

# The Herczeg Institute on Aging

Newsletter No. 17 – November 2017. Tel Aviv University



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## - A Letter to Our Readers -

Dear Readers,

At the start of the new academic year, we are pleased to present issue no. 17 of The Herczeg Institute bulletin, which includes a variety of content about aging and old age.

During the past academic year, The Herczeg Institute has continued its research, alongside professional and community activity. The institute's researchers have published a large number of articles in periodicals, participated in professional committees and science conferences, and received research grants from several competitive foundations. In addition, we held two prominent events this year: a bi-national workshop titled *Aging Well*, in cooperation with the Heinrich-Heine University in Dusseldorf, Germany, and a conference titled *Aging in a Hostile World – Strength or Vulnerability: How do these two Exist Simultaneously?* based on The Herczeg Institute's research, funded by the ministry of science.

The bi-national workshop took place on March 19-20, 2017, as part of the cooperation between The Herczeg Institute and Tel Aviv University and the Heinrich-Heine University in Dusseldorf. Among the participants were researchers from both universities from a variety of fields related to aging and old age, who created a pleasant atmosphere for discussion and exchange of opinions. We look forward to continuing this partnership and creating joint research and community projects, which we'll be happy to inform you about in the future.

The conference *Aging in a Hostile World – Strength or Vulnerability: How do these two Exist Simultaneously?* took place on July 4, 2017. You can read more about it on page 14. We'd like to add that the research is already past the stage of collecting the findings of its various samplings, and we look forward to publishing the final findings soon.

This year we also held a series of lectures for professionals in the field of aging, titled 'In Sickness and in Health: Physical and Mental Welfare in Old Age and the Arts'. In addition, we held a series of lectures for Discount Bank pensioners. As in previous years, the diverse program included topics related to culture, science, psychology and more.

For each of this coming year's events, we will send a separate announcement through our mailing list. This year we hope to hold another series of lectures for professionals in the field of old age, but this time, the format will be broader. We will also be holding conferences and additional seminars. Please follow the updates on our website and mailing list for more details.

We wish everyone a successful, fruitful academic year, and we appreciate your support and encouragement. We're always happy to receive your feedback, comments and ideas.

**The Herczeg Institute on Aging Team at Tel Aviv University**

## Rehabilitation after a Hip Fracture

Dr. Eli Mizrahi

Head of Geriatric Medicine and Rehabilitation Department

The Geriatric and Medical Center "Shmuel-Haroffe," Be'er Ya'akov



Hip fractures are a very common occurrence in the elderly population, which could lead to disability and even death. In this article I will briefly describe the different types of hip fractures and methods of treatment, and afterwards I will go into detail about the rehabilitation process.

Most hip fractures are caused as a result of falling, but for the elderly, minimal force, such as a change in sleeping position, getting up from a chair or just walking, could be sufficient to cause a fracture. This is usually a result of osteoporosis, which weakens the bones. Hip fractures may occur in a number of locations:

Subcapital and femoral neck fracture (see diagram)

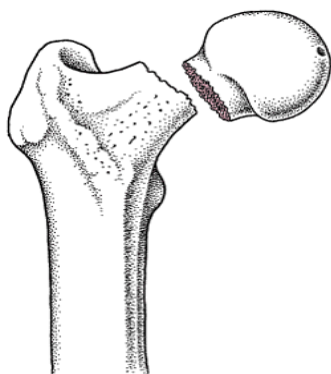


FIGURE 22-1. Subcapital and femoral neck fracture.

Intertrochanteric fracture (between trochanter major and trochanter minor; see diagram)

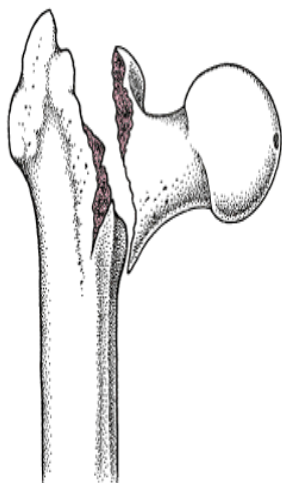


FIGURE 22-3. Intertrochanteric fracture.

Femoral neck fractures and intertrochanteric fracture are the most common.

