

## Being in Time: The Problem of Hope in Older Adulthood, the Last Developmental Frontier

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*Increased life expectancy is a new phenomenon in human history. With longer life comes new potential for psychological development into our 80s, 90s, and beyond. Yet many people, young and old, fear growing old. Death, looming and inevitable, can shroud the whole period of older adulthood with morbidity. In this paper we will sort out the fears, false beliefs, transferences, and realities of older adulthood that inveigh against hope. A recent psychotherapy session with a 91-year-old woman will be presented. And we will consider the special challenges and opportunities in continuing development in older adulthood—a new frontier in human existence.*

While the first half of life is about expansion, vitality, and development—onward and upward!—the second half of life appears wholly defined by physical decline and overwhelming loss. And then we die. At midlife many feel an urgency about “being in time”—to be, to do. As we proceed into older adulthood, we realize, finally, that we have no ultimate control over our body or our body’s destiny, and fear that we may even lose our mind along the way. Why wouldn’t we dread older adulthood?

The quest of this paper is to investigate how hope and development are possible in older aging. First, in Part I, I will sort out the realities from the false beliefs, fears, and transferences associated with older aging that inveigh against hope. In Part II I will present a recent psychotherapy session with my 91-year-old patient, Anna. Finally, in Part III I will present findings that may surprise the reader: the facts as we know them about what is physically normative and developmentally possible in older adulthood. And, we will take a moment to consider our relationship to time.

A word about semantics. I will not follow the trend and refer to older aging as simply “aging.” At every age, if we are not aging, we are dead. Instead, I will refer to “older aging”—awkward, but differentiating. The term “older adult”

signifies an adult older than middle-aged, which these days extends into the 60s. The word “elderly” is reserved for those people in their late 80s, 90s, and beyond who are physically frail and depleted.

Aging is intimate to each of us. Just as our trajectory through any phase of life is individual and idiosyncratic, so it is with older aging. The following sketch will introduce my patient Anna.

Anna, 91, is long a widow. Her only child, a daughter, predeceased her in a tragic accident a few years ago. Anna began treatment with me six years ago, when she was 85, after the last surviving member of her original family had died. Anna lives with significant physical pain from numerous medical problems: stenosis, osteoporosis, bronchiectasis, and a leaky heart valve. She has lived most of her adult life in fear of recurrent depression. She takes anti-depressants as well as a host of other medications. She walks with difficulty, and when out of her apartment uses a walker. I visit her at home, for a double session once a week; during the period after her daughter suddenly died, she was up to four sessions a week.

What does Anna have to look forward to? What is developmentally possible for her? How can she have hope?

## **PART I: Realities, False Beliefs, and the Decline Model of Older Aging**

There are realities in older aging that make us fearful. Not only do we have to face living on when we survive our beloved spouse, partner, family members, and friends, then they are not there to comfort us, to help us bear our suffering and aloneness, to encourage us to persevere. We also lose our peers and our colleagues, those who remember and knew the world we grew up in. We may have to leave our home, old neighbors, a familiar neighborhood, and move somewhere new. As we gradually lose physical strength and energy, we may become more vulnerable to illness, accidents, and falls. Our sensory abilities may be compromised; impairments in hearing or seeing, or both, affect our sense of orientation to our environment, and our confidence about fitting in and connecting. With body parts or functions faltering or wearing down, we may have to spend more time on physical maintenance, going to doctors; we may have to learn how to move or maneuver our bodies differently. We may have to leave old work roles, or may have to work in a new way, or not work at all. Old anxieties about dependency surface. Bad habits, a lifetime in the making, take their toll. If we gradually lose the mirrors and roles we have relied on that have helped us identify ourselves, we may have trouble seeing and recognizing ourselves.

Also terrifying is the threat of dementia or Alzheimer's disease in ourselves or in our loved ones.

