey, New Mexico, New York, and Texas.

Approximately 11 million Hispanics are undocumented (Hummer & Hayward, 2015). The current political climate reinforces marginalization and stereotypes and has resulted in increased anxiety and fear among many Hispanics, not only the undocumented, but also even immigrants who are in the United States lawfully and citizens who worry about possible separations from family members who are undocumented and who fear ICE stops and law enforcement sweeps targeting Hispanics (NBC News, 2018).

As evidenced in exchanges in therapy, Hispanics encounter pervasive stereotypes on a daily basis. For example, some people believe that (1) Hispanics are second-class citizens; (2) they are less educated; (3) they are less intelligent; (4) they are less productive; (5) they are less well-adjusted; (6) they are more physically violent; (7) they have criminal tendencies; (8) they are taking away jobs; and (9) they are less worthy of services because they are "illegals." In addition, Hispanics are also sometimes subjected to outright prejudice, including: (1) they are the subject of racial jokes; (2) they are subjected

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to widespread social injustices; and (3) they are invalidated because of their speech or accent and because of their appearance (Ditlmann & Lagunes, 2014; Gonzales-Backen & Umaña-Taylor, 2011; Hansen & Dovidio, 2016; Roth, 2010).

These stereotypes result in many negative consequences to Hispanics and are issues that clients must frequently address through therapy. Some of these are potentially debilitating, devastating, and even deadly, such as: being denied treatment or medication for serious medical conditions, being denied treatment for severe depression and possible suicidal ideation, having to move to dangerous neighborhoods or becoming homeless, denial of needed services including education and career opportunities, loss of income, loss of benefits, and enduring emotional and physical conditions. (Bustamante, Leclerc, Mari, & Brietzke, 2016; Landale, Oropesa, & Noah, 2017; Parra-Cardona & DeAndrea, 2016; Tran & Ponce, 2017).

Dismantling DACA (Deferred Action for Childhood Arrivals) has created a sense of foreboding and doom for immigrants whose legal status is based on DACA. Almost 800,000 were approved for DACA since it was instituted in 2012 (Abrego, 2018). DACA enabled young people to pursue their dreams. They are students, employers and employees, homeowners, and business owners. They are sons and daughters; some now are parents.

Diversity has been the hallmark of what makes this country great. Yet, in my four decades of work with immigrants and disenfranchised groups, I have seen the very roots of diversity eroded and pulled out from under us, and the already-precarious lives of many Hispanics grow increasingly tenuous. The many microaggressions, macroaggressions, stereotypes, discrimination, and prejudice encountered by the numerous patients I have seen through the years in three offices present as a constant source of harm to Hispanics; but the political climate over the past two years surrounding Hispanics and immigrants and their legal status has cast a huge net of new insecurities and vulnerabilities (Hummer & Hayward, 2015; Pew Research Center, 2018).

Many undocumented immigrants live in the shadows, fearful that any exposure might lead to detention and deportation proceedings. Fear has permeated the lives of immigrants, not only undocumented aliens but also immigrants and nonimmigrants granted the right to reside in the United States, and children born in the United States to undocumented parents. Many face very real uncertainties of being picked up in ICE raids. They have no rights and may be subjected to immediate removal. Families are torn apart by separations.

In therapy with me, adult Hispanics present with PTSD-like symptoms including: intrusive thoughts, flashbacks, nightmares, feelings of intense distress when reminded of the trauma, intense physical reactions to reminders of the trauma, avoidance, inability to remember important aspects of the trauma, loss of interest in activities, feeling detached and emotionally numb, having a sense of foreshortened/changed future, sleep disturbance, irritability, difficulty concentrating, hypervigilance, being easily startled, feeling guilty, increased alcohol use, increased use of medications, substance abuse, depression, hopelessness, helplessness, and somatic complaints.

And, in my therapeutic work with minors, children experience symptoms such as separation anxiety, regression, symbolic play, emergence of new fears, fear of the dark, fear of sleeping alone, behavioral changes, mood changes, enuresis, physical complaints, and changes in school performance.

Families face a multitude of stressors: frequent relocations, inadequate housing, economic hardship, poor physical and mental health, being less likely to use available services, discrimination, fear of ICE detentions and deportation, witnessing arrests, toxic stress, and (for the parent) having to decide to leave their child(ren) behind or take their child(ren) with them (Arbona et al., 2010).

Thus, the psychological toll in the face of what I refer to as “living in the shadows” and removal fear and panic, is significant: depression, anxiety, PTSD symptoms, withdrawal, behavioral changes,

increase in self-harm behaviors, somatic complaints, academic failures/dropping out, parental rights may be terminated, and the child may need to be placed in another home. (Arbona et al., 2010; Aranda, 2016).

ICE raids have spiked and result in avoidance and missed hearings because the Hispanic immigrant is afraid of getting arrested and not being able to contact family and being deported expeditiously (NBC News, 2018).

Children are especially vulnerable. Children are more susceptible to the dangers of the world than adults, and unaccompanied children who face their situation alone are even more vulnerable. Aside from obvious physical consequences (diseases, injuries, malnutrition, etc.), the emotional trauma and lingering emotional consequences are significant (e.g., Trauma and Stressor-Related Disorders including PTSD, Depressive Disorders, Anxiety Disorders, Substance-Related Disorders, acquired Neurocognitive Disorder due to TBI pursuant to abuse/injury, etc.). The long, arduous, and dangerous journey to “freedom” poses remarkable challenges, obstacles, and emotional trauma and consequences to the children along many stages. (Aranda, 2016; National Latina/o Psychological Association, 2015a; National Latina/o Psychological Association, 2015b).

How can Hispanics, and particularly elderly Hispanics, cope in the face of so many risk factors? There are approximately 80 million Baby Boomers in the United States of which 10% are Hispanic (Gassoumis et al., 2008). This sizable cohort of our society takes on greater significance taking into consideration that, given the steady increase of Hispanic population in the United States as noted above, by the time all Baby Boomers are 65 years old and over in 2029, it is estimated that more than 20 percent of the U.S. population will be over the age of 65 (Colby & Ortman, 2014).

Definition of Terms

It is important to consider the meaning of several terms:

Hispanic — This term is used to denote the culture and people of countries formerly ruled by the Spanish Empire, usually with a majority of

the population speaking the Spanish language. Collectively known as Hispanic America, this definition includes Mexico, the majority of the Central and South American countries, and most of the Greater Antilles. People from the nations formerly pertaining to the Spanish East Indies sometimes include themselves in this definition, as their cultures have some Spanish or Latin American elements. The term was first adopted by the U.S. government during the Nixon administration. It has been used in the U.S. Census since 1980. *Hispanic* is more broadly and frequently used in states like Florida and Texas.