### **Clinical Indications of Fractures**

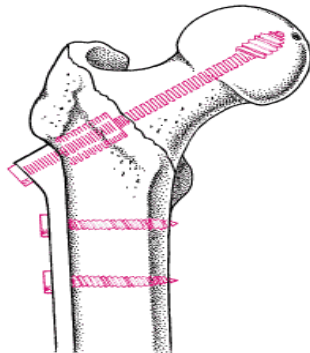
Hip fractures typically cause groin pain and inability to walk. Sometimes the pain is projected to the knee, so the problem may be misdiagnosed as a medical problem of the knee instead of the hip bone. Patients who experience movement of the hip bone in the area of the fracture are not able to walk, and the leg in which the fracture occurred may appear shorter than the healthy leg. Differently, patients with fractures with no movement of the hip bone are able to walk, the pain is relatively moderate, and the leg is not shortened. In this case, a medical exam will reveal extreme pain when the patient moves the femoral neck while the knee is bent.

### **Diagnosis**

Hip fractures are usually diagnosed by x-ray imaging. In rare cases, a CT or MRI scan is required. In cases where regular x-ray images do not show a fracture, but there is clinical evidence (such as extreme groin pain) of such a fracture, an MRI scan should be performed, as it is the most precise exam for fracture diagnosis.

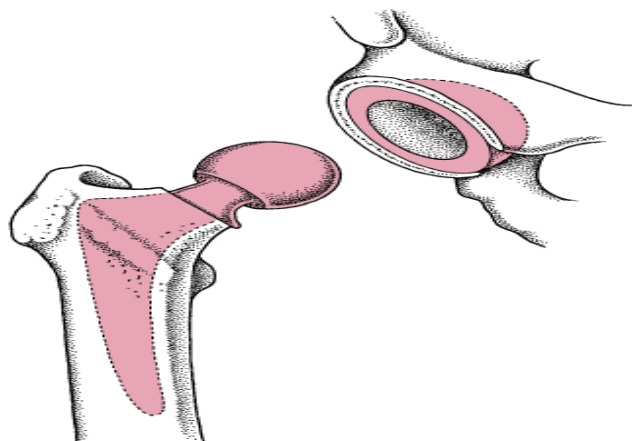
### **Treatment**

In most cases, hip fracture patients require surgical treatment. The patients are taken to the operating room just hours after emergency room admittance and diagnosis. Fractures between the two trochanters and/or under the two trochanters are fixated with a screw (see diagram).



**FIGURE 22-6.** Fixation of an intertrochanteric fracture with a sliding compression screw and side plate.

On the other hand, femoral neck fractures are treated by partial or full femur replacement (see diagram).



**FIGURE 22-5.** Hip replacement. Treatment of a displaced femoral neck fracture may involve use of a Moore solid-stem prosthesis (*left*) or total hip replacement, consisting of a femoral component and a polyethylene bipolar component (*right*).

As previously mentioned, most hip fractures are treated surgically, to reduce the patient's time in bed to a minimum, and also to alleviate pain intensity. If the fracture is not operated on, the patient will have to spend a long time in bed, thus increasing the risk for many complications, particularly for elderly patients, such as deep vein thrombosis, pressure sores, pneumonia and a significant drop in ability to function. After hip fixation or replacement surgery, rehabilitation should begin as soon as possible. Treatment with anti-thrombotic agents (Fragmin, Clexane) may reduce the risk of developing deep vein thrombosis.

### **Rehabilitation after a Hip Fracture**

The purpose of the rehabilitation is to encourage recovery after functional loss. In general, functional loss may occur after a fracture, amputation, stroke, arthritis, heart disorders or a significant drop in function after a long hospitalization. The rehabilitation process includes: physical therapy, occupational therapy, speech therapy, psychological counseling and aid and guidance from a social worker regarding the fulfillment of the patient's rights when they are released back into the community.

For some patients, the purpose of the rehabilitation is assistance in returning to a similar functional level as before the hospitalization. For others, the purpose is assistance in independent functioning, as much as possible, for everyday activities.

The results of the rehabilitation process depend on the type and severity of the injury, as well as on the patient's motivation. For about a week after hip fixation or replacement surgery, all patients will experience functional decrease. Then, assuming the patient's medical state is stable, they will be examined by a physician who specializes in geriatrics. The purpose of the exam is to determine whether the patient qualifies for rehabilitation – meaning, whether their functional state is likely to improve at a geriatric rehabilitation ward, to a point where within several weeks they can return home. The geriatric physician's exam includes:

1. Examining the patient's cognitive state: whether the patient can understand what is being said to them and follow instructions given by the multi-professional staff (physical therapy, occupational therapy and more) in the rehabilitation ward.
2. A depression diagnosis exam: if the patient is severely depressed, they will refuse to cooperate with the multi-professional staff.
3. A medical exam: the geriatric physician must confirm that the patient's other diseases have not worsened. Worsening of heart failure, for instance, could cause the patient not to be able to perform physical tasks which are required during rehabilitation.

