Common Stressors of Old Age and Their Effect on Resilience

Throughout their lives, all people are destined to experience adversities that have the potential to affect their health and quality of life. However, the effects of adversity on health and function in later life can vary significantly depending on the individual. Typical adversities experienced in the context of aging include chronic illnesses, cognitive impairment, the psychosocial stress of caregiving, grief or bereavement, and personal losses of independence and financial security. Although some individuals succumb to depression and early death as a result of such adversities, others continue to lead lives of personal fulfillment despite these challenges. These individuals' protective factors lead to successful aging, even in the face of the conditions that increase the risk of disease and mortality.

The common psychological mechanisms that underlie coping with many stressors in the end of life can be affected by loss or crisis of attachment in significant relationships. Although John Bowlby conceptualized attachment theory as applicable across the life span, researchers have been relatively slow to examine attachment phenomena specifically among older adults. Three common areas of focus emerge: (1) the role of attachment bonds in caregiving and chronic illness; (2) the influence of attachment in coping with bereavement and loss; and (3) the relationship of attachment to adjustment and well-being in old age (Fricchione 2011). Bowlby believed that "reorganization" of one's working models was necessary for successful adaptation to the loss of an attachment. To the extent that individuals possessed insecure (i.e., rigid and defensive) models of attachment, such "grief work" was unlikely to occur, leading to maladaptive or pathological bereavement (Bradley & Cafferty 2001).

Can we reverse negative outcomes of exposure to adversity by boosting individual resilience? Is it possible to estimate rates of resilience in the popu-

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lation of older adults? Or can resilience only be appreciated in a context of one individual? Clearly, the answer is far from simple. In addition to the nature of stressors and their potential impact on an individual's future, a host of genetic, family, social, and cultural elements influence individual differences in resilience. However, the rate of depression in at-risk populations serves as a tentative estimate of the incidence of individuals who experience reduced psychological resilience. Models of chronic exposure to stress as a forerunner of mental illness in older adults have been studied in several populations, including the chronically medically ill, those with spousal bereavement, and family dementia caregivers. This evidence supports the stress-health relationships associated with stress, coping, and mental illnesses.

Resilience in Chronic Illness

With the benefit of contemporary advances in treating chronic illnesses related to increasing age spans, resilient individuals are more likely to recover and adapt after illnesses such as heart disease and cancer. The rate of depression in victims of stroke, heart disease, and certain cancers can approach 40–50%; this provides an estimate of the proportion of individuals with reduced psychological resilience.

Friedman and Booth-Kewey (1987) analyzed the health outcomes of the disease-prone personality, in which negative emotions (depression and anxiety) were associated with an increased risk of chronic disease. Increasing evidence suggests that neuroticism predicts increased distress and disease. However, it is unclear whether positive traits such as optimism predict a lack of disease or, rather, reflect a more positive perception of health status. The World Health Organization (2002) defined health as a general sense of well-being, accompanied by physical well-being, mental, social, and functional improvement. Thus, health is more than achieving a singular outcome; it involves a process of challenge, negotiation, and adaptation that unfolds over the course of life. Together, healthy aging and longevity can serve as markers of personal resilience, whereas rates of mortality and morbidity (e.g., rates of depression associated with physical illness) can serve as proxies for deriving estimates of less resilient individuals. Kern and Friedman (2010) describe personality features, such as conscientiousness, that relate to greater productivity, good physical health, and longevity, which also involve better health habits, involvement in life, and better relationships.

Therefore, in the context of adaptation to chronic illness, resilience involves flexibility and adaptability to stress rather than just hardiness or the absence of disease. Further, psychological and physical resilience are not

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necessarily separate entities; instead, they are two sides of the same coin. Temperamental predisposition, internal stress and coping, social relationships, and health behaviors may all be relevant in predicting whether an individual will thrive in the face of challenge or succumb to depression and disease.

Resilience in Bereavement

Another common stressor in older adults is bereavement. According to the U.S. Census Bureau, in 2003 approximately 14% of men and 45% of women 65 years and older were widowed. Among those age 85 and older, this increased to 43% of men and 80% of women. About 33% of surviving older-adult spouses experience a "complicated bereavement," placing them at significant risk for major depression, high morbidity, and mortality (Fry & Debats 2010). Previous research has identified psychosocial resources that serve as protections against stress and promote health, well-being, and resilience. A good example is community or familial support that involves affect-type ties and social engagement.