Resilience — The American Psychological Association (APA, n.d.) defines resilience as “the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress—such as family and relationship problems, serious health problems or workplace and financial stressors. It means ‘bouncing back’ from difficult experiences.” The APA notes further that “resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone.” Bonanno (2008) defines *resilience* as the “ability of adults in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event, such as the death of a close relation or a violent or life-threatening situation, to maintain relatively stable, healthy levels of psychological and physical functioning” (p. 102). Luthar and Cicchetti (2000) view resilience as “a dynamic process wherein individuals display positive adaptation despite experiences of significant adversity or trauma” (p. 858). Among Hispanic populations, my experience with Hispanics in psychotherapy informs me that resilience is a process that encompasses a host of factors: culture, family, community, and the individual’s personality.

Aging — Aging is a seemingly simple concept, but defining it is not so easy. Rose (1991) provides the following definition: “a persistent decline in the age-specific fitness components of an organism due to internal physiological deterioration” (p. 1). Magalhães (2013) refers to aging as a “complex process composed of several features: 1) an exponential increase in mortality with age; 2) physiological changes that typically lead to a functional decline

with age; 3) increased susceptibility to certain diseases with age. So, I define aging as a progressive deterioration of physiological function, an intrinsic age-related process of loss of viability and increase in vulnerability” (p. 6). The National Hispanic Council on Aging (2018) recently provided that “many Americans think of aging as deterioration, decline, and dependency. If we reframe how we talk about aging, over time we can change how we think about aging. Aging is a process of “building momentum.” When discussing aging, we need to focus on experience and wisdom which enable older adults to improve their communities. By framing aging as a dynamic and forward-moving process we can help people see aging in a more positive light (National Hispanic Council on Aging, 2018).

Resilience in elderly Hispanics requires a close examination and understanding of the role of these factors in addition to risk and protective factors among elderly Hispanic populations. For policymakers, this knowledge will play an important role in understanding the needs of elderly Hispanics and making available and allocating appropriate resources. For treatment providers, this knowledge goes to the heart of developing and increasing “cultural competence” with aging Hispanic subpopulations.

Factors Associated with Resilience

There are several factors associated with resilience among Hispanics: individual characteristics; family involvement; cultural factors; and community support (Cardoso & Thompson, 2010); Consoli et al., 2011).

Individual characteristics pertain to personality traits that by and large stem from the interplay of biological and psychosocial influences. It is the sum total of the being and exposure to risk and protective factors that play a role in shaping resilience.

Family involvement is very important in Hispanic cultures. Family resilience is marked by strong family support. Close parental ties with children are a key protective factor that enhances resilience. Among many of my patients, the extended family is close and tightly knit. Members reach out to one another in times of illness and need, at various celebrations and events, and in moments of loss and mourning.

Cultural factors pertain to a sense of ethnic and cultural pride. Individuals who retain cultural traditions and values harbor a positive ethnic identity conducive to resilience. Among my better adjusted patients, their eyes light up when we talk about their country, their culture, and the kids of food they enjoy and prepare during special occasions and holidays.

Community support pertains to networks that are available to Hispanics such as the church, the neighborhood, and extended community networks. For many of my patients, the church is a very important source of community support. They not only attend regular services but attend special gatherings during special events and holidays. Often, my patients are invited to the homes of other congregants and, when sick, congregants visit them and bring food.

Recommendations

To address the needs of older Hispanic adults and their caregivers, the National Hispanic Council on Aging in consultation with community leaders, organizations, and members, and drawing upon available research and data collecting, has advanced a number of recommendations to local, state, and national leaders, policymakers, and agencies that provide services to elderly Hispanics to more adequately tend to their needs (National Hispanic Council on Aging, 2017; National Hispanic Council on Aging, 2018):

- Eliminate health-related disparities among Hispanic older adults.
- Increase affordable and quality housing for seniors.
- Strengthen financial programs for caregivers and families.
- Prevent discrimination, age exploitation, and disability exploitation.
- Bipartisan passage of H.R.947 and S.337, the Family and Medical Insurance Leave Act (the FAMILY Act).
- Bipartisan passage of S.1028, the Recognize, Assist, Include, Support, and Engage (RAISE) Family Caregivers Act.

- Pass local level regulations to financially support family caregivers who are aiding older adults.
- Include positive aging and age inclusive principles in relevant academic forums. Reframe aging and caregiving as a multigenerational issue. Build intergenerational bridges to include the support of millennials.
- Invest more funding in training initiatives to support and train family caregivers in their roles as caregivers.
- Create a database in which organizations can upload information about services available for caregivers.
- Partner with Hispanic organizations to develop programs and services that meet the specific needs of caregivers.
- Educate Hispanic families about caregiving and identify the caregiver trainings available in English and Spanish.
- Provide training to caregivers of older adults and health care providers to provide culturally, linguistically, and age sensitive care to diverse elders.

The National Latinx Psychological Association (NLPA) provides several recommendations in their Guidelines for working with children that, nevertheless, are applicable to older Hispanic adults (National Latina/o Psychological Association, 2015a; National Latina/o Psychological Association, 2015b):

- Mental health services ideally should be delivered by qualified professionals with expertise in culturally sensitive interventions.
- Mental health providers should have specific training and experience in the interventions they provide.
- Mental health providers should be provided with ongoing supervision as needed.
- Elderly Hispanics who are Spanish-dominant and do not speak or understand English or are not fluent in English should be given access to bilingual workers.

Much more research is needed. Many factors described above that are known, and have been studied, but there are many unknown factors that impact health and longevity of Hispanics residing in the United States that may lead to statistical mistakes. For instance, how many undocumented immigrants who live under the radar are not accounted for in our surveys and research? What is the health status and ages of the approximately 400,000 undocumented immigrants who are removed every year (Homeland Security Office of Immigration Statistics, 2017)? What becomes of them once removed? What is the health and mental health status of the approximately 70,000 children, with and without their parents, and other persons crossing the border illegally every year (Robertson, 2018)? Consider the life and death circumstances for many who decide to flee their country of origin and encounter traumatic experiences during their journey to the border, crossing the border, in detention centers if apprehended, and adjusting to life wherever they settle and live in fear of deportation. Mortality data for Hispanics is underestimated (Arias, Schauman, Eschbach, Sorlie, & Backlund, 2008). What is the health status of those who are ill and return to their countries and what becomes of them there? This is known as “return migration bias” or the “salmon bias” (Arenas, Goldman, Pebley, & Teruel, 2015). How are immigrants who come to the United States different than those who stay in their countries? This may have some relevance to health and is known as the “healthy migrant effect” (Hamilton, 2015).