If the patient qualifies after the preliminary evaluation, they will be transferred to a geriatric rehabilitation ward for rehabilitation and medical follow-up. These wards are usually located in geriatric medical centers, such as the Shmuel Harofe Hospital in Beer Yaakov. There is no doubt that hospitalization in a geriatric rehabilitation ward is the best setting for rehabilitation, achieving the best results. When the patient is admitted to the ward, they will be evaluated by a skilled multi-professional team, including a geriatric physician, a physical therapist, an occupation therapist and a nurse. Each patient will receive an intensive, personalized, daily rehabilitation plan, in accordance with their mental and cognitive state, so that in most cases, they will be released back to the community in a satisfactory functional state. As the patient's release date nears, they will be invited, along with family members, to guidance sessions with the multi-professional staff, who will explain

how the patient must behave when returning to the community. The patient and their family will receive an extensive explanation from the social worker regarding the patient's rights in the community, in relation to their functional state.

As previously mentioned, rehabilitation must begin shortly after surgery. The main purposes of rehabilitation are preventing reduction of muscle strength and muscle atrophy in the healthy leg. For the leg with the fractured femur bone, only muscle-strengthening physical therapy exercises should be performed, while the leg itself is in straight position. Pillows should never be placed under the knee of the operated leg, to avoid tendon contracture in the hip and/or knee joints. During the second stage of rehabilitation, the patient will gradually begin stepping on the operated leg, until full stepping is achieved. The rehabilitation partially depends on the type of surgery. For example, after full or partial hip replacement – using a prosthetic, rehabilitation time is shorter and results are better, compared to surgery where the fracture was fixated with a plate and screw.

Ideally, within two days after surgery, the patient may step with full body weight on the operated leg. Walking exercises begin 4 to 8 days after surgery (assuming there is no indication which prevents full stepping, as in a state of instability of the fracture even after surgery). Exercises for ascending and descending stairs begin about 11 days after surgery. In addition, patients are taught to independently perform exercises to strengthen the quadriceps of the operated leg. Lifting heavy objects or jumping on the operated leg is not recommended, to prevent damage. During walking exercises, the mechanical load rate on the operated leg will be identical if the patient uses a walking cane or two, but the use of two canes may prove to be a disturbance while performing everyday tasks. Patients cannot sit on any chair, particularly low chairs, for an extended amount of time, and they must use the chair's armrests when getting up from a sitting position. While sitting, patients must not cross their legs, to avoid damaging the operated leg.

## An Interview with Nitza Eyal about her New Book: *To My Mother*

Interviewer: Tom Aival

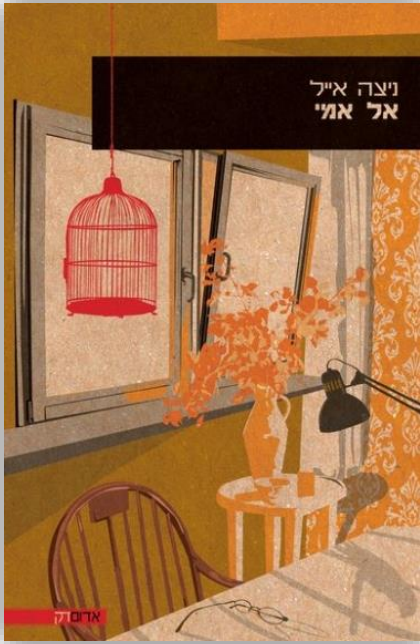


Illustration by courtesy of the Hakibbutz Hameuchad-Sifriat Poalim Publishing Group

Hello, Nitza. I am happy to have this opportunity to interview you about your new book, *To My Mother*. I see it as a very important book, not only because of the beauty of the writing, but also, perhaps mainly, because of the depiction of your relationship with your mother. This brings me to my first question: the book mainly depicts your mother in old age. This is a difficult time, almost devoid of consolation, when she is hospitalized and her physical and mental abilities gradually deteriorate. You often describe the great difficulty for both of you in this situation, but also the strong relationship between the two of you, even when your mother is almost non-responsive. *To My Mother* is not a book that describes a chronological chain of events, but jumps back and forward in time, to your mother's past and your own childhood. However, the setting of the story is, as previously mentioned, the depiction of your mother's old age. I'm interested to know, what made you choose to focus on your mother's elder years? An additional question I have is related to your memories from that time. How much of that time is etched in your memory? Do your memories of your mother (today) mainly include that time, or also earlier times, when she was in better condition? And finally, what helped you cope from day to day while your mother's condition was deteriorating?

