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## A Positive Aging Framework for Guiding Geropsychology Interventions

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This article characterizes the human aging process from the perspectives of normal, pathological, usual, successful, and positive aging. Positive aging is described based on four characteristics: the mobilizing of latent resources, psychological flexibility, an affirmative decision-making style, and the propensity to generate an optimistic response to stressors inherent in age-related decline. A positive aging strategy framework is proposed, inclusive of recent developments in intervention research employing gratitude, forgiveness, and altruism to preserve subjective well-being. The role of positive aging strategies in conjunction with behavioral intervention approaches to promote well-being in one's later years is recommended for addressing the complex needs of our graying population.

THE NUMBER OF OLDER consumers of psychological services has increased precipitously in the past decade. Factors that have influenced this demand have included increased average life expectancy, the expanding demographic of older persons who report age-associated physical and cognitive impairment, and increased incidence of diseases of aging, including Alzheimer's disease and other forms of dementia. Extended average life expectancy means that a greater percentage of persons in the United States will be living into advanced age. The very old are substantial consumers of health-care services because almost every person in this age group is dealing with some form of chronic illness and/or age-related disability. In fact, recent demographic and epidemiological surveys have indicated that over 85% of persons 80 years and older have at

least one chronic health condition and many (62%) have more than one (Anderson & Horvath, 2004).

In the psychological sciences, geropsychology has received increased attention as a specialty practice domain. Guidelines are now available that describe not only the role and function of the geropsychologist, but also issues of focus and the level of training needed for professional competency (Knight, Karel, Hinrichsen, Duffy, & Qualls, 2009). Within the past decade, evidence-based treatment (EBT) interventions have been developed for an older (or geriatric) clientele (Scogin & Yon, 2006). These approaches, not unlike those EBTs for other client groups—children, adolescents, early and middle-aged adults—focus primarily on the amelioration of pathology or symptoms associated with chronic physical and psychiatric conditions. Scogin (2007), editing a special issue of the *Journal of Psychology and Aging*, dedicated space to a comprehensive meta-analytic review of EBTs for some of the more pressing problems facing a geriatric clientele, including depression, anxiety, sleep disorders, caregiving, and behavioral problems in dementia.

The approach to treating the older patient's chronic disease conditions parallels much of what is published in the medical literature where attention has focused on the treatment of the symptoms of pathology and the role of intervention to address maladaptive conditions as a consequence of aging and disease. Although this approach has important public health implications, it is also driven by socio-contextual forces that shape how most people characterize the human aging process and the role of the health-care professional as the point person in treatment delivery. These forces, like the process of aging itself, are dynamic and have evolved over the past several decades. The promulgation of terms (or labels) that have their genesis in the scientific and clinical literature and have migrated to the popular media impact not only

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how the average person thinks about the process of growing old, but also the emphasis and the subsequent validation of interventions designed to mediate age-related decline.

Normal aging, pathological aging, usual and successful aging, and, more recently, positive aging are prominent in the lexicon of the science and practice of geriatrics. Such terms attempt to capture the phenomenon of age-related change from various perspectives, and this expanding taxonomy has aided in our understanding of how aging affects objective longevity, health, and quality of life. It has also influenced the kinds of interventions and outcome variables that are employed to deal with the issues of old age.

The purpose of this article is to: (a) briefly trace the evolution of prominent terms in the scientific literature descriptive of the human aging process, (b) examine the role of behavioral and related psychological interventions that have proliferated from these terms, (c) introduce a relatively new concept in the scientific literature, "positive aging" (Hill, 2005), that has been promoted from within the recent positive psychology movement (Seligman, 2000), and (d) describe an emergent positive-aging strategy framework for guiding future interventions with an older clientele.

### Normal and Pathological Aging: A Threshold Model

Early definitions of human aging characterized it as a biological process akin to chronic disease; that is, aging (like disease) was viewed in the 1960s and 1970s as time related, irreversible, and deleterious (Dovenmuehle, Busse, & Newman, 1970). A limiting aspect of this formative definition was the difficulty of disentangling aging from disease. For example, arteriosclerotic disease could also be considered a form of aging because, like aging, arteriosclerosis is deleterious to health, becomes progressively more severe with the passage of time, and the impact of arteriosclerosis, particularly in its more advanced stage, is irreversible.

In the late 1960s, the term *normal aging* was proposed by Paltmore (1970), who stated, "When we can distinguish normal and inevitable processes of aging from those which may accompany aging simply because of accident, stress, maladjustment, or disuse, we can better focus our attention and efforts on those factors which can be changed and corrected" (p. vii). The term *normal aging* has evolved as a result of large population-based studies, such as the Baltimore Longitudinal Study, that follows multiple cohorts of adults throughout their lifespan. A critical aspect of this definition is

the presence or absence of disease. Shock (1984) defined normal aging as senescence in the absence of disease. Later definitions refined this view through a threshold model; namely, normal aging is the phenomenon of growing old when disease is not discernible or is at a subthreshold stage. In other words, until a disease reaches the threshold of symptom emergence, normal aging is the descriptive term of age-related decline. For example, in the normal aging lung, alveolar surface area decreases by up to 20%, which reduces maximal oxygen uptake by as much as 55% by age 85 (Wahba, 1983). Diminishment of organ capacity of this type may not be noticeable in everyday functioning, but such changes can exert a measureable impact on maximal output capacities. On the other hand, in Chronic Obstructive Pulmonary Disease (COPD) the walls of the alveoli break down appreciably, reducing the gas exchange area of the lungs. Depending on the stage of COPD, this can have a substantial impact on day-to-day function, and the effects of disease are magnified by the aging process. Figure 1 depicts a threshold model used to distinguish normal from pathological aging processes (adapted from van Boxtel, 1997).