Advocating for the recommendations noted above and conducting further research and ongoing needs assessments because the needs of the Hispanic elderly fluctuate over time and as a function of systemic changes are laudable aspirational goals that need more of a bite through the creation of new governmental policies and laws and more aggressive enforcement of existing policies and laws.

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On Telling Your Patients You Are Going to Die: An Analytic Odyssey

Herbert Gingold, PhD¹

What does a therapist do when discovering that he or she has a serious, perhaps fatal illness? Where does one go to find out? Analytic tradition has it that the therapist remains a blank screen, divulging little or nothing. I will talk below about the support for this notion and the problems with it when it comes to existential issues such as serious illness and death.

In comparing the literature on illness and mortality of both physician (psychiatrist) and psychologist analysts, we see a mutual acknowledgement that there is a surprisingly small body of writing despite the importance of the topic. Below are highlights from both psychiatric and psychological perspectives. Much of the psychiatric literature is collected in Schwartz and Silver's (1990) *Illness in the Analyst: Implications for the Treatment Relationship*.

Psychiatrists give various explanations for the paucity of literature on the subject of discussing their own illness, death, and dying with their patients. Both Wong (1990) and Dewald (1990) suggested that many physicians are in denial that they might ever suffer from the illnesses they treat or the seriousness of the procedures and medical care they themselves receive. Schwartz and Silver point out that this denial is intensified by the psychiatrist analysts' concerns about reputation (continuing to get referrals) and perceived weakness, which have kept them from writing about the subject or even thinking about it. Wong (1990) pointed out that throughout his long recovery from a dangerous esophageal perforation, he laughed and joked and made light of his illness and treatment, repeatedly expecting to be back in the office in a short while.

While Cousins (1979) wrote extensively about the importance of laughter in recovery from serious illness, the denial described by Wong resulted in a long delay before his eventual realization of how close he had actually come to death, despite everyone else around him understanding this. In Dewald's case, the regression as his illness developed caused him to neglect the necessary planning for patient notification and care, and even of his own finances.

Dewald (1990) discussed at length the nature of transference and countertransference when the analyst faces serious illness. He noted that the more information the patient is given, the less the patient can engage in transference distortions. Because he himself did not understand the severity of his own condition, information was disseminated by others without knowledge or regard for the patients' needs and thus complicating the future of those treatments. Patients sent gifts and advice, tried to visit his hospital room, and wrote letters. Dewald (1990) noted, "To remain abstinent and not acknowledge the patients' gestures would have also affected the therapeutic process" (pp. 78–79).

Abend (1990) noted the dearth of information about how to handle the countertransference implications in treatment. In reviewing his own decision-making regarding which patients to inform about his illness and how much to relate, he tried to develop a rationale. He later decided that full abstinence was advisable, simple announcing absences as under any other circumstances. He concluded that all of his decisions in which he "had attempted to assess each patient's needs on an individual basis" were ultimately "neither accurate

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nor objective” (Abend, 1990, p. 108). Eventually, Abend concluded that we don’t know enough to make an unequivocal decision whether to tell nothing, something, or everything and under what conditions.

My own prospective differs from that of Abend. The decision to reveal nothing is a luxury only available to those with time, like Abend himself, between the diagnosis and treatment. If the therapist has a medical emergency, there is a question of who calls the patient and what should be said. The very fact of a stranger calling to announce the therapist’s absence can only lead to more questions, concerns, fears, and even panic. Similarly, if the therapist’s appearance changes or their schedule is altered due to medical treatments and their effects, patients are going to have fantasies about it. Is it even humane to remain absolutely uncommunicative, especially if the treatment is not psychoanalytic?

Singer (1971), a psychologist, unhesitatingly decided to disclose his wife’s serious illness to all his patients, after having taken a break from his practice to help her through her illness. Singer had misgivings about his possible unconscious motives: stopping difficult patients from attacking him or demanding too much, inducing patients’ guilt by showing them how trivial their own problems were and burdening already-distressed people. He ultimately decided that it was appropriate for several reasons, not least of which was that since he expected them to explore their own absences from therapy, why not explore his? In almost all cases, Singer found that the disclosure either did not have any serious effect on the course of therapy or actually accelerated it in a positive way.

In fact, the psychological literature in general is more favorable toward disclosure. This reflects a long tradition of resistance to the abstinence model. Recently, Newirth (2017) decided to disclose fully regarding an illness he was experiencing, as he had long believed that the psychoanalytic relationship should be more egalitarian. He decided “to put my money where my mouth was” (p. 214). Again, reporting on his disclosure to his patients, “For the most part it worked out quite well” (p. 214). Similar

views regarding disclosure have been expressed by Searles (1975), Hoffman (1983), Silver (1990), Singer (1971), and many others.

Importantly, Searles (1975) wrote that one important curative element in psychoanalysis was the role of the patient as the therapist’s analyst. He wrote that there is a desire in all patients to cure the analyst and be acknowledged in this endeavor. If that is not allowed to occur, the treatment is less likely to come to fulfillment.

Illness and Death Becoming Personal

I discovered in December 2017 that I had advanced metastatic lung cancer and was given the impression that I was likely to die within the year or even sooner. As a psychologist in private practice, I was immediately struck by the necessity to plan how and when to inform patients and shut down my practice.

Does one inform patients at all? One part of me speculated that it was narcissistic self-indulgence on my part. Can there be a therapeutic reason to reveal such an intimate piece of information? At that point I had no idea how to find out.

Without yet being aware of this literature, my own decision evolved spontaneously. Like both Newirth and Singer, I have adopted a more egalitarian stance in therapy. So, when certain patients began to ask questions like, “What’s going on?” “You don’t look well.” “Is there something wrong?” I was inclined to reveal what was happening. Believing at this point that my lifespan was very limited, I felt it was imperative to let my patients know that things could be coming to an end sooner than we had anticipated. To test the waters, I initially revealed my diagnosis to only a few patients, ones I believed could deal with it. One young man who had emerged successfully from a childhood of deprivation and loss tearfully responded, “Why does everyone I care about get taken away?” Similarly, a young woman who had surmounted a difficult childhood cried out: “Why does this always happen to me?” In the first case, the patient began to request frequent and last-minute changes of appointment until confronted with the possibility that he was withdrawing from

me before I could abandon him. In the second case, this patient became increasingly demanding and angry until the therapy came apart completely. An older woman who was a survivor of cancer showed heartfelt concern and promised she would stick with me until the end (see more about these cases below).