**Thank you for your sensitive questions. They inspired me to take a new journey to my mother and to the book I wrote. Sometimes, the passing of time allows a new perspective, clearer than other angles. As you mentioned, the book does not depict a chronological occurrence of events; it travels between a present where I am saying goodbye to my mother and grieving for her, and a past where the special mother-daughter relationship formed. The book was not written according to chapter headings or an organized table of contents. After each visit with my mother, I felt the need to preserve the things she said and I wrote them on any scrap of paper I could find: a napkin, a page from a notebook, a cigarette box. I'd put the scraps of paper into a big envelope and never look at them again. In this manner, her words were**



collected and her character was sketched. The writing stage is like weaving a rug or assembling a mosaic: another small stone, another strand of colored thread. The book *To My Mother* is not a biography, it is a memoir. And by nature, memories are personal, they form and change. To some extent, we choose what to remember and what to forget, and sometimes forgetting or repressing difficult experiences can be an effective coping mechanism. I chose to write about separation, illness and death because during that sad and difficult time, my bond with my mother strengthened, both emotionally and physically. During our lifetime, we take different elements of our lives for granted. My mother's fatal illness demanded full awareness of every moment and gratitude for her still being alive.

Your question about my memories of her today is particularly interesting. Those memories have been through a process of reconciliation, screening and purification. Writing the book allowed me to reexperience emotions and different events, and to observe our relationship from the place in life I am in today, as I move closer to her.

I am contemplating your question about the support I had during the time when her condition was deteriorating. Of course, I had the full support and the embrace of my family, who were a safe place I could go to anytime and in any state. My children growing up and my eldest son's wedding represented processes of growth and renewal for me, symbolizing the future. At the same time, there was much pain in the knowledge that she would no longer be part of the family's future. I had additional support from my profession as a geriatric psychologist, and from meeting with elderly people who showed me a variety of different ways to cope. I understood that there is no set method that is right for everyone and I needed to seek and find the right way for me.

When I read the book, I got the impression that your mother was an introverted, quiet woman. You write: "(...) Words were Dad's expertise (...) he'd stand 5'1 tall and speak. Enthusiastically, excitedly, intensely (...) From him I learned the strength and beauty of words, from him I also learned their weakness. She, on the other hand, stayed away from words. She was never opinionated and she never raised her voice, but in her own quiet, reserved way, she was present and influential. She spoke without words." Now, I'd like to ask about your mother's life story. Do you feel that by publishing the book, you gave your mother a voice and an important role that may not have been otherwise manifested?

**My mother's life dream was to become a nurse, to take care of people in pain and aid them, but because of the events of that period, her dream could not be fulfilled. She volunteered for Magen David Adom, where she met my father. A turbulent man and a quiet woman. My mother's unique voice was in her pleasant personality, in her ability to listen and in the compassion she had for others. Now I understand that she was a natural psychologist. I think that neither my mother nor myself are the center of the book – we could be replaced with other people, and hence it is not a biography. The focus of the book is the array of emotions between mother and daughter during a time of severe illness and saying goodbye. One of the first titles I gave the manuscript was "Sometimes Spirits, Sometimes Angels". I think this name expresses the deep, complex emotional tempest that accompanies the separation from one's mother.**

In the book there is also a meeting point between two developmental periods, between mid-life and the end of life, between other time perspectives and various developmental roles.

**This meeting point raises difficult thoughts. Our parents are the mirror in which we reflect in the future. This type of reflection has a role: examination, contemplation, objection, making changes. Many people look in the mirror in the middle of their life and decide it's time to fulfill dreams, to realize plans, to study, to switch to a new profession, to travel the world.**

Earlier, you mentioned that the writing process of *To My Mother* was fragmented, based on lists and notes that were collected over the years. When did you decide to publish the book?

**I don't have a direct answer for your question. I guess that for years, I went through an internal, unconscious process of separation from her, which allowed me to get up one day, open the bag where I was saving all the lists and notes, sit at the computer and start writing. Writing the book brought her character back to life for me, making it a deep and rewarding emotional experience.**

There are many references to death throughout the book. Beyond the book's main setting, you write about the deaths of people who were close to you, and to the relation to death in other cultures. It seems that most of these references emphasize the void and the loss that death brings about. However, when your mother died, alongside the grief and loss, I assume there was also an aspect of relief and liberation from pain, maybe even liberation from the need to aid her. Could you expand on that?