In this model, there is the presumption of the existence of both protective and vulnerability factors that interact with the aging process. In the case example of lung function, protective behavioral factors would include regular aerobic exercise

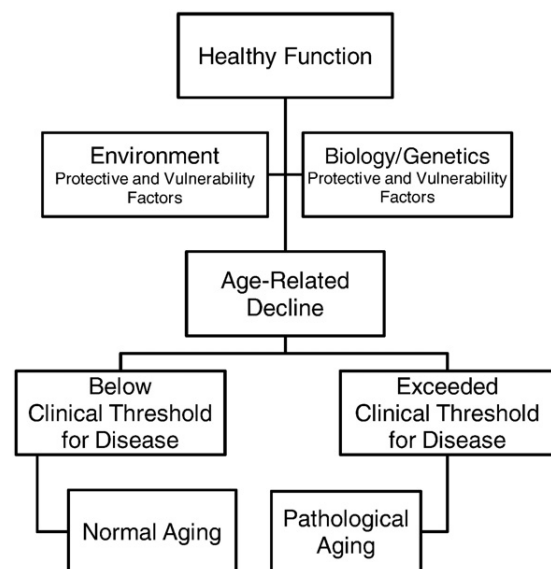


FIGURE 1 A Threshold Model of Normal and Pathological Aging. Note. Adapted from *Physical Health, Vascular Risk Factors and Age-Related Cognitive Decline*, p. 23, by M. P. J. van Boxtel, 1997, Maastricht, NL: Neuropsychology Publishers. Adapted with permission.

and optimal diet. These would be contrasted to cigarette smoking or residing in a region with poor air quality that would represent vulnerability factors. Protective or vulnerability factors have their origin in biological processes, genetics, and one's environmental context and, as noted in this example, lifestyle behaviors. It is when normal physiological function is impacted by disease that the threshold from normal to pathological aging is crossed. In their seminal text, Fries and Crapo (1974) argued that the pathological aging process is similar to normal aging in that both produce functional loss—but pathological aging accelerates the progression of loss. The threshold model has given rise to interventions such as pharmacologically or behaviorally driven blood pressure control strategies to delay disease symptoms from exceeding the threshold of clinical detection.

#### Usual and Successful Aging: A Mediator Model

In later years, Rowe and Kahn (1987) proposed that the process of aging could be captured in terms more representative of its greater dimensionality, with emphasis on those individuals who experienced preservation of health and functionality even though they were aging. It was their view that the term *normal aging* was descriptive of two subcomponent processes that they labeled “usual” and “successful” aging. Usual aging emphasized extrinsic factors of deterioration, including diminished bone density, deficits in carbohydrate metabolism, diminished episodic memory efficiency, or other manifestations of deterioration that could be anticipated to occur for all persons as they increase in chronological age, especially through the latter half of the life span. Conceptualization of usual aging was similar to the term *normal aging*, although the *usual aging* terminology emphasized the substantial heterogeneity in the trajectory of functional decline in any given individual in the absence of detectible symptoms of disease. *Successful aging*, on the other hand, referred to the role of health behaviors as mediators of the aging process. They noted: “It is at least a reasonable hypothesis . . . that factors of diet, exercise, nutrition, and the like have been underestimated or ignored as potential moderators of the aging process” (Rowe & Kahn, p. 144).

Through this definition, Rowe and Kahn (1987) introduced and later popularized (see Rowe & Kahn, 1998) the idea that behavior and behavior change strategies could affect the course of aging for any given person, and in aggregate, could also alter general trends in longevity. This view, along with findings that emerged from the McArthur Longitudinal Studies of Successful Aging (Berkman

et al., 1993), culminated in a general definition of successful aging based on three components: (a) active engagement with life, (b) absence or avoidance of disease or risk factors for disease, and (c) maintenance of high levels of physical and cognitive functioning (Depp & Jeste, 2006; Rowe & Kahn, 1999). In many respects, the successful aging terminology opened the door to designing and deploying behavioral change strategies such as regular exercise, proper nutrition through dieting, weight control interventions, as well as interventions that altered maladaptive lifestyle pattern such as smoking cessation and alcohol abuse interventions to mitigate the impact of age-related decline. The number and extensiveness of these interventions that have targeted an older clientele with the goal of not only helping them to maintain health and optimal function but to increase longevity has proliferated (Gage & Goreczny, 1998; Gallagher-Thompson, Steffen, & Thompson, 2008).