Additional factors that positively influence morbidity and mortality are beliefs in self-efficacy, self-control, and self-esteem. Moreover, spirituality and religious beliefs can compensate for a lack of close relationships following trauma and loss (Granqvist & Hagekull 2000) and can protect against early mortality and morbidity. The association of psychosocial resources—such as spiritual development, family stability, social engagement, and commitment to life tasks—with increased longevity may represent important resource domains, and these may contribute significantly to a surviving spouse's resilience and healthy longevity by assisting with psychological adjustment following his or her loss. It is plausible that a life span may be lengthened when a person possesses personal and psychosocial resources like the ones just mentioned. Thus, it may be that those with more psychosocial resource networks are better protected against early mortality. Intervention programs for older surviving spouses can concentrate on coping with grief and mobilizing psychosocial resources to promote resilience and preserve longevity.

Resilience in Death and Dying: Is There a "Good Death"?

End-of-life care for older adults frequently presents challenges because the pervasive suffering of those who die from incurable illnesses is often characterized by profound psychosocial and spiritual crises that may manifest

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as depression, heightened anxiety, and hopelessness (Grassi, Malacarne, Maestri, & Ramelli 1997; Hopwood & Stephens 2000; Loge, Abrahamsen, Ekeberg, & Kaasa 2000; Mraz & Runco 1994; Pollock & Williams 1998). Terminal care, as it is conceived and practiced, emerged as a visible social issue in the final quarter of the last century. For the majority of Western-trained providers in healthcare settings, the suffering and pain of dying older adults drives a problem-focused approach to death and dying. Elisabeth Kübler-Ross's (1969) development of a stage theory about people's adjustment to dying, described in her renowned book *On Death and Dying*, made a great contribution and raised awareness about this issue. Her theory laid the groundwork for the idea that human development and insight can grow as people work through difficult feelings and situational challenges associated with dying, although several studies have since indicated that the details of her stage theory were not supported by empirical evidence.

Despite the benefits of medical approaches to life prolongation and symptom relief, addressing psychosocial and spiritual care at the end of life solely from a medical point of view limits the potential for helping. The limitation is due to the traditional focus on human shortcomings instead of on trying to discover what people can achieve. Recently, researchers in gerontology have begun to coalesce around the need to adopt a more holistic conceptual framework (Sulmasy 2002). This interest expands the current prevailing negative conceptualization of aging, death, and dying that is centered on coping and adapting to losses and grief in old age.

This recent research synthesizes emerging trends in terminal care and gerontology that view human beings as capable of more than coping and adaptation. In death and dying studies, some writers have found that people can find profound support in spirituality to heal and grow during serious and terminal illnesses (Canda & Furman 1999; Reese 2001; Smith 1995, 2001; Wilber 1991). To advance the cause of optimal aging, some gerontologists have moved away from a stance of pathology and prevention through the development of enhancement research (Mackenzie, Rajagopal, Meibohm, & Lavizzo-Mourey 2000; Miller 1991; Ryff & Essex 1992; Ryff & Singer 1996; Seeman, McEwen, Rowe, & Singer 2001; Wong & Watt 1991). These scholars and clinicians honor people's resiliency and urge us embrace a more affirming and hopeful notion of dying in old age. This stance represents a major shift in intensity, away from the current paradigm that is preoccupied with deficits and pathology.

Nakashima and Canda (2005) reported that resilient older adults in a hospice setting did not deny or unrealistically portray their suffering or

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dying. They experienced many losses and grief issues of differing natures and magnitudes, suggesting that good quality of life at the end of life is not necessarily dependent on the absence of problems. Individual resilience coexisted with the ability to proactively approach death and the dying process. A close association was found between a high level of quality of life in the psychosocial and spiritual dimensions and personal growth and healing. Preparation for such a positive end-of-life experience cannot be accomplished without fostering resilience factors over the years.