**If you're asking me if I felt relief when she died, yes. I felt that a period of my life had come to an end. I felt relief mainly because it was the end of the suffering and humiliation, but also of my craziness, the constant running, the insomnia, the fear that the phone would ring in the middle of the night and someone would say, "come quickly." And in the end, that is what happened. I felt that now I was in the mirror, reflecting for my children. The generations had switched.**

**In conclusion, I'd like to add that my mother and I always met on Saturday mornings. During the week, I'd stop by whenever I could, between meetings, after work, but Saturday mornings were hers. To this day, I sometime wake up on Saturday morning and feel that I want to go visit my mother. Just get in the car, place the bag of goodies on the seat next to me, not forgetting the warm socks I bought her, her feet are always cold. And drive. I miss her.**



Nitza Eyal, staff member at The Herczeg Institute, has a master's degree in clinical psychology. In her position as researcher at The Herczeg Institute, she has written and led studies in the field of psychological development throughout life. Among her books: *Life as a River* (Yediot Acharonot, 1977), *The Wonders of Memory and the Delusion of Forgetting* (Arie Nir, 2004), *Psychological Pictures* (Arie Nir, 2010). We would like to thank Nitza for her graciousness in devoting the time to this interview.



- Personal Article -

## My Relationship with my Grandfather and the Processes of Coping with his Death

Tom Aival



My grandfather, Jonathan Aival, passed away a little over a year ago. I'd like to start by writing about our relationship and my grieving process, and afterwards, I will share the findings of a relevant study.

I was born in Haifa in '83, and I was my grandfather's first grandchild. He lived nearby my parents, who tell me that from the moment I was born, he was a very involved and active grandparent. My first memories from his home are probably of his well-groomed garden, where the plants seemed huge to me. I also remember him at my preschool birthday parties, which he attended regularly. When I grew up, my bond with my grandfather remained very strong. He was a very loving, pampering grandparent, and I loved staying with him as a child. I loved the regularity of the daily routine: he always had chocolate milk, ice cream, rye bread and salami at his apartment, and breakfast was a European-style scrambled egg – meaning, never overcooked. I also loved my room there, and the big garden I could play in.

In comparison with other close figures in my life, my grandfather had a different approach to life, one you might call European or "Yekke". Music, culture, politics and science were very important to him, and in his free time, he'd listen to classical music, read newspapers and books, travel abroad, or study the history of his family in Germany. I was very fond of the atmosphere in his house and of his interests, and perhaps they allowed me to form my own similar interests, especially because from a young age, I was attracted to fields such as history, literature and politics.

My grandfather was also a very impressive man, due to his military past, his job as head of Israel Friends of Technion, and also the order that was a big part of who he was. But apparently, beyond that, there was something in his personality that radiated calmness and security. As a boy and teenager, my relationship with him gave me a sense of security. Even afterwards, and up till his death in fact, he always helped me and took care of me.

As the years went by, our relationship changed. In his late 80s, my grandfather didn't leave the house much, and started having trouble with basic actions he'd done easily all those years, such as walking or driving. His leisure time also suffered, and most of the time, he'd get bored reading a book or watching TV. At that time, I maintained a particularly close relationship with him, helping him whenever I could with cooking, driving and more. In his elder years, my grandfather maintained his elegance and his sense of humor, and even during that time, when I was a college student, I still liked visiting him at his home. I felt a connection to the quiet in his house, and to the slow, regular pace of his life. Despite his physical weakness, during this stage of his life I could still ask him for advice on personal or family matters, and even when his interest in culture and current events had diminished, he was still very interested in the lives of his family members.

After his health deteriorated during the final years of his life, my grandfather passed away on August 23, 2016, at the age of 92. After his death, I immediately felt contrasting feelings of relief and grief. Relief, because it was difficult for me to watch his condition deteriorate during those last months, and grief over the death of a person who was very close to me, who had a very important role in my life. Up till his death, I had never had to deal with the death of a loved one, so I was feeling like this for the first time. My grandfather's death was not at all sudden, and it did not bring about feelings of shock or regret, which are common when a young person must cope with loss. For this reason, I think my feelings of grief after his death were more restrained, perhaps more minor. As he died at a very old age, after a fulfilling, meaningful life, I did not feel regret, but happiness over the fact that he'd been able to achieve so much in his life, mullied with sadness over a life that had ended. However, it's surprising that still, despite his very long life, it's difficult for me to grasp the fact that his life has ended.