The concept of successful aging has stimulated a large body of research that has examined the impact of strategic behavioral interventions to alter behavior (e.g., smoking cessation) that can impact trajectories of physical decline associated with disease and with aging, including blood pressure control, the preservation of maximal oxygen uptake, and the maintenance of muscle strength and bone density. Recent studies have emphasized training regimens for mediating specific indices of cognitive health that are particularly susceptible to the aging process. Within the successful aging label, engagement in activities such as reading, crossword puzzles, or word or numeric exercises has been shown to mediate age-related cognitive decline (Shinya & Kawashima, 2008). In many respects, the “use it or lose it” mantra within the successful aging framework has been extended from sustaining physical fitness in old age through exercise to maintaining cognitive functioning through strategic forms of mental exertion exercises. These studies and others provide evidence that behavioral interventions that promote intellectual engagement are important in preserving cognitive functioning in healthy older adults into very advanced age (Ball et al., 2002).

Much of the research conducted under the umbrella of successful aging has focused on healthy individuals who are essentially disease free and are presumably highly resistant to age-related deterioration in physiological or cognitive processes. Whether such an approach to the preservation of physical health and cognitive function is possible within disease conditions such as Alzheimer's disease remains relatively unknown. This may be partly due to the narrow confidence interval of

health within which the successful aging label is defined (Strawbridge, Wallhagen, & Cohen, 2002). For those older persons who are not endowed with such inherent resistance, or who are more vulnerable to age-related decline due to a history of poor lifestyle habits, poor living contexts, or who have simply lived to such an advanced age that their physiological constitution can no longer withstand the deteriorative effects of aging, a prominent need of these older persons is not simply to mediate age-related decline, but to find well-being, purpose in living, and happiness, even when physical deterioration is present.

More recent articulations of the concept of age-related frailty has focused on characterizing the condition of advanced aging as a kind of functional disability due primarily to unavoidable physiological and cognitive degradation. Hogan, MacKnight, and Bergman (2003) described frailty as a biological syndrome that leads to decreased resistance to stressors resulting from cumulative declines across multiple physiological systems, resulting in general vulnerability to adverse outcomes. Frailty, as defined in this way, not only increases with age but is further exacerbated by disease, which is expected to co-occur by virtue of the highly vulnerable and compromised state of the aged physiological system. Frailty is manifested by mobility restriction, acquired functional dependency, and deficits in cognition that constrain everyday living routines. Studies have documented that the concept of successful aging is viewed differently when those who are disease free define it versus when those who with chronic health conditions define it. A prominent theme in this relativistic approach to successful aging is that, among those persons who are less healthy, the emphasis on coping, adjustment, acceptance of one's limitations, and the acknowledgment of suffering in the presence of decline is what constitutes the lay definition of "successful aging" (Phelan, Anderson, Lacroix, & Larson, 2004).

Thus, although the concept of successful aging has awakened society to the relationship between behavior, genetics, and the maintenance of functionality in the presence of advancing years, it has not been without its critics, who have argued that the successful aging terminology and the subsequent zeitgeist that has spurred people to believe that age-related decline can be thwarted through interventions in biology, genetics, pharmacology, or engaging in pro-health behaviors may have inadvertently created a barrier to life satisfaction for those individuals who cannot meet the successful aging criteria (Masoro, 2001). One example of the inevitability of age-related decline in even the

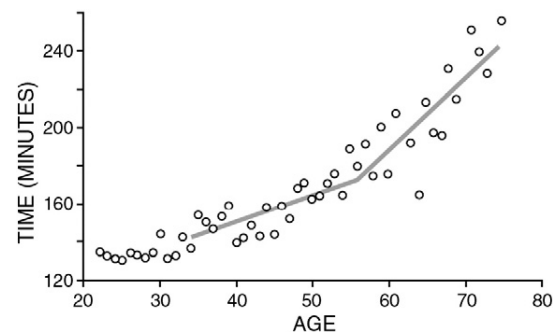


FIGURE 2 1997 Boston Marathon Top Male Finisher for Each Age.

most healthy (or fit) individuals is depicted in Figure 2, which plots 1997 Boston Marathon times by competitor age (Williams, 1998). In this graph, it is clear that, even among professional marathon runners, those who are older record longer completion times. This does not mean that a 60-year-old practices or prepares any less diligently than a 28-year-old runner; this function simply means that age-related decline exerts an absolute physiological effect on functionality, irrespective of one's baseline physical condition or any effort that a person might engage in to ameliorate the impact of aging on performance times.

#### SUCCESSFUL AGING: A PROPOSITIONAL MODEL

In a revisionist approach to the concept of successful aging, Baltes and Baltes (1990) present a propositional model that focuses on the role of coping strategies to sustain optimal function in the presence of age-related decline. In this paradigm, deterioration in function is explicitly acknowledged and its consequences are construed as a dynamic between the biological processes inherent in human aging and the adaptation potential of the human organism through sociocultural mechanisms. A central tenet of this view that has become an important guiding principle in contemporary behavioral therapy interventions with older adults is a three-component model of adaptation that Baltes and Baltes describe as "Selective and Compensatory Optimization." The elements of this approach consist of three processes: selection, optimization, and compensation (SOC).

