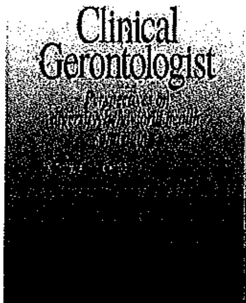

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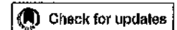

Enhancing Meaning when Facing Later Life Losses

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ABSTRACT

Objective: This article presents several client cases to illustrate psychotherapeutic interventions for helping older adults facing later life losses enhance their sense of meaning.
Methods: Cases are derived from the client population of a community mental health clinic which provides psychotherapy for low income, seriously mentally ill, culturally diverse older adults, many of whom experience serious medical illnesses. Over the course of 24 years in this setting, the primary author has observed various interventions which offer possibilities to provide hope and meaning for clients with severe problems.
Results: Interventions discussed with individual cases include utilizing life review and reminiscence therapies, helping in grappling with the ending of life, facilitating enhanced relationships, encouraging creative endeavors, enabling spiritual and religious practices, honoring wisdom and legacy leaving, and engaging in mindfulness practices. Each approach is reviewed with reference to empirical support, clinical utility, and treatment considerations.
Conclusions: Helping older adults to find hope and meaning in their lives can be challenging. Specific interventions which target meaning-making may be adapted to fit each client's needs.
Clinical Implications: Clinicians may focus on enhancing meaning as a core or adjunct aspect of treatment with older adult clients. Considerations for implementing interventions may depend on contextual factors relevant to each case.

KEYWORDS
Enhancing meaning; older adults; psychotherapy

Introduction

Later life can be a time of troubling concerns such as physical and/or cognitive decline, pain, loss, awareness of life ending and approaching death. Standard approaches to mental health treatment often require physical and cognitive abilities, focus and energy. Clinicians working with older adults may struggle in helping clients find satisfaction in the face of serious, irreversible declines and losses. Mental health interventions can help by assisting aging adults to alter their perspectives and shift their sense of meaning. Renowned psychiatrist Victor Frankl (1986) considered three avenues of meaning, including creating a work or doing a deed, experiencing something or encountering someone, and changing one's attitudes about situations. Other authors also emphasize the importance of helping clients develop new forms of meaning after losses and trauma (e.g., Horowitz, 1986; Neimeyer, Harris, Winokuer, & Thornton, 2011).

The interventions to enhance meaning described below are linked with positive outcomes supported by empirical research. Reminiscence therapy and life review may improve life-satisfaction and emotional well-being in older adults, as well as decrease symptoms and impairment associated with late-life depression. (Bohlmeijer, Roemer, Cuijpers, & Smit, 2007; Bohlmeijer, Smit, & Cuijpers, 2003; Pinquart & Forstmeier, 2012). Through the discussion of death, dying, end-of-life concerns and decision-making, mental health professionals may play a critical role in improving the experiences of older adults and their families (Haley, Larson, Kasl-Godley, Neimeyer, & Kwilosz, 2003). Helping older adults to minimize loneliness and isolation by improving relationships with others can reduce their risk for mortality (Holt-Lunstad, Smith, Baker, Harris, & Stephenson, 2015). Older adults who engage in creative work are more likely to report increased quality of life and less health problems (Fraser et al., 2015). Psychotherapeutic

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interventions which integrate creative modalities (e.g., creative writing in reminiscence treatment) may help reduce symptoms of depression (King, 2017). Spirituality and religiousness have been correlated with improved health, well-being, positive affect, and optimism which may buffer stress associated with aging-related changes, including problems with depression, dementia, and chronic illness (Koenig, George, & Titus, 2004; Hawyward et al., 2012; MacKinlay & Trevitt, 2010; Kirby, Coleman, & Daley, 2004; & Ostir, Ottenbacher, & Markides, 2004). Acknowledging the development of wisdom may have a positive effect on older adults' well-being, life satisfaction, physical health, and relationships with others (Ardelt & Edwards, 2015; Ardelt, 2000; Sternberg, 2005). Encouraging older adults to cultivate a mindfulness or meditation practice can help foster improved health and coping behaviors, especially for those experiencing issues with stress, sleep or chronic pain (Black, O'Reilly, Olmstead, Breen, & Irwin, 2015; Morone & Greco, 2007; Perez-Blasco, Sales, Melendez, & Mayordomo, 2016). Clinical methods for helping aging clients enhance meaning and achieve goals of later life in the context of co-existing challenges will be discussed.

