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Mitigating the Existential Suffering of Older People Transitioning Through Loss and Grief: Understanding the Liberating Influence of Compassionate Care

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ABSTRACT

Later life is seen as the forerunner to multiple transitions involving loss and grief that have implications for the health and well-being status of older people. Common transitional challenges in later life involve bereavement, retirement, and relocation, including losses relating to the aging process per se. In essence, life-related transitions in later life present a range of possibilities for growth or decline in developmental capacities. This critical commentary draws attention to the need for awareness among health professionals and family caregivers to understand the potential for a disconnect of empathy and compassion from the existential loss and grief experiences of people in later life. A case is made for healthcare workers to explore the aging process more carefully and thoughtfully, with particular attention to the relationship of compassionate care to the existential aspects of loss and grief in later life. Shortfalls in the healthcare system are shown to hinder or endanger the provision of a high-quality, compassionate care culture for older people. It is suggested that any serious psychology of aging requires improved depths of study and understanding surrounding the existential dimensions of loss, grief, and bereavement.

KEYWORDS: Compassion fatigue; existentialism; inner world; opportunity value; perspective-taking; unconditional positive regard.

KEY PRACTITIONER MESSAGE

1. This article provides useful material for healthcare professionals working with older adults experiencing unresolved issues and anxieties surrounding loss, grief, and bereavement.
2. This article provides information and insights considered helpful for planning and delivering professional development workshops that recognize and respond to loss, grief, and bereavement among older adults.
3. This article is a valuable resource for healthcare professionals committed to providing empathetic and compassionate care for older adults experiencing complex and debilitating issues surrounding loss and grief.
4. This article offers essential insights and understandings considered necessary for the initial education and training of healthcare professionals destined to work with older people, particularly those held to be vulnerable and at-risk concerning loss, grief, and bereavement

INTRODUCTION

Older age can be seen as a time of reckoning for facing existential questions concerning the meaning and purpose of life while having to face sooner or later the stark reality surrounding the transitory nature of personal existence (Baars, 2012; Langle, 2001). Peterson (2018), based on his experience as a clinical psychologist, offers a view applicable to vulnerable older people "The heightened knowledge of fragility and mortality produced by death can terrify, embitter, and separate. It can also awaken" (p. 366). Indeed, later life confronts the older person with a mix of existential issues, not the least of which concern loss and grief.

The transition from middle age to later adulthood challenges a person's sense of self as they experience and face a range of changes and discontinuities involving physical, psychological, and social losses that threaten their overall sense of worth and purpose (Brandtstädter & Greve, 1994). Failure to successfully deal with these existential issues may result in a decline in health with implications for psychological disorders, often leading to protracted bouts of depression and illness.

Vrkljan et al. (2019) suggest that the three most common transitional challenges resulting from major life events involve bereavement, retirement, and relocation in later life. There is, of course, the issue relating to losses related to the aging process itself that include both normal and pathological changes that impact "the individual's construction of self and personal continuity" (Brandtstädter & Greve, 1994, p. 55).

Laceulle (2013), on the matter of age-related vulnerability and loss of one kind or another, contends that "losses" rather than being seen as preventing further growth in developmental capacities and self-realization offer instead "a new perspective that transcends the common language of decline and opens up new possibilities for meaning" (p. 112). For Adams et al. (1977), transitional events in the life of each present a range of "possibilities for both danger and opportunity" (p. xi).

The preceding authors posit that a transition embodies the potential for allowing the individual to grasp the "opportunity value" for personal growth and development. On the other hand, the experience of traversing a transitional pathway following a significant life event can often be the precursor for a mix of dysfunctional coping behaviors with subsequent deleterious consequences for an individual's health and well-being. Robertson (2014) reminds us that transitions do not occur in a vacuum per se but result from significant life events that may be predictable or unexpected. For Robertson, major life events "are defined as significant occurrences involving relatively abrupt changes that may produce serious and long-lasting effects" (p. 9). While transitions generally follow from a significant life event, they are accompanied by a grief response to the loss or losses arising from the ending of a previous way of life.

The pathway through a transition can be complicated and, for some people, complicated due to a pervading sense of instability until a new, balanced and acceptable beginning is found. There is, of course, the reality for some older persons who may be faced with the daunting challenge of having to deal with two or more significant transitions either simultaneously or over a short period. For example, older people receiving palliative care may experience several negative and challenging transitions involving changing treatment regimes, differential levels of functional status, symptoms diversity, and changes in the overall sense of well-being (Duggleby et al., 2010).This paper aims to provoke meaningful ongoing discussions relating to philosophical and ethical issues facing the helping professions, including family caregivers surrounding the need for adopting a more open and humane approach to understanding and supporting older people during times of loss, transition, bereavement, and change. The stance taken in the present situation involves adopting a phenomenological or existential perspective, thereby valuing and giving voice to the unique personal experience of each older person. It is perhaps important from the outset to emphasize the importance of allowing a person who is experiencing loss to engage in a proper grieving process. For those involved in helping older adults who are bereaved, there must be awareness and recognition of the need for the application of humane care and support that includes patience and the provision of a compassionate, caring culture aimed at enabling the individual to resolve existential questions, anguish, and related issues and suffering. (Firestein, 1989) provides a timely reminder to all and sundry that loss is an inevitable part of the life journey:

> *The experience of loss of something prized-a person, a thing, or a condition-is genuinely universal. No one is exempt from this experience* (p. 37).