Selection refers to the conscious reduction of choices to preserve resources; with fewer options available to the individual, coping becomes more amenable by a simplifying of the number of decisions that must be made within any given domain of functioning. An example of selectivity in social engagement is provided by Carstensen, Isaacowitz, and Charles (1999), who proposed socioemotional selectivity theory to describe how

older persons may choose to engage in fewer but more strategic social interactions to preserve functional resources in the presence of advancing age. Selection through the reduction or “pruning” of one's social support network frees up an older person's resources to make it possible to maintain more meaningful relationships as one's overall capabilities for social interchange decline with age. Optimization infers practice and rehearsal of abilities that are intact and which one chooses to preserve. If a person desires to retain the ability to walk, then the practice of walking on a regular basis, even if this means incrementally decreasing the distance one walks as muscle weakness gradually increases, is engaging the process of optimization. The traditional notion that “practice makes perfect” is modified in optimization to “practice preserves function.”

Compensation is employed when a behavior is no longer executable in its typical form. When walking is no longer possible due to lost leg function, ambulation may still be possible through the means of a walker or a wheelchair. The concept of compensation has received substantial attention in the empirical research as it relates to nearly every form of rehabilitation training (Dixon & Bäckman, 1995). As a formal concept, compensation means the preservation of functioning through an alternative mechanism or method. Thus, one way to address a lost ability (walking) is to find an alternative means to engage in the function (ambulation via a wheelchair) even though walking using one's own leg power is no longer possible.

Another criticism of the successful aging terminology is its narrow focus on the preservation of subjective well-being through the maintenance of physical functioning (Bowling, 2005). Even though most people know that subjective well-being is still possible in the presence of declining physical health and diminished functional abilities, the implications that are embedded in the strict definition of “successful” aging do not easily lend themselves to concepts of preserved well-being when physiological functioning is compromised through disease and/or aging. Can well-being and life satisfaction be found when an older person is experiencing limited mobility due to progressive osteoarthritis, or impaired cognitive function as a consequence of dementia? Is it possible to construe that an older person who is struggling with speech difficulties due to stroke would qualify as a successful ager? These are challenging questions about the extent to which the successful aging definition is sufficient to capture the wide range of change that is associated with age-related deterioration and the capacity of the individual to find well-being and life satisfaction across the

full range of circumstances and health outcomes that are a consequence of age-related decline.

#### POSITIVE AGING: A PSYCHOLOGICAL RESOURCES MODEL

Positive aging (Hill, 2005; see also Hill & Mansour, 2008) is an extension of the positive psychology movement, which focuses on issues specific to old age. To paraphrase from Seligman (2000), through processes embedded in valued subjective experience that one acquires across the lifespan, people who are the most proficient in engendering well-being in later life learn how to construe age-related transitions in such a way that optimizes well-being. In aging, many of these transitions are a consequence of age-related decline—and to preserve well-being and happiness in the presence of this diminished functional capacity, particularly in advanced age, means dealing with unavoidable loss. A terminology that captures the processes to remain affirmative even in the presence of physical and cognitive decline, loss, pain, disappointment, grief, and suffering that is associated with aging will become increasingly important as greater numbers of older adults live into their 8<sup>th</sup> decade and beyond.

As was noted for successful aging, specific behaviors were postulated to mediate the deteriorative effects of aging. In an earlier work (see Hill, 2005), I described this approach in terms of positive aging characteristics; namely: (a) the ability to mobilize latent or dormant coping potentialities, (b) flexibility in thinking and behaving, (c) a decision-making style that affirms personal well-being even when choices represent departures from familiar activities that may no longer be possible when functionality for these activities is irretrievably compromised, and (d) an optimistic viewpoint about issues embedded in decline.

#### *Recruiting Latent Potentiality*

When confronted with a demand, whether it involves the expenditure of physical or psychological effort, personal resources are needed. Not unlike the concept of successful aging articulated by Baltes and Baltes (1990), there is explicit acknowledgment in the label of positive aging that functionality deteriorates irreversibly as a consequence of aging. Resources can, however, be recruited that are latent (or in reserve) when the need arises. In normal aging, the threshold model postulates that reserves are automatically recruited to offset loss. The presumption is that biology/genetics in the form of organ redundancy, for example, interact to offset age-related deficiencies. In Baltes and Baltes's propositional model of successful aging, the concept of reserve capacity recruitment is described as a more active process involving the

learning and application of strategies to offset age-related deficits. Kliegl, Smith, and Baltes (1989) use terms such as *developmental reserve capacity* to describe this phenomenon for cognitive deficits where mnemonic strategies are employed to recruit latent resources to offset age-related memory deficits. In two related studies, Kiegl, Smith, and Baltes (1989, 1990) trained older adults to use the *method of loci*, a commonly known imagery-based mnemonic, to diminish age-related word-recall performance deficits.