Gerontophobia is defined as fear of what is happening to the self when elderly (Cath, 1980), a fear of aging itself. For many people anticipating older adulthood and old age, often the whole period of life after our 60s and 70s is shrouded in morbidity. I once worked with a woman in her mid-60s who, without being conscious of it, was emotionally and psychologically preparing for death after her retirement: her whole sense of self was bound up in her work and the world of her work. Another woman who started therapy in her 70s was convinced she would succumb to inevitable deterioration and disability in her older aging. Yes, she slowed down and had various discrete impairments—a little loss of hearing, some arthritis—but she was still walking the twenty blocks to my office (in the latter years with a walker) well into her late 80s. Due to fear of aging, and the associated fear of death, older people often overestimate the very slight changes in their capacities, and “the effects of this awareness may be more debilitating than the change itself” (Langer & Rodin, 1980).

Ageism is based on false beliefs, transferences, and projections about old people and old age, and has been called “prejudice against the self” (Karpf, 2015). Ageism is not only deeply personal but is embedded in our culture. Dr. Robert N. Butler, who coined the term “ageism,” has documented and tracked age discrimination, health discrimination, and elder abuse in our country, and has decried the fact that 25% of Americans over 65 live on less than \$38 a day. The majority of medical schools don't teach about older aging and elder care. In psychoanalytic institutes, even in courses on human development, development in the second half of life receives scant attention. Medicare doesn't cover long-term care, a sore need for many older people. Ageism in health care professionals has been dubbed “compassionate ageism”—treating old people as if they are helpless and dependent. Butler has said definitively that we need to think differently about older aging, but the decline or deficit model of aging continues to define for many what old age is all about.

### **The decline model of aging and the denial of age**

So much fodder for stigmatizing and fearing older aging leads many people to a defensive “denial of age,” an attempt to stay young. Denial of age is devastating to one's emotional and physical health, and is partly rooted in the decline model of aging, as well as in some of our deepest fears, especially our fear of death.

In the analytic literature, Freud in 1905 famously declared that older adults were not “educable” due to the decreased elasticity of their mental processes, and he was afraid the mass of material to be dealt with would prolong the treatment indefinitely. Although Freud had changed his views significantly by 1912, and went on to a creative and productive old age himself, and although scores of authors have written about successful analytic treatment of the old and very old, the views Freud initially espoused are still shared by too many of us, young and old alike, and dominate the decline model of aging.

The false belief that older people are “rigid” has rigid staying power, despite authors such as Martin Berezin (1980) who wrote: “Those who are rigid in youth are rigid in old age.... Rigidity is not a function of aging, it is a function of personality structure.” And Jung, speaking of what he called “the wooden man,” wrote:

“Natural life is the nourishing soil of the soul.... Anyone who fails to go along with life remains suspended, stiff, and rigid in midair. That is why so many people get wooden in old age; they look back and cling to the past with a secret fear of death in their hearts” (Whitmont, 1969).

Many still retain the false belief that we lose brain cells, that our brains harden, and we lose intellectual prowess as we become old. Research has shown, however, that the presumed loss of brain cells does not occur in normal aging; in healthy people the brain does not shrink or lose neuroplasticity. Vital new brain connections can continue to develop until the end of life. In fact, it has been found that “older people compensate for deterioration in specific areas of the brain by recruiting additional neural networks in other regions—an increase in so-called neuroplasticity” (Rauch, 2014). In the presence of good-enough physical health and mental activity, intelligence actually increases in most individuals into their 80s and beyond (Nemiroff & Colarusso, 1985).

In her book *Fountain of Age*, Betty Friedan has documented that a lot of our fears and false beliefs about old age initially came from longitudinal studies of institutionalized old men and from values embedded in our culture. For example, diminished estrogen and testosterone production are believed to be responsible for a decline in sexual functioning in the elderly, when actually, more important are individual psychological factors, physical health, medications, substance abuse, cultural attitudes, and the availability of partners. In Japan, where elders are revered, the incidence of memory loss in old people is dramatically less than in the U.S., where we overvalue youth and appearances, and see old people as nonproductive, dependent, over-using

economic resources, passive, and debilitated. Socially speaking, we may rise or fall to expectations.