Among the barriers to better coping with death and dying include a lack of resources for care, conflicts in relationships, long-standing mental illnesses, and similar stumbling blocks. In contrast, protective factors in facing mortality include an open awareness of the universality of death and an affirmative outlook on dying. Such positive qualities are often attained through personal experiences with death and dying, as well as through spiritual beliefs (Nakashima & Canda 2005).

Resilience in Caregiver Stress and Depression

Studies of caregiver stress have supported the dominant view of the diathesis stress model emphasizing stress-induced mental illness, particularly in the presence of a neurobiological or genetic vulnerability. Stressful life events are robust predictors of the onset or recurrence of a variety of neuropsychiatric disorders. Different types of stress—acute stress, chronic stress, early childhood trauma—may differentially influence the type and severity of a neurocognitive or neuropsychiatric disorder. A disorder may develop with age, or the stress may increase the risk of developing comorbid medical and psychiatric conditions.

The relationship of adverse experiences to the onset of illnesses in special populations (e.g., caregivers) has provided epidemiological estimates of the rates of subsequent psychiatric disorders following exposure to stress. In the case of family dementia caregivers, the prevalence and incidence of depression are estimated to be 50%, which means that at any given time, 50% of dementia caregivers can be diagnosed with clinical depression but another 50% are not depressed (Lavretsky 2005). Both acute and chronic stressors increase the risk that older adults will experience depression, declining resilience, and compromised quality of life.

Stress among family caregivers taking care of their relatives with dementia has been a recognized chronic-stress model resulting in high levels of depression, anxiety, and mortality (Lavretsky 2005). The majority of dementia caregivers are elderly women. These caregivers are twice as likely to

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report physical strain and high levels of emotional stress as a direct result of their caregiving responsibilities. Caregiver burden and depression are related to the severity of the patient's dementia, disability, and behavioral disturbances. As a result of impaired resilience to stress with advancing age, an increased allostatic load and reduced tolerance to stress may result in cardiovascular disease and declines in health and quality of life. In a longitudinal cohort study of 400 older spousal caregivers, caregivers who experienced mental or emotional strain related to caregiving had mortality risks 63% higher than noncaregiving controls (Lavretsky 2005).

Pinquart and Sorensen (2006) integrated findings from 84 articles on differences between caregivers and noncaregivers on perceived stress, depression, self-efficacy, general subjective well-being, and physical health. The largest differences were found with regard to the first four of these, whereas differences in the levels of physical health in favor of noncaregivers were statistically significant but relatively small. However, larger differences were found between dementia caregivers and noncaregivers than between heterogeneous samples of caregivers and noncaregivers.

Bereavement can further fuel caregiver depression. Aneshensel, Botticello, and Yamamoto-Mitani (2004) describe trajectories of evolving depressive symptoms among caregivers following bereavement. Aneshensel, Pearlin, and Schuler (1993) connect these trajectories to earlier features of caregiving using life-course and stress-process theory in a six-wave longitudinal survey of spouses and adult children caring for patients with Alzheimer's disease. Of the four trajectories identified, three represent stable symptom levels over time, with two-thirds of the surveyed caregivers being repeatedly symptomatic (medium symptom levels), compared to two smaller groups of repeatedly asymptomatic (effectively absent of symptoms) and repeatedly distressed (severe symptoms) caregivers. According to the findings, caregivers with few symptoms before bereavement tended to maintain these states afterward, but emotionally distressed caregivers tended to become more distressed. Role overload before bereavement substantially increased the odds of following an unfavorable trajectory afterward, whereas self-esteem and socioemotional support played protective roles. These findings suggest that an intervention during caregiving may facilitate more positive adaptation following the death of a loved one.

The nature of psychiatric symptoms that develop as a result of stress exposure most often depends on the individual predisposition, severity and nature of stressors, and duration of exposure. However, knowledge concerning the temporal relationship between adverse experiences and the onset of anxiety and depressive disorders remains sparse despite the awareness that

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life stress forms a pivotal component to social, neurological, and cognitive scientific models of their etiology. Analyses show clear evidence of progressive decay in the adverse effects of life events over time. The time until recovery depends on other vulnerability and resilience factors, such as coping and personality styles, prior history of depression, and anxiety (Surtees & Wainwright 1999). Developing preventive interventions for mood and anxiety disorders in these high-risk groups should take into account relevant vulnerability and resilience factors in developing interventions that would boost their resilience to stress.