In attempt to get a better understanding of the phenomenon of coping with the death of a grandparent, I checked the literature on the topic. An article by Manoogian, Vandenbroeke, Ringering, Toray, & Cooley<sup>1</sup>, published this year in the periodical *Omega: Journal of Death and Dying*, reviews studies about the connection between grandchild and grandparent, as well as the influences of a grandparent's death on the grandchild in early adulthood. As in my own personal story, the research literature on the topic also emphasizes the significance of the intergenerational relationship and the closeness and mutual caring between grandchild and grandparent. The death of a prominent family figure, such as a grandparent, can create difficulties in the grandchild's personal and professional life, due to the sudden independence in early adulthood. In a study that Manoogian and his colleagues conducted on American college students, they show that the common narratives between grandchildren who had lost a grandparent were narratives of sadness and pain, alongside guilt and regret that their relationship hadn't been close enough. Several significant factors influenced the grandchildren's reactions to the grandparent's death, including the level of closeness between the grandparent and grandchild (a closer relationship produced a larger sense of loss), the grandparent's age and the suddenness of the death (the younger the grandparent was and the more surprising the death was, the larger the trauma experienced by the grandchildren). In addition, feelings of relief were found among grandchildren after the death of a grandparent who had suffered from a serious illness. Regarding the rest of the family, the death of the grandparent strengthened the family bond in most cases, but created distance in a small number of cases.

An additional finding showed that after the death of the grandparent, there was a surge in positive feelings, such as self-awareness, motivation to act and understanding of the importance of the family unit. It seems that the experience the participants went through helped them grow, leading them to think about their place as adults in the familial context and in their relationships with others. For many of them, it was their first experience with death, leading them to think about their lives as mortals, and to cope with the grieving process.

My story is very similar to the findings of the study by Manoogian and his colleagues. It seems that as my grandfather died at an old age and his death was not sudden, the coping process was easier, leading to the strengthening of familial bonds and to processes of growth. As so, even in his death, my grandfather has a positive influence on my life.

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<sup>1</sup> Manoogian, M. M., Vandenbroeke, J., Ringering, A., Toray, T., & Cooley, E. (2017). Emerging adults' experiences of death. *OMEGA-Journal of Death and Dying*. doi: 10.1177/0030222817693140

Several weeks after his death, and even now, in fact, I can hardly remember him as he was during his last months. The figure in my imagination is a strong, independent man, as he was for almost his entire life. Once in a while, I read the little booklet he wrote about his life or look at his family tree. Every week, I pass by the cemetery where he is buried. From conversations with my family, I believe he left a similar mark on all of us, one of closeness, caring and love.

Tom Aival is the academic coordinator at the Herczeg Institute on Aging.



## Aging in a hostile world: Resilience or vulnerability?



On July 3, 2017, The Herczeg Institute hosted a conference about the quest for positive quality of life under the adversities of old age. This conference was based on an ongoing study at Herczeg Institute, funded by Israeli Ministry of Science. The conference included lectures about four groups of older people in Israel, which represent four disadvantaged populations in current Israeli society:

the poor, the handicapped, bereaved parents (resulting from a disease or accident - as opposed to military or terror deaths, which have been widely studied in Israel), and homosexual men. The aim of the study was to understand the links between resilience and vulnerability in each disadvantaged group, and to give the target groups a voice and raise awareness of their circumstances and needs, so as to improve their lives and the way people relate to them. The study applied Shmotkin's model of *the pursuit of happiness in a hostile world* as a unifying conceptual framework. Accordingly, the basic assumption of the study was that happiness-promoting systems (notably subjective well-being and meaning in life) regulate, or reconstruct, the hostile-world scenario, indicating one's image of potential negative occurrences.