From a psychological adaptation framework within which positive aging is embedded, if available coping resources are deficit as a consequence of age-related decline and are presumably irretrievable, latent resources may be recruited to sustain subjective well-being. This is accomplished by altering one's personal focus. Specifically, by engaging strategies that can enable acceptance of irreversible age-related loss, it becomes possible to modify life routines while at the same time preserve self-consistency (or internal continuity) in the process. This capacity is captured by Robert Atchley (1999) in a continuity model of aging:

Despite significant changes in health, functioning, and social circumstances, a large proportion of older adults show considerable consistency over time in their patterns of thinking, activity profiles, living arrangements, and social relationships. . . . Continuity is conceived of . . . as strong probabilistic relationships among past, present, and anticipated patterns of thought, behavior, and social arrangements. (p. 1)

Psychological well-being is maintained by shifting one's expectations when diminished functionality compromises activities. When capabilities are lost, consistency can still be maintained by recruiting features of one's context to offset such a loss. For example, when personal tasks that generally involve the independent operation of a car (e.g., grocery shopping) are not possible, one could still accomplish such tasks by recruiting social resources to negotiate the task. In the previous example, an older person might still believe that he or she is independent although the construal of the personal meaning of independence in the presence of ongoing help from others would require, from a positive aging framework, reserve capacity recruitment (soliciting the help) as well as flexibility in reinterpreting a view of personal independence with regard to this issue.

In their study, Strawbridge et al. (2002) found that many older adults who were experiencing chronic disease and declining functionality that would disqualify them for meeting the formal definition of successful aging continued to perceive

themselves as successful agers and to enjoy well-being as a consequence. They accomplished this by altering how they construed the term successful aging (e.g., "the best old age one could expect"). In doing so, the study participants were able to maintain a view of themselves as successful agers even when chronic disease diminished or eliminated many aspects of independent function.

#### *Flexibility*

Flexibility refers to a person's capacity to invoke novel strategies of behaving or thinking to promote better adaptation. Schaie (2005) defined flexibility as an approach to cognitive problem solving that involves the dynamic manipulation of multiple solution sets to yield the best outcome in the shortest amount of time. From a successful aging paradigm, flexibility has been characterized as a kind of plasticity or malleability that facilitates an individual's search for the conditions that encompass the upper boundary of performance (Baltes, Staudinger, & Lindenberger, 1999). Both of these definitions emphasize performance outcomes through skill acquisition. Alternatively, as a psychological mechanism for dealing with stress, Lazarus and Folkman (1984) described flexibility as involving the balancing of one's existing skills and personal resources to facilitate adaptation in stressful or demanding contexts. Flexibility in their definition is also skills based and is associated with specific behavioral outcomes. The focus of flexibility in dealing with stress, however, moves in the direction of adaptation to challenge versus maximizing performance gains. Rozanski and Kubzansky (2005) linked the active adjustment of one's goals or priorities to address changing circumstances, setting limits on one's abilities, invoking social support, and seeking advice or counseling as indices of coping flexibility. From a behavioral therapy perspective, the principle of flexibility is also demonstrated in the capacity to reframe automatic thoughts as a way to reduce their emotional impact and as a consequence yield an adaptive coping response.

The case of Edna, described by Robert Atchley (1999), is an example of flexibility in her behavioral routines responsive to irreversible loss that allowed her to maintain a sense of internal continuity (and personal satisfaction) even though she was replacing behaviors with more limited lifestyle routines as a direct response to progressive age-related deficits.

By 1991 Edna's physical mobility problems had worsened considerably, but at age 88 she still maintained her very positive outlook on life. . . . She adapted her lifestyle to her more homebound state by doing less gardening and cutting back on her participation in politics. . . .

However, she . . . spent more time with her collection of family photographs . . . and watched more television. . . . Adapting to her changing mobility was a major goal. . . . In 1995, Edna still had very high morale, a realistic appraisal of her personal agency and a very . . . satisfying life. (pp. 19-20)

Edna's willingness to let go of established patterns and alter behavioral routines to accommodate functional decline as well as her effort to psychologically reframe her changing situation with the goal of preserving her positive attitude and maintaining life satisfaction is characteristic of the positive aging principle of flexibility.

#### *Decisional Ability*

Decision making involves evaluating the variables that will be influenced by a given decision and valuing the limited set of consequences that follow. Older persons who are better at evaluating choices and making decisions generate more satisfying life routines and, when the balance of decisions made across the lifespan weigh in favor of those where the consequences are sustained well-being, internal continuity is preserved. This is the case in very late life when decisions may involve the acceptance of unalterably diminished functionality. The focus of decision making as a positive aging skill in this regard is on establishing a plan to address a goal that acknowledges deficits. For example, most persons in our Western society are familiar with a Will (or a Trust) that represents a future financial plan for distribution of personal assets after one dies, and it has been estimated that over 80% of Americans have recorded a Will or a Trust for posthumous distribution of financial assets. The growing movement toward extending the concept of a Will to one's care in advanced age—sometimes known as a Living Will—is a late-20th and early-21st-century positive aging manifestation of decision-making processes to address issues that are integral to loss. The most effective Living Wills influence the logistics of health care and preserve well-being and dignity near the end of life—and such a strategy is often designed to buffer the escalating medical and personal/family decision-making challenges just preceding the point of ultimate personal loss of one's own life by relieving the individual (and the system) of the need to engage in what might otherwise be futile life-sustaining efforts.