Major and Nonmajor Depression: A Continuum of Vulnerability

Older adults commonly experience depressive disorders in the form of major and minor depression, as well as transient depressive reactions to stress. Despite a lower severity of depressive symptoms, from a population perspective the overall burden is greater for those with minor depression than it is for those with major depression. Although minor depression represents a time-limited condition in some people, others experience it on a continuum toward more severe and persistent states. However, individuals with minor depression may become "at risk" for chronic or major depression, particularly around adverse life events such as bereavement or caregiving.

In the absence of intervention studies, clinicians are limited in the availability of guidelines to support their decisions about using antidepressants rather than psychosocial treatments, or using "watchful waiting" strategies in the treatment of minor depression. Age-appropriate psychotherapeutic approaches (e.g., cognitive-behavioral, interpersonal, or problem-solving) involving major and nonmajor types of depression have been developed since the early 2000s. In clinical practice, antidepressants are being prescribed for patients with significant levels of depression and functional impairment regardless of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) categorical diagnosis. For individuals with major or nonmajor depression, the question of predicting who is more likely to require active psychotherapeutic or pharmacological intervention is especially important.

In our recent studies involving caregiver depression, my colleagues and I established both that antidepressant drugs can be helpful in building resilience to stress and depression and that yoga and meditation can reduce caregiver burden and improve coping. Accordingly, psychotherapeutic and mind-body approaches (e.g., meditation, yoga, tai chi) can be tried prior to

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instituting pharmacological therapies (Lavretsky et al. 2011). It would be beneficial to develop preventive interventions for high-risk groups based on the available empirical knowledge of these and other protective factors (e.g., increased social support, resilience training, and so on).

Optimism as a Protective Factor in Late Life

As mentioned in chapter 2, research now supports the long-held folk belief that positive emotions are good for health. Robust evidence demonstrates that the stress process includes positive and negative emotions (Edwards & Cooper 1988). Previously, a revision of stress and coping theory incorporated these positive aspects of stress. "Coping" can be defined as efforts to prevent or reduce the negative impact of stress on individual well-being (Edwards & Cooper 1988). The paradigm offered by the broaden-and-build theory of positive emotions outlines the part positive emotions can play in coping and in related psychological and physical well-being, even during stressful times. Lazarus, Kanner, and Folkam (1980) long ago described hope and optimism as contributors to overall successful coping. Now we are also finding that successful aging is associated with a positive psychological outlook in later years, along with general well-being and happiness (Depp & Jeste 2006; Peel, McClure, & Bartlett 2005; Vaillant 2002).

So we see that the drive to seek personal happiness and fulfillment is inherent regardless of age (Lazarus et al. 1980). With populations aging globally, many nations are developing and implementing healthy aging policies designed to promote *quality* of life in addition to extending the number of years of health (Peel et al. 2005). One such approach is to implement interventions that boost resilience to stress in older adults.

A recognizable pattern has emerged of individual characteristics associated with resilience and successful adaptation. Salient characteristics include commitment, dynamism, humor in the face of adversity, patience, optimism, faith, and altruism (Lavretsky & Irwin 2007). Certain emotional and cognitive aspects of resilience are innate or can be learned. The innate affective or emotional styles of an individual that are likely to influence resilience refer to styles of affect regulation, which are usually a part of personality structure (e.g., optimism, pessimism, social intelligence). Protective factors relating to an individual's temperament include sociability, intelligence, social competence, internal locus of control, warmth and closeness of emotional ties, and active emotional support within the family network or within religious groups. As such, resilience may represent an

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important target of treatment and prevention for anxiety, depression, and abnormal stress reactions in aging. The question remains whether or not resilience can be taught to older individuals coping with daily stress to boost their coping response to stress and life's adversities.

