Resilience in Retirement

Donald H. Meichenbaum, PhD

Research Director, The Melissa Institute for Violence Prevention and Treatment
Distinguished Professor Emeritus, University of Waterloo

CURAC 2024 National Conference
University of Waterloo
May 24, 2024

Dr. Donald Meichenbaum is one of the world's leading experts on psychotherapy and cognitive-behavioral therapy (CBT). In addition to co-founding cognitive-behavioural therapy, he is a leader in the treatment and prevention of post-traumatic stress disorder. As a clinician and researcher, he has treated all age groups for traumas suffered from violence, abuse, accidents, and illness. His innovative approach has become a cornerstone of trauma therapy.

Dr. Meichenbaum's book, C*ognitive Behavior Modification: An Integrative Approach,* is considered a classic in the field of CBT. His popular publication *Roadmap to Resilience,* which offers manageable strategies for building and maintaining resilience, has been downloaded, at no charge, by more than 45,000 people in 138 countries.

For more information about Dr. Meichenbaum's presentations, visit The Melissa Institute for Violence Prevention and Treatment.

https://melissainstitute.org/scientific-articles/meichenbaum-d/

TABLE OF CONTENTS

THE NATURE OF THE CHALLENGE

At present, there are approximately 37 million people aged 65 years and over, in the USA, accounting for 12% of the total population.

By the year 2030, the number of individuals aged 65 years and over in the U.S. is expected to nearly double to 71.5 million, accounting for approximately 20% of the U.S. population.

Older adults (65+) experience a number of changes in life circumstances. These age-associated events include changes in:

a) physical appearance and body composition;

b) increasing likelihood of chronic health conditions (approximately 80% of older adults have at least one chronic health condition);

c) functional limitations such as decreased stamina and mobility, diminished sensory capacities, an increasing dependence on the assistance of others;

d) numerous losses and stressors such as having to live on a fixed income; increasing medical expenses, relocation;

e) alterations in social position, changes in work;

f) death of family members, friends and loss of social networks, experience loneliness and social isolation;

g) caregiving of spouse or living parents;

h) widowhood.

Many of these stressful events may co-occur or pile up. Consider the New York Times (March 21, 2015) description of the Florida resident Teresa Mears who had to deal with her partner's death, helping to care for a mother with Alzheimer's, the loss of a steady job and the loss of her house. What is impressive about Teresa is the level of resilience and her coping ability in spite of these cumulative life changing events. As the adage states: "Life is flux."

In spite of the increasing number of physical, financial, and psychosocial adversities, the vast majority of people (like Teresa) age well and evidence resilience. They evidence the ability to resist the negative impact of adversities and even "flourish" and achieve happiness, well-being and have a satisfactorily and good quality of life. In fact, overall, the diagnosis of psychological disorders declines with age. Although, subsyndromal levels of depression and anxiety do occur.

Epidemiological studies indicate that only some 13% of those aged 65 and over meet criteria for a mental disorder other than dementia (Elmore et al., 2011).

(1) What distinguishes “resilient” elderly individuals from the non-resilient elderly?

(2) What are risk and protective factors that predict successful aging and longevity? What are the building blocks of resilience?

(3) How can resilience be nurtured in the elderly? Moreover, how do such interventions have to be tailored in an age-appropriate fashion?

(4) What are the implications of these research findings for prevention, clinical applications, and public policies?

(5) Many people can maintain healthy and fulfilling lives into old age. How do they do this?

ASSESS FOR RESILIENCE

Self-report Measures

Connor-Davidson Resilience Scale	Connor and Davidson, 2003
Quality of Life Measure (CASP-19)	Hyde et al., 2003
Post-Traumatic Growth Inventory	Tedeshi & Calhoun, 2004

Use of Clinical Interview

Possible Interview Questions

> ***"How often do you feel you have too little money to spend on what you feel your needs are?"***
> ***((1) Never to (5) Most of the time)***
>
> ***"How much can you rely on others if you have a serious problem?"***
> ***"Who would you ask for help?"***
> ***"Have you done so in the past?"***
> ***"How did they help?"***
>
> ***(Give examples of Emotional, Practical and Informative Supports)***
>
> ***"How much can you open up to them, if you need to talk about your worries?"***
>
> ***"What are your chances that you will live to be (present age plus 10 years), or more?"***
> ***(The expectation to survive the next 10 years, predicts longevity.)***

Behavioral Indicators of Resilience

Life-space Activity (**LSA**) measure - - a measure of the extent and frequency of movement outside of one's home. The longer the LSA measure, the longer one lives. (Mackey et al., 2014).