Method

Over 24 years, the primary author has worked as the Clinical Director of a community mental health clinic, providing direct psychotherapy and supervising other clinicians providing psychotherapy. Clients are older adults with serious mental illness who are economically challenged and often physically frail and socially isolated. The primary author has supervised approximately 1,000 clinical cases. In so doing, she, as well as the second and third authors, have developed methods of helping clients who have limited resources other than their own internal processes. Providing beneficial help to these clients who have limited resources has compelled a review of clinical practices relevant to supporting hope and meaning in challenging circumstances. Seven clinical cases[1] are presented and followed by a discussion of the meaning-based interventions used.

Case 1: Life Review & Reminiscence

Sarah was an 80-year-old divorced, Caucasian woman who was referred for depression following a stroke. Prior to the stroke, she had been very independent, still managing numerous apartment buildings which she owned. While her sons had been helping her with her real estate business, now she was no longer able to participate in the business at all. Using an instrumental reminiscence approach, the clinician asked Sarah to recall accomplishments when she was in school, how she had managed after her divorce and raising three sons, how she had built up and managed her real estate business, how she had made many decisions along the way and managed large sums of money. She enjoyed thinking about and relating her past successes and developed a greater sense of well-being and self-esteem.

Erik Erikson (1982) proposed that the developmental task of older adulthood is to resolve the conflict between integrity and despair. Approaching death stimulates a review of life to prepare for death. Life review includes consolidating one's understanding of the life one has lived, achieved through the struggle between integrity and despair. A successful life review may involve, "mourning for time forfeited and space depleted ... autonomy weakened, initiative lost, generativity neglected, identity potentials bypassed and having too limited of an identity" (Erikson, 1982, p. 63).

Butler (1963) and Birren and Cochran, 2001 also considered later life as a time to review one's life, allowing a return to consciousness of experiences and unresolved conflicts. Upon reflection, one may expiate guilt, resolve internal conflicts, reconcile relationships, renew ideals, and bring serenity and wisdom (Butler, 1963). Birren and Cochran (2001) suggested that the purpose of life review is to develop an acceptable image and leave an acceptable legacy; that an awareness of coming death can stimulate a person to review one's life to integrate the actuality of life with what might have been, and reorganize attitudes towards one's life.

The developmental process of life review has been adapted to a form of psychotherapy called either Life Review or Reminiscence Therapy, a structured activity to access and process thoughts

[1]Names of individuals in each clinical case example are pseudonyms in order to protect client confidentiality.

about past experiences (Lewis & Butler, 1974). "Integrative" reminiscence refers to reappraising losses, shortcomings and difficulties, reviewing values and personal meaning, and working towards a renewed understanding and perspective on life (Wong & Watt, 1991). "Instrumental" reminiscence refers to recalling past successes, achievements and positive adaptations to reactivate a positive self-concept. This was the approach that was used with Sarah in Case 1, illustrated above. Techniques which can prompt therapeutic discussion include marking down a timeline and writing in dates and major life events, then analyzing and discussing the meaning of the events, using important world events as markers, using aids to evoke memories (e.g., photos, letters, music, foods), encouraging clients to take a pilgrimage (e.g., to an old home), and/or writing an autobiography.

Clinicians can consider using life review or reminiscence in a number of different situations. *The Handbook of Structured Life Review* (2007), by Barbara and Barrett Haight can be a helpful guide. For example, when a client seems defeated because later life losses impede his/her ability to engage in previously valued activities (e.g., work, active volunteer job, or athletic activities), an instrumental reminiscence approach could help her/him recall and honor past positive activities and accomplishments, as illustrated with Sarah, above. Writing these recollections down (either by the clinician or the client) can help to concretize and remember these prior accomplishments.