Resilient Outcomes and Preventive Interventions

What would be the outcome of developing preventive interventions in the earlier-discussed specific stressful situations? For those still free of chronic disease, the continued absence (i.e., prevention) of any disease should be considered an ideal outcome in the general population, as well as in the at-risk population (e.g., caregivers at risk for depression). In populations with established disease, an example of a resilient outcome would be successful coping with the disease. Of course, it is impossible to prevent death and dying in the elderly, as these represent a universal phase of the life cycle. Therefore, the emphasis in older-age populations, especially in hospice and palliative care settings, should be on developing successful coping and resilience. In particular, hospice and palliative care settings could involve spiritual care, life review, and acceptance as therapeutic approaches. Some of these interventions may cause tension in the defiance-surrender attitudes toward death by creating meaningful narratives of living and dying (Nakashima & Canda 2005). Finally, secondary and tertiary preventive interventions in those with mood disorders should focus on preventing relapses and recurrences of mood disorders.

Prevention of late-life depression affects the entire population of older people. Public awareness campaigns have been launched in many countries. Cuijpers (2003) has asserted that even in a disorder like depression, which has quite a high incidence, studies testing the effects of universal prevention are unlikely to be feasible. One way to prepare the public would be to mount educational campaigns to teach that depression is a disorder that can be successfully treated and, if left untreated, can lead to chronic mental and medical illness and premature mortality. Given the rapid technological advances and widespread access to electronic media among older people, "e-health" preventive interventions for older people are being developed. These may shift action toward much more widespread prevention. While it is feasible to launch universal preventive programs aiming to prevent depression, current methods of research do not allow rigorous testing of their effects.

An interesting example of public health significance of building public resilience is the global need to cope with climate change and extreme weather

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events, including heat waves, drought, wildfire, cyclones, and heavy precipitation that could cause floods and landslides. Such events create significant public health needs that can exceed local and individual capacity to respond, resulting in excess morbidity or mortality and in the declaration of disasters. Human vulnerability to any disaster is a complex phenomenon with social, economic, health, and cultural dimensions. Enhancing individual capacity to cope with or recover from disaster consequences has become an obvious imperative for local governments and healthcare providers. Vulnerability reduction programs reduce susceptibility and increase resilience. Susceptibility to disasters is reduced largely by prevention and mitigation of emergencies. Emergency preparedness and response and recovery activities—including those that address climate change—increase disaster resilience. Because adaptation must occur at the community level, local public health agencies are uniquely placed to build human resilience to climate-related disasters (Keim 2008), and the use of social media can facilitate this process (Keim & Noji 2011).

Conclusion

I have reviewed the common stressors of later life that typically test individual vulnerability and resilience and may lead to depression or disability. Examples of high risk groups are older people with chronic disease, those who have lost spouses, caregivers, and those who have a prior history of depression. Selective prevention aims to reach older people who are exposed to known risk factors for depression. Several tested interventions are available. They usually involve identifying those at risk and engaging them in the intervention. However, engaging older people who are currently not depressed in an intervention is not easy. Prevention on the societal level would involve education of the general population about mental health and risks for illness. Some helpful preventive interventions in cases of natural disasters or mass-traumatic experiences would resemble self-help versions of cognitive therapy, interpersonal therapy, reminiscence, and problem-solving. Often these are modified to cater to people exposed to specific risk factors and circumstances. Other intervention components involve engaging in pleasant activities, physical activity, and using nutritional supplements. Although these do not target resilience itself, the prevention of disease is an important example of a resilient outcome. Future research should include measures of psychological and cognitive resilience in older adults along with other lifestyle factors subject to examination.

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Clinical Case

Mrs. A. first came to see me following the suicide of her eldest son, an aspiring jazz musician who killed himself at the age of 45. She was 84 years old and also dealing with losing her vision to macular degeneration, increasing arthritis, and becoming more dependent on her husband of 50 years. She was legally blind and attended Braille Institute in Los Angeles. She was depressed and grieving her loss, and she contemplated whether to keep her son's musical instruments because they reminded her so much of him.

Over the course of the following year, she responded nicely to a low-dose antidepressant and bereavement counseling. Some closure to her grief occurred during a jazz concert in her son's memory that his friends put together at a New York jazz club. It gave her some solace to know that his presence was cherished by so many. She decided to donate his musical instruments to his alma mater school of music. At the same time, she found more relief in her own creative endeavors, which included gardening and, of all things, silk painting. To my surprise, this almost blind woman was able to create the most colorful and poetic silk scarfs and paintings. She either exhibited them, including at the Braille Institute, or sold them online or gave them to friends. Although the lines of the drawings were not well defined, the colors of her creations were vibrant and alive.