As was described by several writers, I quickly moved into a position of humorous denial and prevailed upon closest friends and family to join me in this stance. After several initial serious medical disappointments, I refused to take a position of “hope” and would say things to friends and colleagues like, “Of course I’m going to die, soon, but I’m making sure everything is being taken care of.” In retrospect, I must have driven people crazy during this period. I regained my balance after 2 weeks of intense depression, following which I made a concerted effort to “treat” my depression as I would my patients’.

It became increasingly clear I was going to have to explain certain things to patients: my absences, changed appearance, and occasional eruptions of symptoms. Not only that, but I was becoming different in the way I thought and behaved. Patients had begun to take notice.

I would like to describe in the rest of this piece the experience of telling several patients that I had a serious and possibly terminal illness, and the results of these disclosures both on the treatment and on my thinking as a therapist. As Wong described his evolution in this process, in the beginning I gave careful thought to whom I revealed the information. I will give examples of patients who I told for therapeutic reasons and those I decided not to tell because it might have endangered the therapy. There are two patients I believed I told for purely narcissistic reasons but subsequently realized I was wrong about my motivation.

Within two months of my diagnosis, I was entered into a clinical trial of a promising experimental treatment that actually halted the cancer and eliminated the metastases. But, as I was informed, the effects could end at any time and are almost certainly time limited.

Clinical Vignettes

Sue-Ann: “Don’t give up hope for us! Don’t die inside and leave us before it even happens to you!”

Sue-Ann had been in treatment for nearly 18 months. The treatment was complicated and thorny. Sue-Ann is a giver, a person who thrives on helping others, but can be resentful afterward. From the beginning, she had offered advice on areas of treatment I was unfamiliar with. I learned to graciously accept this.

For many months, our sessions would end with Sue-Ann tearfully overstaying her session as she fruitlessly tried to help me understand her experiences. One session, shortly after my initial diagnosis and before I was being treated, she got up and announced that she was ready to walk out. It sounded like she intended to leave therapy. As she stood up, my mind flashed on what would happen if I had to stop working or died, and she called to set up an appointment (this was not an unlikely possibility). I announced that I had something important to tell her; I had been diagnosed with cancer, was very ill, and might have to stop my practice before many more months had transpired. I explained that I couldn’t bear the idea that she might call and find me unavailable, even unable to call her, and think that it had to do with her or with our therapeutic struggles. She had had enough rejection in her life for me not to want to add to it gratuitously.

Sue-Ann appeared touched both that I had confided this very important and personal information and that I was doing it because I was more concerned with her treatment than I was with strictly maintaining the therapeutic frame. She sat back down, and we completed the session talking about illness, cancer, and my particular cancer.

In the following weeks, Sue-Ann, as was her wont, supplied me with valuable information about cancer and cancer treatments, about surviving a diagnosis and treatment, and about the health care system. This was what she does and does well, and I

was not going to reject something that she felt very positive about offering. At the same time, I insisted that we continue to focus on her treatment, and not on my illness.

During this period Sue-Ann said something of such poignancy that it changed our work as well as my own views of what was happening in therapy with all my patients. I was just about to begin my treatment with a promising new drug, and she asked about it. I was typically pessimistic about it, my strategy for dealing with my illness. Sue Ann said to me firmly, "Don't give up hope for us! Don't die inside and leave us before it even happens to you." This important request alerted me to how I was slowly withdrawing from life much earlier than I would have wished. It has affected me to this day. A perfect Searlesian example of a patient curing the analyst.

Within a short time, we returned to our regular struggles, but with a new tenderness that made these altercations less fraught and more mutual. At times, we still get distracted by issues regarding the health care system, but I cherish her concern and very useful advice.

Ellen: "Why does this always happen to me?"

Ellen is an intelligent and accomplished woman with borderline personality disorder. Ellen has a long history of conflict. This includes several problematic terminations with former therapists. After a brief honeymoon period, in which all of the significant people in her life were described as exploiting and deceiving her, she began the process with me. Around the time of my diagnosis, this accelerated, as she repeatedly accused me of being emotionally unavailable and useless. I took those charges seriously, but was also aware that no other patient had ever leveled them at me. As my apparent defects multiplied, they began to include accusations that were clearly delusional. What was true is that my physical and psychological weakness had become evident. But soon after, I was given a more optimistic prognosis. Ellen's accusations and anger continued, and with a great deal of thought, I decided that I ought to reveal a little of what was going on.

I explained that I had cancer but that I was in an experimental treatment that was very promising. Her immediate response was a stricken "Why does this always happen to me?" After this, she began to talk of other things, and she had nothing else to say about my disclosure. However, after the session, I received a message from Ellen apologizing for her self-involved statement and expressing sympathy. This was the first time in treatment that she had ever done anything of the sort with regard to me or anyone else in her life. It initially boded well. However, the pace of her criticisms picked up again, and several months later, her rage was out of control. She precipitated a termination. My interpretation, far too late to share, was that she couldn't bear the loss of another significant object and was forcing a termination on her own terms. It suggests that I was premature in informing her of my illness.

Selina: "May I bring you a treat?"

Selina is an active and intelligent elderly woman. She had been a patient of mine for a long time, presenting in therapy as frustrated and bored with most people around her. We had hit it off immediately, and she looked at our sessions as a high point in her week. We developed an ironical and joking relationship, which she cherished.

One of Selina's frequent statements was to assure me that she would be coming to see me for the rest of her life. She repeated how important it was for her and feared that something, perhaps her insurance, might somehow prevent us from continuing to meet.

This theme became more pronounced around the time of my diagnosis. She clearly sensed that something was going on with me. She regularly inquired about whether we would be able to go on, while watching me closely.

I finally decided she was onto something and decided it would be important to inform her. I was somewhat nervous that the news would worry her, but as a survivor of cancer, Selina took the news in stride. She didn't express the usual platitudes, "Of course you will get better." Instead, she talked realistically about the possibility of my deterioration

and even death. She expressed a surprised pleasure in my own joking relationship about it, as that was her own reaction when she was diagnosed. The following week, she asked “a favor”: “If you do become very ill, may I come to your sickbed and bring you a treat?” I thought carefully about this, but the nature of our relationship seemed to make this a reasonable request, a way for her to say goodbye with a gesture of gratitude and comfort.