When a client seems to be struggling with past regrets, an integrative reminiscence could be undertaken. This can include asking the client questions about what occurred in the past, exploring the factors that contributed to those situations, and helping the client to understand and accept their role in what happened. The integrative approach may be contraindicated when an older adult has had overwhelming past traumas and currently is isolated and low in social resources. In these situations, a person might become obsessive and despairing (Butler, 1963), suggesting this type of reminiscence should likely be avoided. Additionally, integrative reminiscence is probably contraindicated for people with significant cognitive impairment, as they may not have the cognitive ability to process and reorganize past regrets, and might get caught in negative emotions. Instrumental reminiscence may be more appropriate for these clients.

Case 2: Grappling with the End of Life

The discussion of end-of-life issues can prove to be a difficult topic for both clients and clinicians. Although health care providers have been encouraged to talk with clients about end-of-life wishes (Steinhauser et al., 2001), clients' fears and concerns about death and dying are often not addressed. Clients frequently worry about pain and suffering at the time of death, what happens when they die, whether they will be alone at the time of death, what happens after death, and who they will leave behind.

Carol was a 69-year-old client seen in therapy by the first author at Heritage Clinic in Pasadena, California. Carol had had a stroke, was bed-bound, and fought with her husband considerably. With some help, the client moved out of her home to an Assisted Living Facility. Carol then began having conflict with the staff. The clinician helped the client talk about her anger and then wondered if her anger might be related to underlying fear. With enough trust established, the clinician asked the client if she was afraid of what was happening to her body. The client identified that she was frightened of having another stroke and having intolerable pain. With consultation with her physician, Carol was reassured that if she were in pain, she would be offered enough medication to relieve her pain. Carol then identified that she was afraid of dying and going to hell, which surprised her to realize, as she was a staunch atheist. Her fear of going to hell was traced back to childhood messages she received at home and in early church lessons. The clinician helped the client challenge and resolve her belief that she was bad and would go to hell when she died. Addressing Carol's fear of pain at the end of her life, and her fears of what would happen to after her death helped to decrease her anxiety, anger and interpersonal conflict, and her satisfaction in her life improved.

Clinicians can begin discussion of end-of-life issues by starting with practical matters. Specifically, addressing how clients want to be

treated if they are unable to make their own decisions (advance directives) can be discussed. The Five Wishes Document (Aging with Dignity, 2011) and other advance directives can be used as tools for facilitating discussions. In addition to discussing practical issues, it is important to inquire directly about clients' beliefs and feelings about death. Clinicians may gently initiate discussions through asking clients questions about their parents' age at and cause of death, how the conditions of their parents' death affect their thoughts about their death, their feelings about their current age, what they think about their end of life, and what they think will happen after they die.

It is also important to obtain information about what clients consider to be a good death. Individuals often consider a "good death" to typically include:

- Optimizing physical comfort.
- Maintaining a sense of continuity with one's self.
- Maintaining and enhancing relationships.
- Making meaning of one's life and death.
- Achieving a sense of control.
- Confronting and preparing for death.

Particular caution should be taken when addressing end-of-life issues with clients of some cultures. For example, among some Asian cultures, bringing up the topic of death and dying can be considered to mean that you want the person to die. In such a situation it will be wise to bring up the topic very gently, perhaps by first asking permission if you can broach a potentially culturally "inappropriate" subject. It is important to consider the role of the family in the discussion of end-of-life decision-making (Kwak & Haley, 2005). For example, Latino older adults may want to include family members in these sessions as end-of-life decision-making is often viewed as a collective practice extending beyond the individual. Among moderately to severely cognitively impaired clients, this topic might also be contraindicated given the risk of misunderstanding why this topic is being addressed.

Case 3: Enhancing Relationships

Later life is often a time of increased frailty and relationship loss, potentially leading to dependence, isolation and/or loneliness. Clinicians may encourage clients to reconcile conflicted or estranged relationships, develop new relationships, and/or reconnect with prior relationships. Below is an example of how reengaging relationships can improve mood and meaning.

Maria, a 73-year-old Latina woman with depression and diabetes, lived with her somewhat distant adult son. After deaths in her family and loss of her own mobility following surgery, she felt lonely and purposeless. The clinician helped her identify her longing for lost connection, her difficulty being cared for by her son, and her worries that she was a burden. Several family sessions were held in which Maria expressed her fears and her son affirmed his commitment to care for her, consistent with traditional Latino norms. Case management helped her acquire a cell phone and facilitated paratransit to enable her to travel. She reconnected with extended family. After attending a celebration of a family graduation and connecting with some young children, she expressed feelings of joy, reflected on the meaning of her role as a mother and what her mother had meant to her, and acknowledged grief over her losses. Though she continued to experience mild depression, reconnecting with family provided some relief from her loneliness and facilitated reflection on the meaning of her own role within her family.