The decline model also has staying power due to inadequate recognition of older people's psychosocial and socioeconomic status.

“[Isolation], lack of intimate companions, or malnutrition—found in surprising numbers of affluent as well as poor older people and often linked to depression—account for a much greater share of the decline in the immune system of older people than is generally recognized” (Friedan, 1993).

In sum, the decline model over-emphasizes negative aspects of older aging, and completely denies what is the fountain of age—at every age: our being and inner world.

### Depression in older age

Depression is the most prevalent yet most under-recognized condition affecting the health and well-being of older adults, and if left untreated it eventually undermines overall physical and emotional health. An older person might attribute a sense of “slowing down” or gloominess to old age: “I have nothing to look forward to—but I’m old, so what can I expect?” Health care professionals also often dismiss what might be symptoms of depression as “only signs of old age.” Depression in the elderly nearly triples the risk of a stroke; significantly increases the risk of heart attack, alcohol and substance abuse, accidents, and falls; and incalculably increases the risk of suicide. Studies have shown that depression and bereavement affect the immune system more negatively in older people (Friedan, 1993). Dementia and Alzheimer’s disease are also associated with the decline model and terrify young and old alike.

### Illness, fear of dementia, and Alzheimer’s disease

There are characteristic diseases of old age. Currently, among persons over 65, heart disease, cancer, and stroke are the top three. Alzheimer’s disease is the sixth leading cause of death, although Alzheimer’s is notoriously difficult to differentiate from other cognitive impairments such as multi-infarct dementia, a condition caused by a series of strokes affecting the brain. There have been found to be more than 100 conditions with symptoms the same as those of Alzheimer’s, many of them treatable (Beck, 2012). Alzheimer’s can only be definitively diagnosed through an autopsy. In spite of this difficulty of

differential diagnosis, statistics that are touted assume an authoritative air: “1 in 12 adults over age 65 will be afflicted with Alzheimer’s” (Moody, 2006). However, studies show that even though 50% of nursing home residents are diagnosed with some form of dementia, 1 in 4 are found to be misdiagnoses (Friedan, 1993). And only 20% of older adults live in a nursing home. Most experts agree that although Alzheimer’s is a major problem, “its prevalence should not be exaggerated ... [because] the overwhelming majority of older people have no mental impairment at all ... and the capacity for learning and growth in later life remains impressive” (Moody, 2006).

And yet there is clear physical decline, albeit very gradual, for most aging adults. What do we know about what causes this normative decline?

## Senescence

After age 50, a process called senescence begins. “Cells begin to send out false positives. The body’s healing ability falters as excess production of the repair signal leads to persistent inflammation, which is the foundation of heart disease, Alzheimer’s, arthritis, and other chronic maladies associated with the passage of time ... Our bodies wear out because they lose the ability to repair themselves” (Easterbrook, 2014).

Cellular senescence, a subset of the overall phenomenon, is currently being studied by longevity researchers, who are working on slowing aging. The idea is, if the rate of senescence can be slowed then the health span can be increased. The effort to expand the health span of older adulthood is changing from a disease-by-disease approach to an interdisciplinary study of the effects of the passage of time and senescence itself on human aging. Senescence slows us down, at first very gradually, then, as distance from death decreases, more intensely. We tend to think of slowing down negatively.

In Ruth Ozeki’s novel *A Tale for the Time Being*, the teenage narrator describes her 104-year-old grandmother Old Jiko, a Zen Buddhist monk, thus: “Old Jiko is super careful with her time. She does everything really really slowly, even when she’s just sitting on the veranda, looking out at the dragonflies spinning lazily around the garden pond. She says that she does everything really really slowly in order to spread time out so that she’ll have more of it and live longer, and then she laughs so you know she is telling you a joke.”

Slowing down, while associated with the decline model of aging, is also a beneficial process and mode of experiencing, which many try to achieve through meditation, gardening, the arts, and other conscious being-in-the-present practices. When faced with imminent death, our bodies go into a

slowed-down shock, which is very merciful. And while youths race over the mountain in record time, old people take their time and actually experience the mountain every step of the way.