Sandy: Medical Advice and a Prayer

Sandy is a health care professional who presented with problems in his professional life that were endangering his health and his psychological health. He was drinking too much, not eating properly, and isolating himself from others. His experience mirrored his experience growing up and being targeted for his ethnic and religious background. His parents were ineffective in protecting him or teaching him skills to soothe himself. Therapy was stuck.

Sandy was one of the first patients I told about having cancer while I was still in the diagnostic phase. Having extensive medical knowledge, he asked about the illness and the various treatment possibilities. Despite my initial misgivings, I answered his detailed questions. Sandy recommended certain actions to ensure that I was getting the best attention and treatment, which included making sure certain tests had been done and looking up the treatment when it had been selected. While I had already done most of what he suggested, his interest and concern, and his recommendations and encouragement, were very moving. Furthermore, he offered to pray for me, a request I had long ago decided to accept from others despite being an atheist. Most important, he began to look after his own wellbeing, cutting down on his drinking, trying to eat better, and spending more time with others in religious activities. He also started exploring what it would take to extricate him from his particular situation. As Searles (1975) pointed out, by treating me and receiving appreciation for it, Sandy was able to fulfill an important need to fix the therapist, ergo his ineffective parents, for whom all his own efforts to fix were in vain.

Madeleine: From a Dead Therapist to a Dying One

Madeleine originally sought me out when her own elderly therapist was taken ill and she needed to ensure a transition should he die. At the time, she was extremely anxious, and I was at a loss to help her maintain her calm. She had cut herself off from work and some relationships and was experiencing both a dependence upon and tensions with family members. In the four or five sessions we had, then, Madeleine spoke in a pressured way, seeming barely aware that I was present. I was relieved when her therapist announced he was better and ready to work again.

Madeleine went back to her previous therapist for several months, following which he died suddenly without having made any plans to inform his patients or arrange for their care. I was aghast and horrified, even before beginning my own bout with cancer, regarding this lack of regard for a long-term and very vulnerable patient (or any patient) as verging on malpractice.

My own diagnosis came shortly after Madeleine started to see me again. For a long time, I was reluctant to say anything to her about my cancer, because of my experience with Madeleine as very vulnerable, and I didn't yet know what the future looked like. I continued to take her vulnerability for granted until I realized I was ignoring demonstrable evidence of her making substantial progress since beginning our work together. Eventually, I decided she was ready to hear it, so I focused mostly on the positive news of my successful treatment. I explained why I hadn't told her until that point. She was very touched that I had confided in her. She asked no further questions, but in the following weeks, she began to express criticisms of her former therapist. She continued to seem more in control and was making progress in therapy. Being brought into the “secret” had a salutary effect on her treatment and on our relationship. She was teaching me that I didn't need to treat her with kid gloves.

Lucky: Asperger's Syndrome, Trust, and Anger Management

Lucky is a 35-year-old man with Asperger's Syndrome who has been in therapy with me dealing with problems of trust, frequent episodes of rage, and an online addiction. Over 5 years, we have established a moderate level of trust, good communication, and a willingness to engage in what may seem to him to be the thoroughly strange techniques of anger management. I decided to confide in his wife, who occasionally attends as ancillary to the therapy. At the time I was rescheduling sessions more frequently due to medical visits and treatments, something unusual for me. She said that he had noticed but didn't want to ask me anything. She advised me to not tell him about my medical condition, as he has a history of losing significant people in his life and consequently becomes reluctant to trust again. We agreed that should it be necessary, I would inform her of any adverse changes in my health and consult carefully on the best way to inform Lucky. At present, my health is stable and nothing has been said.

Larry: Psychosis and Intimacy

Larry is a young man with a history of schizoaffective disorder. He lived nearly 10 years in episodic decompensations, often precipitated by excessive drug use, and had alienated almost all his therapists by being dishonest, withholding, and manipulative. I saw him for 2 years in the middle of the deterioration until I realized he was using me to allay the suspicions of his parents and psychiatrist. He returned to me as a patient after successful treatment with a new anti-psychotic. Our current work together overtly focuses on his indecision about choosing a career and the problems of living with extremely difficult parents. His career plans appear unrealistic and frequently change.

While I believe that Larry likes and trusts me, there continues to be a withholding, as if he expects to be ultimately betrayed. I made a decision that whatever closeness we have achieved would be quickly destroyed by any inkling that I might not be around.

When I initially outlined this article, I had anticipated describing patients who I told about my medical condition to achieve some narcissistic satisfactions. As I began to explore this theme, I realized that there were no patients in this category. Certainly, if I had reported an ingrown toenail or elaborated on my allergies or high blood pressure, dwelling on these issues would have been an indulgence. However, because what I had to report was an existential threat to the treatment relationship, there was little excuse to not divulge it (except in cases where it would be likely to immediately impair the relationship). In most cases, the most important challenge became not whether to divulge but when and how much to reveal, and, furthermore, to be responsive to the tone of the patient and his or her needs rather than my own. This is an entire paper in itself, so I won't elaborate on this here.

Conclusions

Experiencing a threat to one's existence is a challenge about which too much cannot be written. There are as many ways to describe how we cope with the threat of death as there are people facing it. There is a particular challenge when one's profession consists of intimate relationships with others that are typically not reciprocal. However one may try to free oneself from the tyranny of the blank screen ideal (Hoffman, 1983, pp. 389–390), it still hovers in the background, imposed by that first generation of psychoanalysts. The challenge to this ideal, which began in the next generation of analysts, has been ongoing. And nowhere is its inadequacy more apparent than when the analyst has a serious or terminal illness. It is at this point that the intrusion of reality into the treatment is not only appropriate but also necessary.

There has been little question, since Becker's groundbreaking *Denial of Death* (1973), that the most important challenge to the human psyche is facing the inevitable end of life. For a therapist to deprive the patient any possibility of sharing in this experience appears to me a serious loss to the treatment. Obviously, there is yet no formula for how and when it is to be done. A gifted therapist of my acquaintance related an intervention she had made to a dying patient who complained that she had no

purpose left, especially regarding her children. The therapist said: “You have a very important task left, to demonstrate to your children how to die with grace and dignity.” The patient took this to heart and indeed demonstrated it not only to her children but also to all the doctors, nurses, aides, and friends who attended to her last months. This is a valuable gift that a therapist can give to those entrusted to his or her care. It is one we should cherish and take very seriously.