As illustrated by the above vignette, clinicians can query clients about relationships in their lives, including relationships which are troubling, distant or lost. When clients report that they are estranged from previous relationships, clinicians can ask about what they valued in the relationship and what happened to cause the rift. Clinicians can evaluate whether coaching in assertiveness and clear communication may possibly help bring some reconciliation; various types of communication tools can be considered, including electronic and telephonic approaches. Clinicians can also evaluate whether helping clients grieve for lost hopes for those relationships might be more appropriate. In situations of difficult ongoing

relationships, clinicians can help clients consider that even amidst difficulty, there might be moments of affection expressed or tender interactions noted. For example, in working with caregivers of persons with dementia, even though there is a heavy burden, caregivers can be encouraged to consider and notice the moments in which closeness or love is evident. Clients can also be encouraged to connect through volunteering, mentoring, or caring for grandchildren.

Addressing very conflictual relationship conflict directly in conjoint sessions is contraindicated in some situations. With clients with cognitive impairment, the clinician should exercise caution and careful judgment as to whether the client has enough cognitive resources to be able to process significant conflict and be able to successfully communicate in such a relationship. If it is thought to be toxic, it may be best to avoid direct relationship repair.

Case 4: Enhancing Creativity

Phil was a 70-year-old man with depression and mild cognitive impairment. In the past, he had enjoyed a number of artistic endeavors, including drawing and painting, but with his depressed mood and early cognitive loss, he had stopped engaging in his art, expressing that he was "no good anymore." The clinician empathized with his feelings of loss, and gently encouraged Phil to begin returning to his art by drawing her in the session. With the clinician's encouragement and direct positive regard, the client drew the clinician several times. His mood improved and he reconnected with a part of himself that he felt was valuable. The clinician then leveraged this artistic participation to help him engage in a project where he drew portraits of family members of the staff at his senior residence. His mood improved when he drew.

Creativity is important across the lifespan and helps maintain cognitive flexibility and other important skills like problem solving, reasoning, and task shifting (Flood and Phillips, 2007; Schmid, 2006). From this perspective, creativity may be used to help clients find increased meaning in life. Older adults may deny, discount, or diminish their creative abilities due to the pervasive effects of societal ageism and the cultural association between creativity and youth (Hickson & Housley, 1997; Shearring, 1992). Older adult clients with mood problems and low self-esteem may be particularly at risk to ageist beliefs and/or have low perceived self-efficacy about their creativity (Jaquish & Ripple, 1981). Clinicians may counter these beliefs by brainstorming possible ways of engaging in creative activities:

- Strategize a schedule which includes special time for creative work within the client's regular routine.
- Reinforce the client's positive creativity through praise. Explore and challenge self-deprecatory beliefs about their creative abilities.
- Connect the client with others in the community who are interested in similar creative work such as choirs, writing groups, drawing classes, etc. This is illustrated by the following: an older adult who enjoyed writing was encouraged to write poetry, and then proceeded to develop a group of seniors who wrote and shared poetry together.
- Introduce adult coloring books with colored pencils of markers. Books or mandalas have been enjoyed by some of our older clients.
- Using magazines, help client make collages of favorite things/colors/flowers and/or decorate a journal. For example, cutting or tearing flowers out of a magazine and gluing it to the journal cover or piece of paper.
- Help the client start or return to cooking or baking. One clinician describes how she and a client talked about favorite recipes with the aim of easing the client back into her previously enjoyed hobby of cooking, which led to the client start cooking again.