Of course, as Jung mentioned earlier, the fear of death is the shadow that stalks us, not only lurking in fear and denial of older aging, but, as Ernest Becker and others explain, at every stage of our life.

### The fear and denial of death

Human beings have a fear of life and a fear of death, all their lives long, fears that animals are spared. Gregor Zilboorg (1943), among many, avers: "No one is free from the fear of death." As opposed to the morbid interpretation of this fear, the fear of death is, as Zilboorg writes, an expression of the instinct of self-preservation, which functions as a constant drive to maintain life and to master the dangers that threaten life.

Born with the terror of annihilation located in the amygdala part of our brain, we live with a mostly unconscious fear of death that, in our character defenses, we try to manage throughout our development. In the work by Klein, Heimann, Isaacs, and Riviera (1952) on the infant's fear of annihilation,

"there is from the beginning some sense of the organism's being threatened with dissolution and disintegration ... at first entirely physiological, having to do with physical intactness.... Over the course of time, however, the maintenance of integrity, though it never loses its physiological reference, comes to assume primarily ethical-psychological dimensions."

Falling apart—disintegrating—morally or psychologically annihilates our sense of self.

Human beings have a dual nature: symbolic and animal. In our psyche we feel eternal, timeless, like little gods. Freud (1905) famously said "the unconscious does not know death or time: in man's physiochemical, inner organic recesses he feels immortal." But in our animal bodies, we are time-bound: finite, vulnerable, and destructible. Ernest Becker, in *The Denial of Death*, describes "... what seems like an impossible paradox: the ever-present fear of death in the normal biological functioning of our instinct of self-preservation, as well as our utter obliviousness to this fear in our conscious life," which is partly why Sándor Ferenczi declared: "Character traits are secret psychoses."

The denial of death is essential for life. We accomplish this self-preservative denial through repression. As Becker writes, for the well-nourished child who is loved repression of the idea of his own death is made easy ...

"because he is fortified against it in his own very narcissistic vitality... On the most elemental level the organism works actively against its own fragility by seeking to expand and perpetuate itself in living experience; instead of shrinking, it moves toward more life."

Fear of death also extends to belief in immortality, whether through children, good works, art, or faith in a life after death. We can't believe we can be extinguished.

So, what do we know about death to be so afraid of it? Robert Jay Lifton (1976) wrote:

"We can understand the inner idea of death from earliest childhood in terms of three sub-paradigms or polarities. These are: connection versus separation; integrity versus disintegration, and movement versus stasis." In the third mode, "movement versus stasis ... the absence of movement becomes a form of stasis, a deathlike experience closely related to psychic numbing."

It is easy to see how our earliest fears and ideas about death surface and become harder to deny when approaching, or experiencing, old age. And our declining bodies unremittently demand our acceptance of our creatureliness.

As Becker (1973) writes: "When you get a person to emerge into his life, away from his dependencies, his automatic safety in the cloak of someone else's power, what joy can you promise him with the burden of his aloneness?" Typically, we humans "grab at the ego as we would a life preserver, when we face the ocean" (Bouklas, 1997).

Henry Krystal, in *Affect Tolerance*, states:

"...the simple fact remains that every single event of one's life, including dying, presents one with a new combination of affects, which we can learn to handle with grace. For, in the last analysis, what is commonly taken as a fear of calamity, disaster, or even death can be discovered to be the fear of one's own affects."