In addition, a number of other mobility measures and physical capacity measures have been used that relate to level of resilience. For example, the ability to perform transitions (getting up from a chair after seated for long periods; climbing a flight of stairs; higher hand grip strength; and the like).

Measures of Activity of Daily Living (ADL) - - Ability to perform self-care behaviors (hygiene, dressing), cooking, cleaning, finances and the like, independently or with minor assistance ("Budding Skills").

Assess the level of functioning by conducting an Ecological Assessment of living environment.

Assess for list of medications and medical compliance behaviors (Stop smoking, drink with moderation, safe sex practices, consult with a doctor, when indicated).

Assess for sleep behavior, nutrition.

Assess for Social Network - - contact and support from others (Emotional, Practical, and Informational supports). Determine the nature and frequency of social supports, other than family members. Determine use of computer and other technologies (Internet, Texts, Skype, Instagram, Facebook, etc.) to maintain social contacts.

Assess for presence of pets – especially walking the dog.

Cognitive functioning, especially memory functioning (short and long-term); Evidence of executive functioning skill of planning, problem solving, etc. Also, assess for ruminations, regrets, inattentiveness, impulsivity, irritability.

Emotional regulation – presence of subsyndromal anxiety and depression; prolonged and complicated grief disorder; hostility, anger; tolerance for distress and emotion-regulation coping skills (relaxation, acceptance, mindfulness, meditation).

Use Time Lines to assess for the history of resilience, engendering behaviors. These Time Lines are used as an assessment procedure:

Time Line 1 tracks with the client, from birth to the present time, the history of traumatic victimization and loss experiences, and any specific forms of intervention that were implicated when and for how long. This is an attempt to "walk in the client's shoes" and to provide a form of a Life Review process, in order to document all of the risk exposure events the client has experienced.

Time Line 2 is an attempt to review the same time period (birth to the present), but in this instance is designed to denote all examples of resilience-engendering behaviors. What has the client done and accomplished in spite of Time Line 1 stressful events? What examples of "strengths", "islands of competence", evidence of "survival skills" and "resilience" has the client been able to accomplish?

This discussion may also include any evidence from previous generations (the client's forefathers), that have been intergenerationally transmitted.

Ask "HOW" and "WHAT" questions about various ways that the client was able to develop and use strengths-based behaviors, often with the assistance of others. Check on the client's use of his/her faith.

Time Line 3 tracks the present and projects into the future. The clinician can ask the following questions:

> ***"Let me explain what I do for a living. I work with folks, like yourself. I try to find out how things are right now in your life and how you would like things to be improved or changed?"***
>
> ***"What have you tried in the past to accomplish these behavioral objectives/goals? What have you tried? What, if anything, has worked, as evident by…?"***
>
> ***"If we worked together, and I hope we can, then where should we begin? How would we know if what you are trying worked? What would other people notice and see changed in you and your situation?"***
>
> ***"Let me ask one last question, if I may. Can you foresee, envision any potential barriers, obstacles (either external or internal warning signs) that might get in the way? How can we anticipate and address these barriers, ahead of time, so you do not get blind-sided, should they occur?"***

KEYS TO AGING WELL: BUILDING BLOCKS FOR RESILIENCE

We will consider how to bolster fitness and resilience in SIX areas -- physical, interpersonal, emotional, cognitive , behavioral and spiritual.

The Role of Physical Fitness

(***See http://www.evanshealthlab.com/23-and-12-hours/***)

Physical activity has a very positive benefit on the health of older adults.

The greater one's life space (a measure of the extent and frequency of movement outside of one's home) the lower the rate of mortality (Mackey et al., 2014).

Some 80% of seniors (65+ years) do not meet the National physical activity standard of 150 minutes per week of moderate-to-vigorous physical activity (e.g., brisk walking).

Individuals who spend six hours per day watching television live on average five years less, as a result of developing chronic diseases.

The use of Pedometers that count the number of steps taken, have been found to increase physical activity when tied into individualized step goals.

Internet-delivered behavioral interventions have been used to increase physical activity. These programs usually involve several modules that include:

a) How to get started that discuss the benefits of physical activity and instructions on self-monitoring using pedometers that count the number of steps taken and ways to increase overall physical activity in one's daily life;

b) Planning for success that includes how to establish individualized goals and ratings of self-efficacy and confidence and the offering by the client of self-generated reasons for increasing physical activity. Set up a step count goal and monitor progress using a Goal Tracker program;

c) Beating the odds which examines the potential barriers and strategies for overcoming such barriers, as well as ways to develop social supports.

d) Sticking with it ways to maintain an active life-style and engaging in relapse prevention exercises.