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The Essence of Being: An Interview with June Blum, PhD, ABPP

Julia Penn Shaw, EdD¹

June Blum, Ph.D., ABPP, an early advocate for the aging, a founding member of the NYSPA Group Division in 1995, and an active member of the NYSPA Adult Development and Aging Division, is an inspiration to those with whom she comes into personal and warm contact. Her views on life are fresh and unfettered, providing, from among our midst, an example of “resiliency in aging” in action. Although well on in years, she radiates joy while willingly sharing insights gained through her rich and purposeful life.

Julia Penn Shaw, Ed.D., a NYSPA Distinguished Fellow, serving NYSPA in various capacities and a frequent recipient of June’s wisdom, interviewed her for the 2018 NYS Psychologist.

The Essence of Being



June Blum, PhD, ABPP, 2018

With the focus of this edition of the *2018 NYS Psychologist* on aging and resilience, it was natural to seek out New York psychologists who demonstrate resiliency in their lives. Dr. June Blum, Ph.D., ABPP, a member of our NYSPA Division on Adult Development and Aging, was to me an obvious choice. We first met when June invited me to shape a symposium on “Making Meaning in the Face of Change: Spirituality, Sexuality and Security” for a meeting of the Hudson Valley Psychological Association in 2014. The energy that she brought as coordinator of that event was palpable, infusing

both presenters and audience with a felt sense of deep connection. It was this event that started our acquaintance. June’s warmth, wide smile, positive attitude, and perceptive interest in others drew me to her as a person to interview for this journal. June agreed with enthusiasm, so we set a date to talk.

June suggested we meet at the stately Beekman Arms Inn in Rhinebeck, New York. Established in 1766, this beautifully maintained and flourishing landmark at the center of her town seemed the perfect place for us to connect. Perhaps June

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appreciated the synchronicity of our meeting there, as an example of how that which is well-established, well-appreciated, and well-sustained can continue to contribute and prosper across a long lifetime.

In our leisurely conversation across a number of hours, I learned that Dr. Blum, now age 98, maintains a practice as a clinical psychologist and continues to contribute to Weill Cornell Medicine as a clinical associate professor of psychology, with no plans for retiring. Much could be included here, but we have chosen to focus on a theme that permeated her life: experiencing opportunity through connection with others. First, what life experiences did June think led her to seeing possibility where others saw a blank wall? Second, how was she able to carry this over into her practice and her profession? Third, what plans might she have for carrying her enthusiasm for life into the future?

Living a Life of Possibilities: Finding Doors Where Others Find Walls

June Rose

Marking the events of importance in her personal life across almost a century, June discussed how early experiences led to an open-angle lens on life. June Rose Epstein was born in Richmond Hill, Long Island, in 1920. June Rose, as she was known as a girl, was the youngest of three, following her siblings, Sybil and Gustav. A turning point in the life of her family was the sudden death of Gustav at age 9, when June Rose was five. It was at Gustav's funeral that she first saw herself as "an observer who doesn't miss a thing." She watched others but did not talk about this event, which had a profound impact on herself and her family. A communication door in the family was closed, but June used it to open another door to learning by observing.

At home, however, June—as the youngest in an extended older family and still suffering from silence about the death of her brother—"drove them crazy" with her energy. Her concerned mother sought help from a child psychiatrist, a new concept. He concluded, "Leave her alone. She will come to you if she needs your help." June remembers this as a significant turning point in her life: that she was competent to handle her own problems.

June

Showing academic promise, June attended Good Counsel Academy, a Catholic school in White Plains. This early adventure set the tone for adapting to new environments across her life, and her mother became assured that "June would be comfortable anywhere in the world." June's next schooling experience at Ardsley School for Girls, with mostly Jewish girls as students, was also a positive experience.

June's family was deeply impacted by the Depression. They lost their house and lived with friends, sharing expenses. Through these years, June and her family handled issues that they could, and let go of what they could not. As a result of these experiences, June observed her family's resiliency in moving forward in times of stress, even when it was hard not to look back.

June had yet another cultural experience going to college, attending first the Limestone College for Girls (now Limestone College) in Gaffney, South Carolina, and then completing her Bachelor of Arts in American history and education at the University of North Carolina at Chapel Hill. This exposure to Southern ways was her third distinct and positive experience with yet a different group. They treated June, their Yankee friend, at times with curiosity but always with graciousness and generosity.

Mrs. Stanley Blum

Two weeks after starting at Chapel Hill, June met Stanley Blum, the love of her life. They met in the middle of the stairway at a Hillel Meeting, talked and talked, and then left the meeting to go for a walk. In 1941 they eloped while still in school and started a marriage of 75 years, which only ended 2 years ago with Stanley's death. June lights up when she talks about Stanley, who left the business world to pursue a path of poetry, art, and music. From this relationship she learned another lesson: Be open to life. She benefitted from his encouragement to be whomever she was drawn to be.

Through the end of the war into the postwar years, they worked and moved and grew through new experiences, ending in New York City. June

made use of her practical teaching degree as an educator at the Professional Children's School. Soon, however, aspirations to become a psychologist (like Claudette Colbert in the 1935 film *Private Worlds*) motivated her to seek an M.A. in psychology from Teachers College at Columbia University in 1950 while raising her children Andy and Jane. She also attended meetings at Adelphi University, where she heard her former Columbia classmates, now Ph.D.s, leading discussions on psychoanalysis. More than once they asked her, "June, when are you going to get your Ph.D.?"

Building "Possibility" into Her Practice and Her Profession

Dr. June Blum

Serendipitously, at that time, she was offered a chance to join the 20-year follow-up of the Kallmann-Jarvik research on aging twins. This led to her dissertation from St. John University on "Psychological Changes Between the Seventh and Ninth Decade of Life." This work was notable because it was among the first studies of older adults living in communities. Prior to that, most research was done on patients in Veteran's Administration facilities. This work started June's academic career in examining the intersections of the process of cognitive and intellectual functioning across the late adult lifespan in conjunction with the therapeutic process. Some of her publications are listed at the end of this article.

June has shared her expertise on aging in many ways in her profession. She was invited by the National Institute for Mental Health (NIMH) to participate in the National Conference: Improving Psychological Services for Older Adults as a participant for studies of mental health of the aging. She has served on executive and editorial boards for various divisions of the APA (American Psychological Association) and the NYSPA (New York State Psychological Association), the AGPA (American Group Psychotherapy Association), and the GSA (Gerontological Association of America).