Case 5: Addressing Spirituality and Religion

Shirley was a 74-year-old African American woman. She had advanced multiple sclerosis, which rendered her bed bound. A clinician was providing in-home psychotherapy due to her

mobility limits. She lived alone, and was provided care by visiting aides. She was divorced and had two sons, but she was estranged from one of her sons, and was visited rarely by her other son. She was depressed by her isolation, pain, limited pleasurable engagement, and truncated future. Her low income also limited the availability of additional in-home resources. In therapeutic exploration of Shirley's history, it was revealed that she had appreciated church attendance during her childhood, but had given up involvement due to her husband's distaste for church. The clinician explored her current interest in religious activities and content, and together the clinician and client identified Shirley's desire to be more involved. Shirley was helped to reach out to a local church and request visitation, and to find radio shows which resembled the church services she remembered from childhood. This offered her comfort, and relieved some degree of her depression.

Spirituality and religiousness are two closely related but uniquely different constructs which may be of benefit to older adults seeking to enhance their life meaning. Religiousness involves, "specific behavioral, social, doctrinal, and denominational characteristics because it involves a system of worship and doctrine that is shared within a group" (Fetzer Institute/National Institute on Aging Working Group, 1999, p. 2). Whereas spirituality is "concerned with the transcendent, addressing ultimate questions about life's meaning, with the assumption that there is more to life than what we see or fully understand" (Fetzer Institute/National Institute on Aging Working Group, 1999, p. 2). Older adults may identify as spiritual, religious, both or neither.

Though spirituality and religiousness have many positive correlations with successful aging and enhancing meaning in later life, they may also be sources of difficulty or oppression from the past. Clinicians may want to broach the topics of spirituality and religiousness carefully with their clients, assessing first how they fit within clients' overall conceptualizations, including their cultural backgrounds. Clinicians must be careful not to assert their own values or proselytize clients toward their own beliefs. Once the therapeutic relationship has been established and sufficient engagement is stabilized, some ways clinicians may help clients find meaning in life through spirituality and religion include:

- Encourage positive spiritual or religious activities which help the client cope with stress. These may be currently used practices, previously valued practices, or new practices the client wants to develop.
- Remain flexible and affirmative regarding the client's behavioral practices of spirituality or religiousness.
- Utilize a specific instrument (e.g., HOPE Questionnaire; Anandarajah & Hight, 2001) as a starting point for discussion to assess the client's spirituality and religiousness.
- Consult structured guidelines (e.g., "Parameter 4.15," County of Los Angeles Department of Mental Health, 2012) for ideas about how to interact with the client about their spirituality and religiousness.

One contraindication in addressing the area of spirituality and religion involves clinicians who hold very strongly to their own religious convictions and have trouble maintaining appropriate boundaries in this domain. Such clinicians will need careful supervision to help them maintain their focus on addressing the client's concerns from the client's own worldview.

Case 6: Wisdom and Legacy-leaving

Harold, an 85-year-old man was dealing with lifelong alcohol-related illnesses. He suffered from liver and kidney failure, diabetes, and a heart condition. He was depressed and showed early cognitive impairment. Due to medical and economic conditions, he had been forced to give up drinking. He was divorced and had four children, all of whom he had alienated due to his problematic alcohol use behavior. He was open to psychotherapy when his medical doctor suggested it, and seemed to appreciate talking with his clinician. However, any approach to his life history seemed to bring on deeper depression. The clinician explored ways in which Harold had developed wisdom and left a legacy. Harold was encouraged to see how he had struggled and survived a very

difficult life. He was encouraged to see how he had positively impacted people in his life. Despite estrangement from his children, he had mentored others, through Alcoholics Anonymous. After he became sober he attended AA, helped younger recovering alcoholics develop their sobriety, and impacted their lives.

Wisdom is a complex construct typically associated with aging and often ascribed to older adults. Commonly recognized components of wisdom include: knowledge and decision making, prosocial attitudes, self-reflection, acknowledgment of uncertainty, emotional homeostasis, tolerance, openness, spirituality, and a sense of humor (Bangen, Meeks, & Jeste, 2013). Research suggests that increased wisdom in older adults is associated with improved emotional well-being, and that the association is mediated by improvements in coping strategies (Etezadi & Pushkar, 2013).