These programs are supplemented with personal coaching where a positive supportive therapeutic alliance is critical in helping seniors develop a physically active lifestyle to the fullest extent possible (See Dlugonski et al., 2012; Tudor-Locke et al., 2011; Vandelanotte et al., 2007).

There is also a need to consider the REASONS seniors offer for not engaging in more physical activities. These Reasons fall into three categories, each requiring individually-tailored interventions.

Consider the barriers or reasons why seniors do not engage in physical activities.

Type I- Reasons that question the data on the relationship between physical activity (exercise) and the health benefits. Seniors may offer counter-examples.

Type II –Reasons that highlight barriers and fears. Cons outweigh the pros of exercising. Fear of falling, hurting oneself and being victimized.

Type III – Reasons that are personological and tied to belief system. Fatalistic beliefs, stubbornness, not wanting to be told what to do, reminder of limitations, and the like.

In addition to enhancing one's Life Space and becoming more physically active, there is a need to ensure that the senior's basic health related needs are being met (such as nutrition, sleep, adherence to prescribed medication, safe sex practices, regular medical and dental check-ups). There is a need to encourage and challenge clients to be as independent and active as much as possible.

Interpersonal Fitness

Social engagement with others outside of family members

Sense of belonging and social connectedness with others

Learn to ask for help

Help others, make a "gift" of one's experiences (volunteer work, altruistic activities)

Maintain social conduct with others using computer technology (Skype, Text, Email, Facebook, etc.)

Have a spouse who can act as a "Metacognitive Prosthetic Device (MPD) or as a "Surrogate Frontal Lobe (SFL), in a supportive manner. ("***Uh Oh***" example)

Able to engage in a therapeutic alliance

Keep in mind important gender differences in women versus men in the ways that they employ social support. Women are more likely to engage in and benefit from social relationships with other women, whereas men are more satisfied with solitary activities.

Emotional Fitness

Learn to bolster emotion regulation and distress tolerance skills.

Use acceptance strategies - - acknowledging that you are an older person with limitations, get on with things, rather than dwell (ruminate) and harbor regrets.

Memorialize those you have lost - -use restorative restorying.

Nurture hope by engaging in collaborative goal setting (short-term, intermediate and long-term realistic and practical objectives).

Face fears and not engage in avoidance behaviors, nor magnifying one's fears.

Identify and label emotions. "Name them in order to tame them."

Learn to "talk back to the amygdala." Do not allow your emotions to "hijack" your thinking part of your brain (frontal lobe executive processes).

Increase positive emotions ("bucket list activities").

Build and broaden positive emotions of optimism, curiosity, empathy, forgiveness, gratitude.

Educate about what the experience of positive emotions does to the brain and body.

Cognitive Fitness

Hold a belief that one can learn and grow, no matter what your age.

Hold beliefs that life has a purpose and has meaning.

Engage in "generativity" behaviors of wanting to contribute to future generations.

Make a "gift" of one's life experiences and "wisdom" to others. Become a mentor.

Engage in direct action problem-solving coping where indicated for potentially changeable events and use palliative coping acceptance strategies for unchangeable stressors.

Let go of what one knows to be a current reality and embrace new thoughts and behaviors. Let go of what is familiar when it is no longer working.

Conduct life reviews and identify both the positive and negative that come with life shifts.

Bend, bounce back, instead of resisting change.

Recognize that positive outcomes can arise from negative stressful events. Remember, people are not very good at affective forecasting or predicting the future.

Change the "story" you tell yourself and others. Bathe your story telling with "RE" verbs and executive metacognitive "change talk" (see Roadmap to resilience book, pages 127 and 136).

Behavioral Fitness

Maintain a behavioral routine.

Work to **REGAIN** independence.

Work on "Building Skills" that fall in the Zone of Potential Rehabilitation (ZPR) - - not too easy, but not too hard.

Engage in pleasurable activities.

Share your "story", highlighting strengths, survival skills, islands of competence. Be sure to tell the "rest of the story". In spite of behaviors.

Use expressive forms of disclosure (art, dance, gardening). Participate in group activities to combat isolation, withdrawal.

Volunteer, join clubs, church groups, social activities.

Maintain contact with others via the computer, smart phone and other devices.

Journaling, scrapbooking, and whatever other activities that encourage **RE**-storying, **RE**-authoring your life. Provide examples of your ability to adapt in response to change.

Spiritual Fitness

Use one's faith and religion.

Reflect on your ethnic, racial and cultural examples of intergenerational resilience ("What and how did they survive and flourish?")

If you are a veteran, reflect on evidence of resilience, "Band of Brothers", evidence of courage, live for a purpose.

Identify personal values, a "moral compass", life priorities. ("What is really important and how can you incorporate these values into your life"?)