As an established clinician and geropsychologist, June became a diplomate through the American Board of Professional Psychology in Clinical Psychology, Group Psychology, and Psychoanalysis

as well as Diplomate Examiner for Clinical Psychology and Geropsychology. Readers of this journal likely know June through membership in recognized academies and associations for psychology and psychoanalytic practice. June had academic expertise on the aging process long before she engaged it as life experience.

Enthusiasm Into the Future

What are June's plans for now? She says she "wants to be engaged in the present with its possibilities and 'Aha' moments." To enjoy the present, June's professional and personal lives are engaged in constructive and productive work. June finds possibilities through engagement in relationships with others, such as the connection she and I made as we created this article. She reminded us frequently during this interview, by both her example and her words, that curiosity and openness to life are still alive, and must be nourished.

With the gift of extended years, some older adults may go into a "waiting room," while others will use the opportunity for self-inquiry and self-renewal. A good self-question is this: What has made you comfortable but may have also stunted your emotional completeness? To take advantage of the gift of life, one can aim for elasticity, and stretch to reach new aspects of identity. We all still have another chance to loosen the restraints of shadow contracts, to become "free to be."

The tsunami of retirees may potentially be entering a new period of life and self-development—a new therapeutic space between "adulthood" and the frail elderly. June believes through her practice, particularly group therapy for older adults, that individuals may extend the quality of their lives, and explore the secret contracts that have formerly stymied their individuality. As members in an accepting environment, they may feel free to share the ways they formerly short-changed themselves. June attributes this to an openness in life that she projects into her relationships with her clients. She encourages others to think of a horizontal window box with seeds of opportunity and to envision their growth where before they saw a vertical wall. She would like for us to put age in the wastebasket (except for voting, driving, and drinking) and move on. The

key to a fulfilled life is being authentic, coupled with relationships, relationships, relationships.

Regardless of age, the path of self-discovery is open.

Publications

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In Memoriam: Sharon Brennan, PhD, ABPP

Carol Goldberg, PhD, ABPP

With contributions from

Herb Gingold, PhD; Rochelle Balter, PhD, Esq.; Florence L. Denmark, PhD;
David Miller, Ph.D; David Glenwick, PhD;
Rita Perlin, PhD; Carolyn Springer, PhD; Elaine Orolaoe, PhD



From Carol Goldberg, PhD, ABPP

Dr. Sharon Brennan died on August 7, 2018. Omitting her birthdate is not an oversight or commentary on her age, but respecting her wishes. Sharon felt ageless and said “age is just a number and mine is unlisted.” She openly discussed her recent diagnosis of advanced lung cancer and earlier illnesses, yet her death was unexpected because of her optimism and boundless energy. In fact, she was writing an article for this journal.

Many of Sharon’s friendships began through NYSPA. I feel honored to be asked to write this main obituary.

Sharon came from a close, loving family of four girls in upstate New York. She said she had leadership, caring, and ethics in her genetics. After

graduating from College of St. Elizabeth, she taught Special Education in Syracuse and history at the International School of Brussels. Sharon received a M.A.T. from Colgate University and a M.A. in Psychology and a Ph.D. in Clinical Psychology from New York University. She earned a Postdoctoral Certificate in Psychotherapy and Psychoanalysis and an Advanced Specialty Certificate in Couples and Family Therapy from New York University and a Postdoctoral Certificate with “highest honors” in Child/Adolescent Psychotherapy from Adelphi University.

Sharon recently retired after 32 years at Maimonides Hospital. She was a Supervisor at Ferkauf, Yeshiva University. She continued in private practice.

Sharon’s honors include The Allen V. Williams Award and The Margaret Floy Washburn Award,

which are the highest awards from NYSPA and Division of Women's Issues (DOWI) respectively. Her more than a dozen awards were from NYSPA, APA Divisions, and the American Red Cross.

The main theme of Sharon's life was commitment to helping others, especially women, disaster victims, and preventing bullying. Sharon helped at 9/11, Flight 287, Katrina, and Las Vegas disasters. She was dedicated to the Red Cross Mental Health Disaster Relief. She headed NYSPA's Disaster Relief Network and Ambassador Public Education Program. Sharon founded WE CAN: The Women's Exchange for Ovarian Cancer. Her work extended from clinical to organizations and workplaces, and included counseling and training others through workshops and publications.

Sharon was President of NYSPA and of Clinical, OCW, Psychoanalysis, and Women's Issues Divisions; NYSPA Representative to APA's Council and chaired APA Committees; and a NYSPA Distinguished Fellow. She was President of the Manhattan Psychological Association. She never refused to take on extra work for organizations, whether doing a presentation or ordering food for an event.

Sharon loved life, psychoanalysis, intellectual pursuits, and aesthetics. She constantly went to theater, movies, and numerous European vacations. Her life has teachable lessons. Ignore age. Continue to grow through new challenges. Despite illness in early adulthood, accomplishments are possible. Be generous. People appreciate what you do.

The emotional memorial to Sharon from NYSPA and Manhattan Psychological Association was remarkable. She will not only be missed by those of us who knew her best, but also by those who never met her but whose lives she touched via volunteerism.

From Herb Gingold, PhD

I've known Sharon Brennan practically since I joined NYSPA. In that time, we usually found ourselves on the same side of most issues. And yet, we frequently argued, often vigorously.

Sharon was a passionate advocate for social justice. When she saw an instance of unfairness she would want it fixed, immediately! What we disagreed about was how to accomplish this. Her passion for righting wrongs inflamed her to the point where she often found it difficult to convince others to come along with her and this is where we differed. Sharon expected you to take up the cudgels alongside her, ready to die on the barricades of whatever revolution she was fighting. Despite, or maybe because of this, I found myself working behind the scenes to try to speed things up because it so pained her to see lingering unfairness.

When I met her, I used to think that her fierce hunger for social justice was a distraction, something beside the point. From knowing Sharon I learned that it was the point. I will miss her.

From Rochelle Balter, PhD, Esq

I've known Sharon for over 20 years and in all that time, she was always an advocate for the less fortunate and a vocal champion for women's rights. She help to organize programs on workplace violence and on sexual harassment. She was a presenter on many programs related to gender and to discrimination. She was always among the first to volunteer and willing to request help from others for impacted groups, but never considered asking for assistance for herself..

From Florence L. Denmark, PhD

Sharon Brennan epitomized a real fighter for social justice. When the Red Cross needed psychologists, Sharon was there. She volunteered after 9/11 and she went to Las Vegas. It was a blessing to be in the company of such a committed individual.