She overcame the worst within two years of counseling and treatment, and tapered off her antidepressant. She continued to draw pleasure from her paintings, despite her increasing vision loss, and from gardening, limited by her worsening arthritis. I always admired her gentle, sensitive, but resilient soul that refused to succumb to any of the challenges and was constantly beating the odds. Her spirituality also played a role in her recovery; she received some counseling from her rabbi and used Bible reading as a tool to maintain balance in life by maintaining gratitude for what she had been given. Her example was truly inspiring, and I frequently use it in lecturing about resilience.

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References

Aneshensel, C. S., Botticello, A. L., Yamamoto-Mitani, N. (2004) When caregiving ends: The course of depressive symptoms after bereavement. *J Health Soc Behav,* 45(4), 422–40.

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AN: 778035 ; Lavretsky, Helen.; Resilience and Aging : Research and Practice
Account: s4798919

Aneshensel, C. S., Pearlin, L. I., & Schuler, R. H. (1993). Stress, role captivity, and the cessation of caregiving. *J Health Soc Behav, 34*(1), 54–70.

Bradley, J. M., & Cafferty, T. P. (2001). Attachment among older adults: Current issues and directions for future research. *Attach Hum Dev, 3*(2), 200–221.

Canda, E. R., & Furman, L. D. (1999). *Spiritual diversity in social work practice: The heart of helping*. New York: Free Press.

Cuijpers, P. (2003). Examining the effects of prevention programs on the incidence of new cases of mental disorders: the lack of statistical power. *Am J Psychiatry, 160*(8), 1385–91.

Depp, C. A., & Jeste, D. V. (2006). Definitions and predictors of successful aging: A comprehensive review of larger quantitative studies. *Am J Geriatr Psychiatry, 14*(1), 6–20.

Edwards, J. R., & Cooper, C. L. (1988). The impacts of positive psychological states on physical health: A review and theoretical framework. *Soc Sci Med,* 27(12), 1447–59.

Fricchione, G. L. (2011). *Compassion and healing in medicine and society: On the nature and use of attachment solutions to separation challenges*. Baltimore: John Hopkins University Press.

Friedman, H. S., & Booth-Kewley, S. (1987). The "disease-prone personality." A meta-analytic view of the construct. *Am Psychol,* 42(6), 539–55.

Fry, P. S., & Debats, D. L. (2010). Sources of human life strength, resilience, and health. In P. S. Fry & C. L. Keyes (Eds.), *New frontiers in resilient aging* (pp. 15–59). New York: Cambridge University Press.

Granqvist, P., & Hagekull, B. (2000). Religiosity, adult attachment, and "why singles are more religious." *Int J Psychol Relig, 10*, 111–23.

Grassi, L., Malacarne, P., Maestri, A., & Ramelli, E. (1997). Depression, psychosocial variables, and occurrence of life events among patients with cancer. *J Affect Disord,* 44(1), 21–30.

Hopwood, P., & Stephens, R. J. (2000). Depression in patients with lung cancer: Prevalence and risk factors derived from quality-of-life data. *J Clin Oncol, 18*(4), 893–903.

Keim, M. E. (2008). Building human resilience: The role of public health preparedness and response as an adaptation to climate change. *Am J Prev Med, 35*(5), 508–16.

Keim, M. E., & Noji, E. (2011). Emergent use of social media: A new age of opportunity for disaster resilience. *Am J Disaster Med,* 6(1), 47–54.

Kern, M. L., & Freidman, H. S. (2010). Why do some people thrive while others succumb to disease and stagnation? Personality, social relations, and resilience. In P. S. Fry & C. L. Keyes (Eds.), *New Frontiers in Resilient Aging* (pp. 162–84). New York: Cambridge University Press.

Kübler-Ross, E. (1969). *On death and dying*. New York: Macmillan.

Lavretsky, H. (2005). Stress and depression in informal dementia caregivers. *Health and Aging, 1*(1), 117–33.