#### *Optimistic Viewpoint*

An optimistic worldview describes an affirmative approach to life that is characterized by a striving for happiness versus a focus on alleviating symptoms of distress. This approach fits well with a contemporary

conceptualization, proposed by Keyes (2005), of mental health, mental illness, and its treatment. In this scheme, a person's pursuit of better health would be considered “flourishing” (a positive valence) if she or he possessed high levels of positive emotion, including active social engagement, the cultivation of meaningful personal relationships, and a positive future outlook. The absence of mental health, in contrast, Keyes labeled as “languishing,” or the experiencing of emptiness, loss, or stagnation associated with the inability to engage one's environment to establish and sustain well-being. A critical element of this two-component model is that those who are moving in a positive direction toward health will more likely be engaged in coping or acting on their environment to enhance well-being than a person who is trying to escape or alleviate symptoms.

In their review of positive psychology and its role in clinical practice, Duckworth, Steen, and Seligman (2005) stated:

Positive psychology aims to broaden the focus of clinical psychology beyond suffering and its direct alleviation . . . positive psychology is the scientific study of strengths. . . . Viewing even the most distressed persons as more than the sum of damaged habits . . . positive psychology asks for more serious consideration of those persons' intact faculties . . . positive life experience, and strengths of character, and how those buffer against disorder. (p. 630)

This viewpoint extends the concept of optimism as a strategy that mediates the impact of age-related decline on the threat to loss of subjective well-being as one encounters the inevitable challenges of functional and social loss in later life.

#### A POSITIVE AGING STRATEGY FRAMEWORK

A positive aging approach to coping is captured in the ability to recruit latent potentiality (or psychological reserve capacity) and to respond flexibly in age-related transitions, to engage affirmative decision-making processes, and to cultivate an optimistic view by reframing the deteriorative processes of aging in such a way that preserves life satisfaction. Within a behaviorally based strategy framework, two factors are important to consider: (a) the dependent variables and (b) the intervention approach.

#### *Dependent Variables*

Whereas the normal aging model focuses on control of symptoms or the delay of biological manifestations of disease and successful aging focuses on the ideal of aging or maximizing functional ability, positive aging emphasizes subjective constructs of well-being. At its root, positive aging is descriptive

of psychological adaptation to the inevitable consequences of late-life decline. A basic assumption in positive aging is that because decline is unavoidable, it is more adaptive to accept diminished functioning as part of one's lifestyle routine rather than denying, controlling, or mediating it. This does not mean that one should ignore opportunities for controlling disease symptoms, or preserving functionality as one ages, but knowing when to make a shift that incorporates age-related decline into one's lifestyle routine is a central feature for preserving well-being, even though the qualitative nature of one's everyday functioning is unalterably diminished. The dependent variables that fit best within this description are those that emphasize psychological state.

In a study that involved 248 older adults with chronic osteoarthritis, Cignac, Cott, and Bradley (2002) evaluated whether coping behaviors within SOC could facilitate well-being. They defined *selection* as strategic personal restriction from activities that might exacerbate disease symptoms (withdrawing from any trips that involved extended walking). *Optimization* was defined as engaging in limited exercise routines that minimized pain (exercising while sitting in a chair), and *compensation* was defined as the early adoption of assistive devices to facilitate movement (using a walker). The findings from study participant interviews indicated that those who strategically altered their everyday behaviors using SOC strategies, although less engaged in care center activities, reported higher well-being than those who persisted in activities without modification. From a strict behavioral perspective, the reduction in the frequency of planned care center activities engaged in could be construed as a negative outcome; however, in this case, reduced activities were associated with better well-being. This study underscores the value of dependent variables that integrate psychological state with the maintenance of functional independence and/or social engagement. In positive aging, the impetus is to mediate the subjective experience of loss and personal disappointment associated with age-related decline. Preserving subjective well-being could involve choices to become more functionally limited with the goal of preserving resources by limiting the need to employ those resources in the additional care-center activities.

#### *Intervention Strategies*

Interventions that have proliferated within the normal aging and successful aging labels address categories of dependent variables consistent with these terms. To be sure, the pharmacological and/or behavioral treatment of subclinical disease states such as hypertension, or the promotion of healthy

lifestyle behaviors such as regular physical exercise and diet, have as outcome measures biological or behavioral benefits such as diastolic and systolic blood pressure reduction, weight control, or fitness. The unique addition that positive aging adds to these medically or behaviorally generated dependent variables is the inclusion of outcomes of subjective emotional state. But are there intervention approaches that would uniquely characterize a positive aging outcome? That is, like normal and successful aging, how would the efficacy of a positive aging intervention be evaluated?