Participating scholars and topics (in order of appearance):

**Professor Dov Shmotkin**, (principal investigator): *The pursuit of happiness in a hostile world along adulthood and old age*

**Dr. Kfir Ifrah** (the research director and a co-investigator) and **Mr. Noam Markovitz**, (co-investigator): *findings from the older bereaved parents and older gay men's samples*

**Dr. Rinat Lifshitz** (a member in the research team): *Coping with trauma as the time from its onset goes by: findings from samples of older bereaved parents and older adults with physical disabilities*

**Dr. Kfir Ifrah**: *Coping with challenging life circumstances: compensation versus depletion*

**Dr. Irit Bluvstein** (a member in the research team): *The backstage of the hostile-world scenario research: human, ethical and methodological issues*

The concluding part of the conference was an expert panel, with the participation of five renowned experts specializing in trauma and adversities of old-age. The participants were (in alphabetical order): **Professor Ehud Bodner** (Bar-Ilan University); **Professor Karni Ginsburg** (Tel Aviv University); **Dr. Ruth Malkinson** (Tel Aviv University); **Professor Yuval Palgi** (Tel Aviv University); **Dr. Geva Shenkman Lachberg** (The Interdisciplinary Center Herzliya) and **Professor Amit Shrira** (Bar-Ilan University).

For an article on the conference, please [click here](#)



## Two abstracts of new studies by researchers at The Herzeg Institute

Cohen-Mansfield, J., & Brill, S. (2016). **Trajectories at the end of life: A controlled investigation of longitudinal health services consumption data.** *Health Policy, 120* (12), 1395-1403. doi: 10.1016/j.healthpol.2016.09.017

**Background:** Knowledge of individual-level trajectories of Health Services Consumption (HSC) at End-of-Life (EoL) is scarce. Such research is needed for understanding and planning health expenditures.

**Objective:** To explore individual-level EoL trajectories in the Israeli population. This approach differs from past studies which aggregated across populations or disease groups. **Data sources:** We used HMO (Health Maintenance Organization) longitudinal data for HSC of persons ages 65–90 who died during 2010–2011 (n = 35,887) and of an age by sex matched sample of persons who were alive by mid-2012 (n = 48,560).

**Design:** HSC per quarter was calculated for each individual. Trajectory-types of HSC were described through k-means cluster analysis. **Extraction methods:** Data were extracted from computerized HMO files. HSC was computed as a standardized function of HMO costs for each individual.

**Results:** In both samples, low HSC trajectories were the most common. However, among the deceased, all trajectories had higher HSC than those who were alive; the low HSC trajectory cluster represented a smaller percentage of the sample; and all relevant trajectories included a HSC peak. In contrast, the most common trajectory among the living was a flat low HSC. Clusters differed significantly by sex, disease status, and age.

**Conclusion:** This methodology shows the utility of individual-level analysis of HSC at end-of-life and should inform future research and current debates concerning EoL care and resource distribution.



Shmotkin, D., Avidor, S., & Shrira, A. (2016). **The role of the Hostile-World Scenario in predicting physical and mental health outcomes in older adults.** *Journal of Aging and Health, 28*, 863-889. doi:10.1177/0898264315614005

**Objective:** The hostile-world scenario (HWS) denotes a personal belief system regarding threats to one's physical and mental integrity. We examined whether the HWS predicted health among older adults.

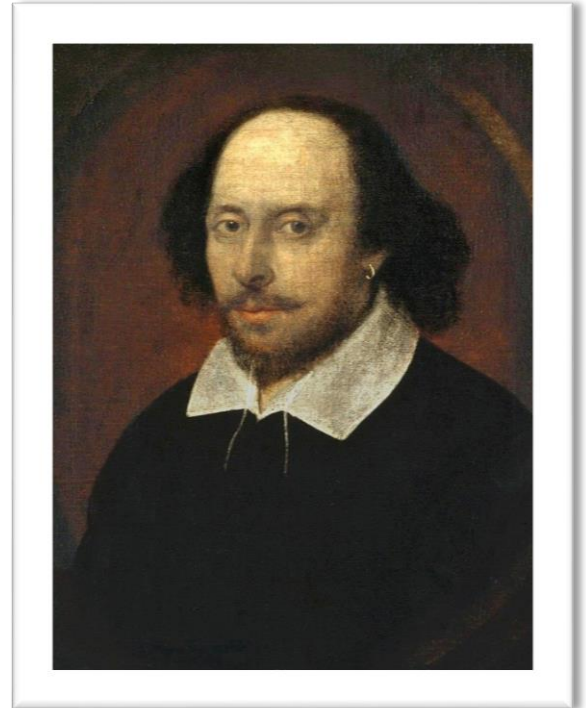
**Method:** The Israeli branch of the Survey of Health, Ageing and Retirement in Europe (SHARE-Israel) provided data on 1,286 participants, aged 50+, interviewed in two waves 4 years apart. A special measure assembled items pertinent to the HWS throughout the SHARE survey. Nine outcomes indicated physical health (e.g., activities of daily living, medical conditions) and mental health (e.g., depressive symptoms, satisfaction with life).