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Lavretsky, H., Alstein, L. L., Olmstead, R. E., Ercoli, L. M., Riparetti-Brown, M., St Cyr, N., & Irwin, M. R. (2011). Complementary use of tai chi chih augments escitalopram treatment of geriatric depression: A randomized controlled trial. *Am J Geriatr Psychiatry, 19*(10), 839–50.

Lavretsky, H., & Irwin, M. R. (2007). Resilience and aging. *Aging Health, 3*(3) 309–23.

Lazarus, R. S., Kanner, A. D., & Folkam, S. (1980). Emotions: A cognitive phenomenological analysis. In R. Plutchik and H. Kellerman (Eds.), *Emotion theory, research, and experience* (pp. 189–217). New York: Academic Press.

Loge, J. H., Abrahamsen, A. F., Ekeberg, & Kaasa, S. (2000). Fatigue and psychiatric morbidity among Hodgkin's disease survivors. *J Pain Symptom Manage, 19*(2), 91–99.

Mackenzie, E. R., Rajagopal, D. E., Meibohm, M., & Lavizzo-Mourey, R. (2000). Spiritual support and psychological well-being: Older adults' perceptions of the religion and health connection. *Altern Ther Health Med, 6*(6), 37–45.

Miller, M. P. (1991). Factors promoting wellness in the aged person: An ethnographic study. *ANS Adv Nurs Sci, 13*(4), 38–51.

Mraz, W., & Runco, M. A. (1994). Suicide ideation and creative problem solving. *Suicide Life Threat Behav, 24*(1), 38–47.

Nakashima, M., & Canda, E. R. (2005). Positive dying and resiliency in later life: A qualitative study. *J Aging Stud, 19*(1), 109–25.

Peel, N. M., McClure, R. J., & Bartlett, H. P. (2005). Behavioral determinants of healthy aging. *Am J Prev Med, 28*(3), 298–304.

Pinquart, M., & Sorensen, S. (2006). Helping caregivers of persons with dementia: Which interventions work and how large are their effects? *Int Psychogeriatr, 18*(4), 577–95.

Pollock, L. R., & Williams, J. M. (1998). Problem solving and suicidal behavior. *Suicide Life Threat Behav, 28*(4), 375–87.

Reese, D. J. (2001). Addressing spirituality in hospice: Current practices and a proposed role for transpersonal social work. *Journal of Religion & Spirituality in Social Work: Social Thought, 20*(1–2), 135–61. doi: 10.1080/15426432.2001.9960285

Ryff, C. D., & Essex, M. J. (1992). The interpretation of life experience and well-being: The sample case of relocation. *Psychol Aging, 7*(4), 507–17.

Ryff, C. D., & Singer, B. (1996). Psychological well-being: Meaning, measurement, and implications for psychotherapy research. *Psychother Psychosom, 65*(1), 14–23.

Seeman, T. E., McEwen, B. S., Rowe, J. W., & Singer, B. H. (2001). Allostatic load as a marker of cumulative biological risk: MacArthur studies of successful aging. *Proc Natl Acad Sci U S A, 98*(8), 4770–75.

Smith, E. D. (1995). Addressing the psychospiritual distress of death as reality: A transpersonal approach. *Soc Work, 40*(3), 402–13.

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Smith, E. D. (2001). Alleviating suffering in the face of death. *Social Thought, 20*(1–2), 45–61. doi: 10.1300/J131v20n01_04.

Sulmasy, D. P. (2002). A biopsychosocial-spiritual model for the care of patients at the end of life. *Gerontologist, 42*(suppl 3), 24–33. doi: 10.1093/geront/42.suppl_3.24.

Surtees, P. G., & Wainwright, N. W. (1999). Surviving adversity: Event decay, vulnerability, and the onset of anxiety and depressive disorder. *Eur Arch Psychiatry Clin Neurosci, 249*(2), 86–95.

Vaillant, G. E. (2002). Aging well: Surprising guideposts to a happier life from the landmark Harvard study of adult development. Boston: Little, Brown.

Wilber, K. (1991). *Grace and grit*. Boston: Shambhala.

Wong, P. T., & Watt, L. M. (1991). What types of reminiscence are associated with successful aging? *Psychol Aging, 6*(2), 272–79.

World Health Organization (2002). The world health report 2002: Reducing risks, promoting healthy life. www.who.int/whr/2002.

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