To address this question requires elucidating recent trends in the positive psychology movement that have pointed to specific interventions to harness features of the human condition that have been a source of meaning and well-being and that could be recruited when meaning or subjective well-being is challenged as a result of age-related decline. Specific examples of these interventions have been articulated in a strengths-based model of coping (Lopez et al., 2006) and there are three prominent meaning-centered life-span strategies grounded within this framework: gratitude, forgiveness, and altruism. These strategies are primarily designed to impact psychological state.

#### GRATITUDE INTERVENTIONS

Gratitude interventions have proliferated in the empirical literature for a range of psychological and health issues. Bono, Emmons, and McCullough (2004) summarized several behaviorally based interventions within an empirical model of gratitude. From a positive aging framework, gratitude is a powerful flexibility strategy that, at its basis, can assist individuals in focusing on positive attributes of events or circumstances even when those events have been associated with objective loss. The underlying dynamic of a gratitude intervention is similar to the reconstrual principle in cognitive-behavioral therapy: that is, reframing automatic maladaptive thoughts to disconnect them from negative affect and therefore generate latent emotional resources to preserve well-being. In one empirical study, Emmons and McCullough (2003) demonstrated in a college-aged sample that gratitude journaling yielded not only improved mood but also resulted in a perception of enhanced personal resources to engage in health-promoting lifestyle behaviors such as physical exercise.

Although gratitude interventions have not been evaluated for older adult issues, per se, such interventions hold promise for addressing issues related to caregiver burden, chronic depression and/or anxiety, and issues associated with death and dying and the bereavement process. As an example,

a positive aging intervention employing gratitude journaling could involve the adoption of a behavioral strategy described by [Emmons and McCullough \(2003\)](#). In brief, this intervention included the following instructions:

There are many things in our lives, both large and small, that we might be grateful about. Think back over the past week and write down on the lines below up to five things in your life that you are grateful. . . . Examples . . . “waking up this morning,” “generosity of friends” . . . (p. 379)

In this example, the recipient of this intervention could be a spousal caregiver or an adult child who is the caregiver of an older parent. Caregivers could be taught the skill of gratitude journaling through a modified curriculum. Outcome measures to assess the efficacy of this intervention would be those that reflect enhanced positive meaning and purpose associated with the caregiving role, for example, the Positive Aspects of Caregiving Scale ([Tarlow et al., 2004](#)). A gratitude journaling intervention might be integrated with additional component techniques that have been enumerated in [Gallagher-Thompson and Coon \(2007\)](#) to relieve caregiver burden and stress.

#### FORGIVENESS INTERVENTIONS

Forgiveness interventions have been reported in the scientific literature to assist persons across the life span in dealing with loss and hurt. The literature that has examined forgiveness in later life has focused on interventions in which forgiveness has been employed to address difficult life transitions: loss of independent function, physical pain due to chronic disease, relieving the psychological burdens associated with caregiving, and repairing damaged relationships ([Worthington, 2006](#)). Forgiveness strategies have been used to manage a range of late-life issues, including chronic depression ([Hebl & Enright, 1993](#)). As a positive aging intervention, forgiveness training may be especially relevant for acute issues that challenge well-being, such as the management of grief. Among adults ages 18 and older, [Toussaint, Williams, Musick, and Everson \(2001\)](#) reported that forgiveness was most strongly associated with life satisfaction and self-rated health among those respondents who were 65 years and older. [Bono and McCullough \(2004\)](#) recommended a forgiveness curriculum for enhancing self-reported health in older clients with chronic illness. One aspect of this model involved construing forgiveness as multidimensional; that is, forgiveness could be engaged to help negotiate lifespan transition issues (e.g., moving from one's own home

to a residential care facility) where there may be a need to forgive one's self (for an accident that may have precipitated the move), others (for initiating a residential care placement), or natural circumstances (the unavoidable consequences of age-related frailty). Forgiveness in any of these instances could be a resource for recruiting psychological reserves to cope with age-related deficits and preserve well-being and could benefit decision-making processes in the negotiation of such issues.

The goal of a positive aging forgiveness intervention would be one of learning to accept deficits as a result of age-related deterioration. Assessments that focus on sustaining meaning and purpose in life in the presence of these changing circumstances would be important outcome variables for assessing the impact of a forgiveness intervention. The Life Orientation Test–Revised (LOT-R) could be used to gauge the influence of forgiveness on the maintenance of optimism in the presence of personal loss ([Robinson-Whelan et al., 1997](#)). Forgiveness interventions could be used to challenge negative relationship interactions that frequently arise in the pressurized context of long-term caregiving, especially when the care recipient is unalterably deteriorating due to a dementing disease. In a related literature, forgiveness intervention strategies have been described for caregivers of persons suffering from AIDS. Aspects of these interventions might be adaptable to caregiver issues in an older adult clientele ([Bono & McCullough, 2006](#)).