## Transferences toward old age and older people

Many of the pressures and fears people experience during the second half of life, already mentioned, are also sources of fear and transferences for younger people. When old age is associated with morbidity and death, people have fears about getting old related to Lifton's inner ideas of death: fear of separation and loss; disintegration; stasis. Younger analysts working with older patients bring their own unresolved conflicts about their idealized or weakened parents; their awareness of time running out (Settlage, 1996), a sense of heightened responsibility in reaction to the elderly patient's fragility; or, when the patient is ill, fear of the patient's sudden death. When an older patient uses illness in the service of defense, the analyst may collude with the resistance and resort to one of the pessimistic prejudices about old age (Hinze, 1987). Younger analysts may not know how to offer hope to the elderly person. And analyst and older patient may collude to maintain a parent-child dynamic out of fear of the older person's regressions, or there may be discomfort or anxiety when the patient sees the younger analyst in a parental or an erotic transference. As in any analytic work, "The analyst is both a transference object and a developmental object." (Settlage, 1996); we know that transference resides in the unconscious and is not a function of chronological age. On the whole, "older patients...have fewer problems with younger therapists than the other way around" (Hinze, 1987).

Another common transference reaction is to attribute impairment of mental functioning to organic deterioration rather than to possible anxiety; insufficient sleep or nutrition; fear or dread; suppressed feelings; medication reactions; or possible depression. In our culture, the current generation over age 65 is the most drugged generation in the history of humankind: we over-rely on anti-anxiety and antidepressant medication rather than inquire about an older person's inner life, what might be stressful at that moment. Anna has been taking anti-depressants for over fifty years. Believing it lids her dreaded depression, she's afraid of going off the medication—but this leaves her with a terrible fear of, and reduced access to, her inner life. Anti-depressants in her case support the rule of shame. As her therapy has proceeded, however, she has been very gradually reducing the dosage, and increasing her tolerance of her feelings.

We all function within different timescales (biological, chronological, psychological, as well as in timeless unconscious processes); our chronological age may have little to do with how old we feel at any given moment. When my grandmother moved to a nursing home, she whispered to me confidentially, "Everyone is very nice here, but they're all so old!" Berezin (1980) writes: "Those of us who work with the elderly even forget that there is

an age difference between ourselves and our patients” which I have found to be true for both patient and analyst.

## **PART II: A Recent Psychotherapy Session with 91-Year-Old Anna**

I take my usual seat with Anna in her living-room. I am relieved to see Anna looks much better than she did last week. She has on a purple outfit and refers to it, saying an in-law had given it to her after the car accident (which killed Anna’s daughter Laurie and Laurie’s husband a few years ago). She says she’s so angry at Pat (her niece) for becoming enraged at the in-laws during all the business with the lawyers, because then she could never go to Laurie’s house to retrieve any of her stuff. I don’t say anything; we’ve discussed this many times before. I wait. She adds that she guesses she could have hired a driver then, but at the time she did not have enough money.

Then she remembers she had a dream — “and this bitch was in it!” She tells me that when she was in her 70s, her boss had asked her to expose what “the bitch” — Anna’s co-worker — was doing wrong; he knew there was a problem and knew it wasn’t Anna but her co-worker. I interrupt: Is this the dream?

“No.”

Anna continues, says she had refused her boss, saying, “I’m not a snitch.” But he appealed to her: how else is he going to figure it out, it’s hurting the business. So Anna told him. He confronted the co-worker, who then told him “a bunch of lies” about Anna — who then got laid off. Sometime later she passed the co-worker in the street. Anna nodded at her and, Anna says, “The bitch ignored me! Imagine: she ignored *me!*”

Anna says she eventually went on to work for a married couple — how they screamed at each other, verbally brutalized each other in front of the staff, just awful — and after that Anna decided to retire, she was feeling tired anyhow.

I ask, “So, Anna, what was the dream?”

“The bitch woman was in the dream and I apologized to her. Why would I apologize to her? I wasn’t facing her, but was on her right side — there were kind of floating sharp angles around me made of very thin metal. I was so angry! Why would I apologize to her?”

After establishing that this dream had happened last night, and that Anna did not have any other associations to it, I ask her if anything had made her angry, maybe something that she felt wasn’t fair to her. She thinks of finally getting to go to the theater last Saturday and the elevator being out in her

building. She tells me how, with her friend's help, she had to walk down then back up the six flights of stairs.