Sharon was always smiling and when asked how she was, her answer was always "fine.". What a tragedy losing a good friend who was a vital person and a distinguished psychologist. Neither DOWI, NYSPA nor I will ever forget her.

From David Miller, PhD

Dr. Brennan was a highly valued Senior Psychologist at Maimonides Medical Center whose career spanned over 30 years. She was an ardent advocate for the many, many children and families whose lives she touched and a priceless educator to the hundreds of trainees who passed through her door.

From David Glenwick, PhD

Along with her many other noteworthy and admirable characteristics, Sharon was a true lifelong learner. She was the first NYSPA member to have attained the requisite credit number for CE's. Sharon was #1 in that respect, just as she was in so many others.

From Rita Perlin, PhD

Sharon was an excellent mentor. She was honest, goal oriented and smart. Sharon was generous with both her time and her money, giving generously of both. She was a First Responder. She was dedicated to NYSPA's Disaster Resource Network and her work with the Red Cross.

Sharon was good company. She had a good sense of humor and enjoyed life.

From Carolyn Springer, PhD

Sharon was an excellent mentor in that she encouraged individuals to step out of their comfort zones and take on new roles while providing sage advice and support. She kept abreast of current social issues and through words and actions advocated for those whose voices are often not heard or silenced.

From Elaine Orolaoye, PhD: "Elegy for Sharon Brennan"

Given at the Manhattan Psychological Association & New York State Psychological Association Memorial Service: Fordham University, September, 16, 2018 (abbreviated for this journal).

Mortal woman, Compassionate professional,
We honor your selflessness, your strength
Your compassion for victims not only of 9/11
But also for so many other victims of disasters
since then...
We remember your recent work in Las Vegas
Responding to that horrific shooting, when,
We remained spectators
Watching, listening from afar...
Now Sharon when we think of you
We will remember how you raised the bar,
A psychologist working only from an armchair
was not your goal
Getting there, being there, with those suffering
on the ground
Reaching out, caring, offering comfort and
heart warming assistance
Was a critical part of your professional plan,
Where there was need for "real" work, you
could be found.
Soft spoken, gracious, beautiful woman,
We mourn your unanticipated, your sudden
death ...
...Your death can fill us anew with an
appreciation and gratitude for you!
Especially, as we bask in the recollections of
Of warm, of wonderful professional and
personal moments
We love you, Sharon,
Fare well

In Memoriam: Franklin Goldberg, PhD

Herbert Gingold, PhD

With contributions from:

Lenore Goldberg; Sharon Brennan, PhD; Howard Cohen, PhD, ABPP;
Karen Greene, PhD, ABPP; Dianne Polowczyk, PhD, Susan Warshaw, PhD, ABPP;
Jerry Grodin, PhD; John Northman, PhD;
Helga Weiss, PhD; Leonard Davidman, PhD



Franklin Goldberg (Frank to his friends) was a legendary NYSPA icon, a talented psychoanalyst and therapist, as well as a charming and loyal friend. He served as a mentor to an entire generation of NYSPA members, whose development and leadership he encouraged. Frank was always smiling and had a wonderful and mischievous sense of humor.

Frank was born on August 7, 1931 in Brooklyn, NY. He went to Lafayette High School and Frank received his PhD in 1963 at NYU and also finished postdoc training there, as well.

Frank was married to his beloved wife, Lenore Greenbaum, on June 4, 1955. They had two daughters, Diana Sadowsky and Terry Klotz, and three grandchildren. His passion for his family was apparent to all who knew him. Despite many pleas

to silence his cell phone during meetings, he always kept it on “in case Lenore calls” and always answered it when she did. Frank was particularly proud of his granddaughter, Jaimie, who recently earned an MA in Public Health. She is very interested in getting a PhD in psychology like her grandfather.

Frank was a devoted oenophile, a wine lover extraordinaire. He very generously contributed bottles, nay cases, of wine for social events, hosting many evenings to educate his friends and colleagues about the pleasures and mysteries of wine. During the State leadership conferences he always invited the NYS delegation out for dinner at a fine restaurant, followed by continued imbibing in his hotel room. His parties were always original and filled with hilarity. At one large and memorable event, a colleague brought out whole heads of garlic before the meal and began chomping on them.

The room was soon filled with the fumes of garlic, the waiters scurried away, and everyone tried to pretend that nothing unusual was happening.

As well as wine, Frank loved food. Not only did he enjoy eating out at fine restaurants but he also liked good ethnic restaurants, even driving long distances to sample the best. He loved to travel and preferred Paris for its food and art. His preferred artist was the impressionist Georges Seurat, known for his tableaux consisting of dots which would resolve into a shimmering scene. To him it was like psychoanalysis, building up a living picture from details.

Frank became involved in NYSPA in the 1960s and was active for more than 50 years. It was a time when the field of clinical psychology was being born in New York State, and he was quite active in it, as well as in APA.

Among Frank's early involvements in NYSPA was participation in the nascent Insurance Committee, chaired then by Howard Cohen. He later became its chair. The task of the Insurance Committee was to negotiate with insurance companies, state regulatory agencies (including the Health and Insurance Departments) and with the legislature. It was a project encouraged and supported by APA. The idea of psychologists taking insurance was a new one and in conjunction with APA, NYSPAs Insurance committee was very active in this endeavor. As chair of the committee, he also helped lead the fight to rein in the excesses of managed care. His time as Insurance chair was long and productive. Frank often sent out insurance advice to members under the sobriquet "The Shadow."

Frank also had a hand in starting and participating in many of NYSPAs Divisions, including the Division of Adult Development and Aging and he was particularly proud of the Division of Psychoanalysis. Frank believed that divisions were the lifeblood of NYSPA, bringing in new members and helping to train and mentor the next generation. He was President of NYSPA from 1997-1998, during a particularly fraught time when the organization was working with New York State to develop the psychology scope of practice. He presciently supported Mandatory CE for psychologists well ahead of its time, but wisely backed off when he realized there wasn't enough support for it in the organization. He was a consummate politician.

A scholar as well as a therapist, Frank was a frequent presenter at NYSPA programs. As his eyesight grew worse, his wife, Lenore, would print out his notes in bigger and bigger type.

Frank remained active in NYSPA through his 70s. He won a Distinguished Service Award in 1999 and a large celebration of his life was thrown in his honor shortly before he became incapacitated. He joked that he wanted to start of "Division of Octogenarians" and that if he lived long enough he would start a "Division of Nonagenarians."

Frank died on November 28, 2017, maintaining his joie de vivre and sense of humor almost to the end.

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