#### ALTRUISM INTERVENTIONS

Altruism is commonly associated with the motivation behind acts of volunteerism. Among older adults, volunteerism is connected to a wide-range of positive outcomes, including increased longevity, resistance to negative affective states, better health, and enhanced well-being ([Morrow-Howell, Rozario, & Tang, 2003](#); [Post, 2007](#)). Interventions that have engendered volunteerism in older adults have yielded positive outcomes even when the participants have been, themselves, in poor health and from lower socioeconomic strata ([Dulin, Hill, Anderson, & Rasmussen, 2001](#)). An extensive literature has examined the benefits that have followed when older persons have engaged in naturally occurring volunteer activities ([Shmotkin, Blumstein, & Modan, 2003](#); [Tan, Xue, Li, Carlson, & Fried, 2006](#)). These studies provide preliminary evidence that volunteering is a potent source for generating meaning and purpose in life and that engagement in volunteer activities, even as one's own health is declining, can be a source of well-being. To date, most of the research that has

examined volunteerism and enhanced well-being has focused on cognitively intact adults who are, for the most part, ambulatory. Whether engineered volunteer experiences could preserve well-being, for example, in older persons suffering from dementia is unknown.

An element of altruism that is not commonly considered in this clinical realm, but that may be relevant to a very old and/or impaired clientele, is learning how to “receive” help from others. In this way, older help recipients could, themselves, be instruments of altruistic acts from others (e.g., helpers need someone to help). However, among the barriers associated with this kind of approach to altruism is the social stigma that can be associated with receiving help. In other words, many persons, especially among those born in the 1930s and earlier, may hold expectations that it is socially unacceptable to receive help (e.g., the adage “There is no happiness in having or in getting, but only in giving”). For these persons, potential negative costs associated with imbalanced relationships when help-receiving cannot be reciprocated could create substantial subjective discomfort (Gergen, 1974). Some researchers have suggested, however, that the ability to receive help is a skill that, if learned, has the potential to promote subjective well-being even when the recipient cannot reciprocate the helper (Jett, 2002). It may be that the construal of help-receiving as a form of altruism is adaptable for older persons who are substantially physically or cognitively impaired.

#### IMPLICATIONS FOR CLINICAL PRACTICE

This introduction to positive aging as a term descriptive of strategies for preserving the subjective experience of well-being into one's later years has highlighted the importance of meaning-centered interventions to facilitate this process. The positive aging label should not be construed as a replacement term for normal or successful aging. That is, most persons are already very familiar with accessing sources of meaning and purpose in life (e.g., there are few people who would not acknowledge the role of forgiveness in healing relationship wounds). Positive aging may, however, represent a framework for an expanded repertoire of strategies. The clinical implications of incorporating behavioral strategies that can recruit latent psychological resources through gratitude, forgiveness, and altruism requires an expanded view of what it means to adapt by learning to accept (versus ameliorate) the irreversible deficits in age-related decline. To employ a positive aging strategy within a behavior therapy framework presupposes the identification of dependent measures to not only

assess the impact of such interventions on indices of health but the role of self-perceptions in adapting to old age. This article has provided examples of outcome variables that fit within a positive aging framework, but, for the most part, tailored instruments of subjective psychological state in later life have yet to be fully elucidated in the extant literature. Further, instrumentation to assess the impact of specific meaning-centered interventions (a gratitude measure tailored to age-related decline) is currently unavailable.

There are multiple challenges in implementing positive aging strategies for enhancing well-being in one's later years. Intervention designs that are specific to the range of old and very old clientele have yet to fully emerge. For example, it is relatively unknown whether a gratitude intervention could enhance life satisfaction in a person with dementia. Such an approach would require generating not only age-specific materials but a curriculum that is manageable by an older person with cognitive deficits. Quality-of-life instruments for older persons with dementia currently exist (Brod, Stewart, Sands, & Walton, 1999), but whether these could be adapted as dependent measures to gauge the effectiveness of behaviorally based interventions is unknown. As these kinds of issues are tackled, discoveries that highlight the dimensionality of meaning-centered interventions and their potential for preserving well-being in later life emerge.

Issues of quality of life in advanced age have become a part of the larger public health agenda. The Positive Aging Act of 2009 (H.R. 3191) describes the importance of not only providing mental health services to older Americans, but acknowledges that there will be more older persons with mental health needs, many of whom have been otherwise healthy and free of mental health concerns during earlier phases of the adult life cycle. The Positive Aging Act of 2009 (H.R. 3191) has been the first proposed U.S. governmental legislation to acknowledge the challenges of adapting to the inevitable consequences of old age and the role of the professional mental health service provider in this process.

In sum, the need for behaviorally oriented strategies for teaching individuals techniques for meaning finding in the presence of loss and to move, with dignity, through the transitions of old age are an essential complement to strategies for preventing chronic disease and maximizing function. However, when the biology of aging ultimately impacts the individual in irreversible ways, strategies for coping with progressive and irretrievable loss will become increasingly important as more persons in our society struggle with

the challenges of negotiating the vicissitudes of advanced and very advanced aging.

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