She says, "It took me a half hour to get back up—I was exhausted for two days. I thought to myself: I need this shit?"

After exclaiming how impressive it was that she was able to manage the stairs, I say: "You had to work too hard for your night out. And then it made you too tired."

"Yes!"

Then I ask her what happened yesterday.

"Well," she relates, "the elevator still being out I called Susan and told her I couldn't go to chorus. The weather was too cold, too." Then she adds: "But you know, to tell you the truth, I was kind of relieved the elevator was out."

"How come?"

"I was so tired—all this difficulty breathing the last two weeks—heavy chest—had to use the inhaler before you came."

We talk about her difficulty breathing—she hasn't been able to leave the apartment for most of the winter and her lungs are adapting to radiator heat and not getting exercised.

Then I remark, "Gee, Anna, I wonder why you'd need an excuse—the elevator's out—instead of just telling Susan you weren't feeling up to going? Do you know what it'd make you feel to say that?"

She says it would make her very uncomfortable, but isn't sure why. I say how over the past months she has talked about having mixed feelings about going to chorus, because of having difficulty hearing, and also how she hasn't been able to work enough on the material to feel prepared and how vulnerable to shame that makes her feel. So, I ask, is that maybe why she had felt relieved when the elevator was out? She wasn't responsible, it was out of her control? Yes, she agrees, nodding.

I say: "Like the situation with Pat, you had a hard time advocating for what you wanted—to be able to go to Laurie's house. But instead of that being the problem, you blamed Pat."

"That's true," she says, "I could've used my credit card...but you know, it was so soon after the accident, I'm not sure I would've been able to go alone."

"But that's a different problem," I say. "That's not because Pat got enraged and refused to deal with your in-laws."

Anna agrees and we talk about this for a while, not a new subject: her difficulty accepting her dependency needs; her fear of opening her wants and wishes directly.

Then I venture to conjecture: “Maybe this helps us out with your dream. I think maybe you’re the bitch woman, sharp-angled, mean, and critical—toward yourself. And you don’t want to snitch on yourself. That’s maybe why you felt relieved the elevator was out.”

She says, “That feels true, I can see how it connects. And that I dreamed it! That’s amazing! But why was I so angry in the dream?”

“What do you think?”

“Because I felt snubbed by the bitch—yes, ignored! “

“So when you’re critical toward yourself,” I say, “You’re ignoring yourself and you don’t like it! Makes you angry! Does that feel true?”

“Yes, Elissa, you’re killing me!”

(You never want to hear a 91-year-old person say this.) “What do you mean?”

She falls asleep. She wakes up a second or two later and says: “I fell asleep! Why did I fall asleep?”

“Maybe you didn’t like what I was saying.”

She again falls asleep, wakes up: “I did it again!” She seems embarrassed.

“Anna,” I ask, “What are you feeling?”

“After all this time, I’m 91—I’m still dealing with this? Shouldn’t I be over this by now?”

“You’re being critical right now! “

She sighs. “I guess I’m still a perfectionist.”

“Now are you going to be critical about that? Wouldn’t it be a relief to be a mere mortal with clay feet like the rest of us?”

We laugh, it’s the end of the session. She’s wide awake. She walks me to the door and waves me a kiss goodbye.

It is evident from this one session—especially in hindsight and clarified in successive sessions—that Anna is struggling to adapt physically and psychologically to increasing, unremitting fatigue. It not only affects her sense of self—she is falling short of her ego-ideal as someone who can “keep up” and perform reliably; she is afraid of losing her social connections and her

connection to herself. I don't know if the fatigue signifies decreasing distance from death or if, like last winter, she is especially depleted because of the lack of fresh air and will perk up in the spring. Of course, that's my wish. Overall, Anna remains invested in her psychoanalytic work. She enjoys her days, her nights even more. Friends and neighbors visit and look out for her; she keeps up with the news, and takes great delight in her cat. Still growing at age 91, she feels she is accomplishing in this last part of her life her lifelong, cherished ambition and hope: to know herself.