In clinical practice, older adults may be encouraged to enhance life meaning by exploring these aspects of their lives and encouraging honoring the wisdom they have developed which can promote improved emotional resilience. Ways that clinicians may help their clients might include:

- Reflect upon situations in which the client has, either currently or in the past, demonstrated good decision making which has had positive consequences within their life.
- Discuss the client's positive perspectives about the world and hopes they may have for future generations.
- Review tough circumstances or challenges where the client has "kept their cool" and modeled pro-social behavior for others to follow.
- Talk about moments when the client has demonstrated stability, tolerance, and/or openness and how that changed their view of the self.
- Boost dispositional coping by encouraging the client to be flexible, adjust their expectations, and view things in a positive light when they are faced with new conflicts.
- Reframe negative situations in a more positive light by collaboratively discussing ways in which the obstacle has helped the client grow as a person.

An aspect of understanding the meaning of one's life is to consider what legacy the person has left. Irvin Yalom (2008) stated that one may find meaning in life and come to terms with death through understanding "rippling," or the ways in which the person has influenced others, which, in turn, consequently influenced other people's lives and can impact generations to come. Birren and Deutchman (1991) discussed the importance of reviewing a person's legacy, which might include acts of helping others, raising children, creating art, writing, professional successes, political achievement, influencing others, and contributing to science, among other things. To this end, clinicians can help clients consider their legacies, including what they have done in their lives, these actions' impact on others, and potential effects on the future.

Caution should be taken when raising the concept of wisdom or legacy with a client who has had tremendous losses and/or trauma in their lives, given they might feel dejected, as if they have no wisdom or legacy to leave. These older adults can be helped to identify their wisdom or legacy, but the clinician should be prepared to offer suggestions or guide the elder to perceive their own wisdom.

Case 7: Illustrating Transcendence and Mindfulness

Wendy was a 70-year-old woman with a history of back injuries. She had back surgeries and was treated with pain relief medication which she claimed was not working. She had received some sessions of physical therapy which she also perceived as not helpful. Wendy suffered from depression as well as anxiety related to fear of increasing pain. In psychotherapy sessions, Wendy had difficulty focusing on topics other than her pain and disability. Her clinician introduced mindfulness exercises, as well as mindfulness and relaxation exercises. While Wendy continued to maintain she suffered from physical pain, she became able to talk about other emotionally pressing issues, such as losses in her life, and reported that she was able to sleep better, and did not seem to be as disturbed by her back pain.

Transcendence represents the ability to move beyond the immediate circumstances to form connections beyond the self, transcending the gulf between people, between person and the universe,

or between person and the creator of the universe (Brennan, 2008; McFadden & Lunsman, 2009). Within aging, there may be an increased emphasis on internal processes that facilitate expanded consciousness. Older adults may have more time to meditate, contemplate, and reflect (Newman, 1987). Life satisfaction may increase as a person shifts toward increased focus on the cosmic world rather than on the material world (Tornstam, 1999). Clinicians may suggest contemplative practices to older adult clients and explore the idea of transcendence with them to improve their sense of meaning in life.

Mindfulness or meditation can be one approach toward transcendence. Mindfulness is the act of concentrating one's attention on moment-to-moment experience with a nonjudgmental attitude. It has been found to be successful in treating anxiety and stress, as well as other disorders (Kabat-Zinn, 2003). Acceptance and commitment therapy (Hayes, Strosahl, & Wilson, 1999) and Mindfulness-Based Stress Reduction (Kabat-Zinn, 2003), among other evidence-based practices, can be useful interventions clinicians can use to help clients experience their lives in meaningful new ways. Mindfulness may also include encouraging clients to learn new breathing techniques, to listen to recorded meditation lessons, and/or to set up a space to meditate or connect with nature, among other possibilities. Mindfulness can be practiced anywhere and may be a helpful intervention for those experiencing a lack of mobility and consequent boredom or depression.

Discussion

In the course of providing psychotherapy to older adults, it is often important to include meaning making in treatment. We have found this to be especially salient with clients who have been impacted by particularly severe and/or multiple losses. In this article, we illustrate examples of ways in which we introduced meaning making into psychotherapy using a variety of strategies. These draw from the literature and our own clinical experience using creative therapeutic problem solving with clients in sometimes seemingly intractable situations.

Clinical Implications

- Clinicians may find it beneficial to focus on enhancing meaning as a core or an adjunct aspect of treatment.
- Enhancing meaning in the lives of older adults may be strategized by clinicians in many different ways and through various creative approaches.

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