Use positive religious coping responses.

PSYCHOTHERAPY WITH SENIORS

There is an adage that "***One cannot teach old dogs new tricks***". This does not apply in the case of elderly individuals who have various forms of psychiatric disorders such as depression and anxiety. Research indicates that seniors benefit as much, or even more than middle-aged individuals from cognitive behavior therapies and interpersonal therapies. (Google Psychotherapy with the elderly).

There is a need, however, to adjust psychotherapeutic interventions in an age-appropriate fashion. Here are a few examples of ways to conduct psychotherapy with the Elderly.

1. As in psychotherapy with all age groups, the establishment, maintenance and monitoring of the therapeutic alliance (TA) is critical. Use treatment-outcome feedback on an ongoing basis to assess the quality of the TA.

2. Address any potential therapy-interfering behaviors, practical barriers such as transportation, timing (conduct early morning meetings), consider financial costs, and the like. Consider practical barriers like fatalistic beliefs, level of hopelessness, client's implicit theories about the ability to change, and the like.

3. Be culturally-sensitive and maintain continuity of care.

4. Conduct a risk assessment for suicidal behaviors.

5. Engage in Collaborative goal-setting that nurtures hope in establishing SMART goals - - Specific, Measurable, Attainable, Relevant and Timely behavioral objectives in each specific resilience domains.

6. When conducting sessions use Advance Organizers (provide an overview) of what will be covered in the sessions and why - - how the content relates to the client's specific goals. Use discovery-oriented Socratic questioning and intermittent summaries.

7. Conduct simple psycho-education. Do not lecture the client. Use **CLOCK** Metaphor to educate about the interrelationships between thoughts, feelings and behaviors. The **CLOCK** metaphor entails:

    12 o'clock - - external and internal triggers

3 o'clock - - primary and secondary emotions. Treat emotions as a "commodity". "What did you do with your feelings?"

6 o'clock - -automatic thoughts and images- self-talk….

9 o'clock – behavior (what the client did and resultant consequences)

Convey the notion of a "vicious cycle"- the interdependence of thoughts, feelings, behaviors and resultant consequences. Consider "How the client can break this vicious cycle?" "What has he/she tried <u>in the past</u> to break the cycle?" "What else could the client do to break the cycle and become more resilient?"

8. Teach slowly, build in reminders (Simple Acronyms, use Handouts). Schedule extra sessions, use phone calls, texting, emails as reminders (with the client's permission). Address memory limitations.

9. Build on client's "strengths". Use Time Lines. Reawaken old skills. Build in generalization guidelines and put the client in a "consultative mode" - - explaining, teaching, demonstrating skills. Involve significant others as Metacognitive Prosthetic Devices (MPDs), when available.

10. Tailor skills training in an age-appropriate fashion. For example, conduct relaxation training, but be aware of possible impact of the client's having arthritis. Solicit feedback regularly.

11. When conducting cognitive restructuring procedures, keep in mind the findings that with age, seniors put less effort into remembering negative life events, and are more prone to highlight positive life events (Charles et al., 2003). Life Review interventions that help seniors to attend to "positive" life experiences (Time Line 2 and in spite of behaviors). Seniors often use social comparisons to others to view their situation in a more positive manner (Frieswijk et al., 2004). Also, probe about the notion of "generativity" - - of how the client can make a "gift" of his/her experience and "wisdom" to the next generation and to peers.

12. Build in relapse prevention procedures, self-attribution training ("taking credit" for changes), use the Client Checklist like the Strategies for Coping with Grief.

13. Build in active follow-up, booster sessions. Conduct group-based interventions and nurture a supportive environment to sustain behavioral changes.

14. Have fun with clients.

ADDRESSING DEATH ANXIETY

Irving Yalom who is presently 90 and who recently experienced the death of his wife Marilyn by physician-assisted suicide due to cancer has offered the following observations on ways to address the issue of Death Anxiety.

He observes the following:

A high correlation between the degree of Death Anxiety and the amount of persons' REGRETS about how they lived their lives. Will individuals have any regrets when they come to the end of their lives?

”What can you do so you can begin to change your life so it is regret-free?"

"How can you begin to change your life in such a way?"

"It is never too late to begin."

A form of Reminiscence Therapy can help address these issues.

Finally, as you consider your own aging keep the following in mind:

> ***"A paradox of old age is that older people have a greater sense of well-being than younger ones-- not because they are unreasonably blissful, but because they accept a mixture of happiness and sadness on their level, and leverage this mixture when events come their ways. They waste less time on anger, stress and worry." John Leland "The wisdom of the aged" New York Times Dec. 27, 2015, p.28***