### **PART III: Life Satisfaction, Longevity, and Development in Older Aging**

#### **Life satisfaction**

Of all the phases of the life cycle, surprisingly, it is people in their 60s, 70s, 80s, and 90s who report increased feelings of well-being and life satisfaction, compared to their earlier years. This discovery was made by happiness economists—a new branch of economics centered on human well-being, initially begun by Richard Easterlin—who found that: “Whatever set of data you looked at, you got the same things: life satisfaction would decline with age for the first couple of decades of adulthood, bottom out somewhere in the 40s or early 50s, and then, until the very last years, increase with age, often (though not always) reaching a higher level than in young adulthood. The pattern came to be known as the happiness U-curve” (Rauch, 2014). These results have been corroborated by other researchers, first in Latin America then in the rest of the world. Findings consistently reveal that “objective life circumstances do not determine subjective life satisfaction.” And it has also been found that even chimpanzees and orangutans evidence this U-curve pattern! (Rauch, 2014).

Why does life satisfaction increase with older aging? In a 2011 Stanford University study it was found that “the peak of emotional life may not occur until well into the seventh decade” (Rauch, 2014). For one thing, old people regulate their emotions better than younger people, and react less strongly to negative stimuli. Studies show that: social reasoning and long-term decision-making improve with age; spirituality increases; and older adults feel more comfortable coping with uncertainty and ambiguity, have more realistic expectations, and are more accepting of limitations. And for most older adults, living for the moment becomes paramount (Rauch, 2014). While old people may live with less, it means more. In his article, “Being Sick and Facing Eighty,” Martin Grotjahn writes: “I do not work anymore, and I walk little. Peculiarly enough, I feel all right about it.”

## On longevity

In this century, our life expectancy has moved from 46 to nearly 80 years. Older aging is a new phenomenon in human history. Thus far, the cause of increased longevity is not understood. Luigi Ferrucci, current director of the Baltimore Longitudinal Study of Aging begun in 1958, says, “Whether longevity is caused mainly by genes or by lifestyle and environment, we have no idea at all” (Easterbrook, 2014).

Longevity has not only increased dramatically in this last century, it has increased at a predictable regular rate. Every baby born this year can expect to live 3 months longer than a baby born last year. A relatively new discovery, this trend has been verified the world over, in rich and poor nations alike. While there is variation given certain variables such as education, health, and socioeconomic status, when these variables are controlled for, researchers find that “the 3-month per year increase is rising steadily as an escalator” through periods of war, depression, or peace time and prosperity. (Easterbrook, 2014). No single variable can account for this increase in longevity; instead it may well be the result of “a regular stream of continuing progress” (Easterbrook, 2014).

There are known influences on increasing longevity, such as continuing “vital involvement” (Erikson, Erikson, and Kivnick, 1986) and social interaction that keeps people engaged with life; also, decreased infant mortality rates, better sanitation, less pollution, and improved emergency rooms—among many other factors. But it turns out that “the single best yardstick for measuring a person’s likely life span is education. That and date of birth” (Easterbrook, 2014). The best educated live 10 to 14 years longer than the least educated, on average.

## Development in older aging

In the second half of life, as senescence gradually then precipitously increases, the biological goal is death. However, the goal of the psyche is different. Aside from B. F. Skinner insisting to Betty Friedan that “growth in aging” is a contradiction in terms, in the psychoanalytic literature there has been a consensus for a century or so that development continues in older adulthood under the right conditions. The right conditions for development and hope in a child’s young life are the same conditions that foster development and hope in older adulthood. The problem of hope in older adulthood begins in infancy. In Erik Erikson’s schema, in the first developmental stage, Trust and Mistrust—and Hope, he writes that