**Results:** The HWS at Wave 1 predicted all physical and mental outcomes at Wave 2, except cognitive functioning, beyond effects of sociodemographics and the respective outcome's baseline at Wave 1. This predictive effect was stronger among older participants. **Discussion:** The results support the conception of the HWS as a psychological monitor that senses approaching functional declines in later life.

## Sonnet 18

### William Shakespeare

Shall I compare thee to a summer's day?  
Thou art more lovely and more temperate:  
Rough winds do shake the darling buds of May,  
And summer's lease hath all too short a date:  
Sometime too hot the eye of heaven shines,  
And often is his gold complexion dimm'd;  
And every fair from fair sometime declines,  
By chance, or nature's changing course, untrimm'd:  
But thy eternal summer shall not fade,  
Nor lose possession of that fair thou ow'st;  
Nor shall Death brag thou wander'st in his shade,  
When in eternal lines to time thou grow'st:  
    So long as men can breathe, or eyes can see,  
    So long lives this, and this gives life to thee.



William Shakespeare (1564-1616) was an English poet, playwright and actor, widely considered to be one of the greatest writers of Western culture. Sonnet 18 is part of the *Fair Youth sequence* (1609). It addresses the subjects of death, beauty and immortality.



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## List of Recent Publications by The Herczeg Institute's researchers

### 2016

- Cohen-Mansfield, J.** (2016). Non-pharmacological interventions for agitation in dementia: Various strategies demonstrate effectiveness for care home residents; further research in home settings is needed [Peer commentary on the paper "Non-pharmacological interventions for agitation in dementia: Systematic review of randomized controlled trials" by G. Livingston, L. Kelly, E. Lewis-Holmes, G. Baio, S. Morris, N. Patel... C. Cooper]. *Evidence Based Nursing*, 19(1), 31. doi:10.1136/eb-2015-102059
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**Lifshitz, R.**, Nimrod, G., & Bachner, Y. (2016). Measuring risk perception in later life: The perceived risk scale. *The Journal of the American Psychiatric Nurses Association*, 22 (6), 469-474. doi: 10.1177/1078390316659910

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- Cohen-Mansfield, J., Skornick-Bouchbinder, M., Hoshen, M., & Brill, S.** (2017). The relationship between health services standardized costs and mortality is non-linear: results from a large HMO population. *Health Policy*.

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Shenkman, G., **Ifrah, K.**, & **Shmotkin, D.** (in press). Meaning in life among middle-aged and older gay and heterosexual fathers. *Journal of Family Issues*.

### **Books**

Brill, S., **Cohen-Mansfield, J.**, **Hazan, H.**, & Lavi, S. (Eds.) (Forthcoming.). *Lamut Beyisrael: Tmunat Matzav (Dying in Israel: Situation Report)*. Bnei Brak: Hakibbutz Hameuchad publishing group. (Hebrew).

**Eyal, N.** (2017). *El Imi (To My Mother)*. Bnei Brak: Hakibbutz Hameuchad publishing group. (Hebrew).

Monterescu, D., & **Hazan, H.** (Forthcoming). *Twilight Nationalism: From Identity Politics to Politics of Existence in a Palestinian-Israeli City*. Redwood City: Stanford University Press.

(\*) Names of the faculty members of the Herczeg Institute on Aging are Bolded

## About Herczeg Institute on Aging

The Herczeg Institute on Aging was established in 1992 at Tel Aviv University.

The Institute fosters interdisciplinary research, as evidenced by the joint direction of the Faculty of Social Sciences and the Faculty of Medicine.

The presence of this institute on campus signifies the increasing importance of research on aging-related topics at the university. The Herczeg Institute conducts and promotes an array of studies relating to aging and old age. These studies concern issues such as physical and mental health, health promotion, adaptation and resilience at old age, well-being and quality of life along the life span, cognitive and emotional aging processes, the elderly in society, ill-health at old age, dementia, problems in attending to the old, traumatic life events and the long-term impact of the Holocaust.

Additional goals of the Herczeg Institute include the dissemination of gerontological knowledge in the academia and the community, stimulating researchers of aging and old-age in the various disciplines with a particular emphasis on promoting young researchers in the field and maintaining relationships with decision makers and policy makers in areas related to aging and old age.

The Herczeg Institute is directed by **Prof. Dov Shmotkin**.

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Tom Aival –  
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