“... through ever-growing trust in the reliable supportiveness and responsiveness of the environment, the healthy infant develops the origins of hope....This essential strength matures through the life cycle, as the individual struggles to integrate a sense of confidence and belief in the universe, and the relative predictability of its laws, with a discriminating cautiousness and skepticism about the same universe and its realistic unpredictabilities and unreliabilities .... Aspects of intimacy and social connectedness contribute to ‘trustfulness’.... Early concern with the predictability of the day-to-day world expands into concern with understanding the infinite universe .... The strength of hopefulness that ideally comes to underlie the infant’s earliest sensory awareness gradually becomes a basis for lifelong engagement with less directly knowable realms of experience. This basic initial strength sustains the healthy development of all subsequent psychosocial strengths.... At the end of life, we may find that some rudimentary hope has blossomed into a mature faith in being that is closely related to essential wisdom” (Erikson, 1964).

Development in older age requires creative adaptation, which Cath (1980) describes as, in part, “the capacity to neutralize anger at inevitable narcissistic injury...and [the] capability for making [and integrating] restitution for losses.” We can hold our important people within, and become truly a world carrier. When grief and loss are overwhelming, older people are at a terrible loss; their suffering is immense. At these times, art, nature, religious faith, spirituality, or adherence to a philosophy can provide a communing link and comfort.

A Yiddish proverb says: “The soul is a vine that continues to grow until it is severed by death.” The soul—the psyche—keeps expanding while the body is contracting: the fundamental dynamic of our developmental struggle in older age. Jung insists that,

“for the aging person it is a duty and a necessity to devote serious attention to himself [because] the repressions of the first half of life which served ego development can now no longer be maintained....[and] the bill will now be presented for what was by-passed in the earlier years”

(Whitmont, 1969). Erikson (1964) calls this “epigenesis”: the recapitulation or reworking of developmental needs from each successive developmental phase. In addition, in older adulthood, Jung adds: “When

ego development and external adaptation have been adequate...[the] adaptational demand is toward the Self as a symbolic transpersonal reality and mystery” (Whitmont, 1969). In the second half of life, in the drive toward wholeness, Jung believes that “the decisive question for man is: Is he related to something infinite or not.”

The development of wisdom is a potential achievement in old age. The concept of wisdom is defined similarly across the centuries in all geographic regions; the traits of a wise person tend to include compassion and empathy, good social reasoning and decision-making, equanimity, tolerance of divergent values, comfort with uncertainty and ambiguity, and an acceptance of the finiteness of time and personal death (Nemiroff and Colarusso, 1985). In the last stage of the life cycle, Integrity and Despair—Wisdom, Erikson (1964) says, “Some old people can manage human problems in their entirety (which is what ‘integrity’ means) and can represent to the coming generation a living example of the closure of a style of life.” Wise old people indisputably contribute to the survival of the species.

To learn how to live with death and despair is to learn how to tolerate aliveness, to live with being in time. “May I be alive when I die,” wished D. W. Winnicott. For Jung and Becker, it is the breakdown of our repression of our denial of death and our fear of death in older adulthood that provides the developmental opportunity to synthesize our dualistic nature, and to connect with and beyond ourselves to the transpersonal realm and the universe—for the time being.

Zen Master Dōgen tells us,

“...you can't understand what it means to be truly alive on earth until you understand the time being .... Do not think that time simply flies away.... Time itself is being, and all being is time .... In order to understand the time being ... you have to understand what a moment is .... A moment is a very small particle of time. It is so small that ... a snap of the fingers equals sixty-five moments .... Both life and death manifest in every moment of existence. Our human body appears and disappears, moment by moment, without cease, and this ceaseless arising and passing away is what we experience as time and being. They are not separate. They are one thing, and even in a fraction of a second, we have the opportunity to choose, and to turn the course of our action either toward the attainment of truth or away from it. Each instant is utterly critical to the whole world” (Ozeki, 2013).

Beings in time, we are timeless and immortal while—for the time being—our bodies manifest and register the passage of time through all the seasons of our life. In the last analysis, as Joseph B. Soloveitchik wrote in *The Lonely Man of Faith* (1965), we can never know ourselves entirely—and can never be known entirely, no matter how long we live, or how evolved we are, because until our very last breath we never stop becoming.

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