Thoughts on Change in Later Life

The speed and rapidity of social change have brought new questions regarding aging and old age's social and personal meaning. While aging is a natural phenomenon, most people are deceptively unprepared for the experience. Aging is irrefutably liked to change, ranging from a series of gradual and somewhat small and often imperceptible losses to significant losses with the potential for significant negative impact on the individual's health and overall well-being.

Evans et al. (2019) released a report on older adults confronted with life-altering events. They explore the repercussions of life-altering events in this report, claiming that "transitions in older age, whether this is retiring from paid work, changing careers, or terminating or starting a relationship, may have a considerable impact on people's lives and well-being" (p. 8). However, change for some older people presents new opportunities to flourish and embrace a different and invigorating lifestyle approach to living. Schwartz (1974) identified the need for practitioners to pay attention to the accumulating series of losses that accompany the aging process. Indeed, Schwartz refers to "a high price one pays for survival into the latter decades of life is that most (eventually all) those persons with whom one grows up are eliminated from the network-parents, siblings, friends, co-workers. Certainly, if one survives long enough, the attrition rate is increased because of death" (p. 9).

Palmér et al. (2019) highlight that we are socially connected to others, making our lives meaningful. When we lose longstanding relations, our connection with our life-world changes forever. Robertson (2014) draws attention to the challenging and negative situation whereby an individual is in the unfortunate position of experiencing what is termed "revolving transitions" that involves, in a brief period of time, a series of negative and compounding life-changing events, each with its own transitional dynamics.

O'Connor (1988) identified that the aging experience is often impacted by a complex array of uncertainties and fears and that it is not uncommon for an older individual to feel somewhat disconnected from the self, arising in part from "The development of competence in the outer world, the pursuit of success and power often require some diminution or underdevelopment of the inner world regardless of whether one is male or female" (p. xiv). It is in this context that older people are likely to have a close encounter with a range of significant and challenging questions that may include: (1) What is happening in my life?, (2) How can I adapt with meaning?, (3) What is my mission?, (4) How can I increase my effectiveness and purpose as a human being?, (5) Is my life worthwhile?, (6) What will be my legacy when I am gone?, (7) How can I cope when my life is falling apart?

While aging brings with it the accompanying prospect of radical change, it also raises a range of existential uncertainties relating to the usefulness of the self to family and the wider community. As human beings, our experiences of loss and grief expose our vulnerability, frailty, anger, rage, strength, courage, resilience, and adaptive capacities. All of us, both individually and collectively, have to face adversity, trauma, and life changes at one time or another. Major losses in our lives always require some form of personal adjustment and reorganization of thinking and acting in favor of new, healthy, and realistic interpretations of past, present, and future. Allowing for individual differences begins with acknowledging and understanding that no one's attitude, or perception of change is the same. Basseches and Gruber (1984) offer a novel yet realistic perspective on the nature of change:

> *We can never bathe twice in the same stream, for it is ever-changing- and so are we. To those who want to rest, this changefulness is a burden; to those who can embrace change, a challenge and a pleasure* (p. xii).

The Existential Side of Aging and Compassionate Care

Morris (2020) puts a case for exploring the aging process more broadly and thoughtfully, which opens opportunities to consider how loss, grief, and bereavement in later life can be related to "the existential parts of aging, such as senescence, the "medicalization of life"; the issue of where, how, and with whom one will be living in one's later years; and the family dynamics that assist in and impinge on the aging process" (p. 195).

Langle (2001) suggests that when healthcare professionals encounter an older person seeking help and emotional support during bereavement, loss, and grieving that they draw upon an approach that incorporates the existential reality of the older person rather than relying solely on a fixed or prescriptive model of medical and nursing care. Tanner et al. (2015) offer an important caveat for

social workers assisting older people to navigate major life-based transitions "Practitioners working with older people experiencing transitions have to be sensitive, not only to individual meanings and strategies but also to the possible tensions between their professional stance and that of the older person's" (p. 2060). Parkes (1988) speaks of people who have great difficulty in coping with major life-changing events and offers the view that "Social workers and other primary caregivers in the community are in a good position to identify people in transition, to assess their vulnerability, and where necessary, to provide the support needed or refer them to those who can" (p. 63). Likewise, Hashim et al. (2013) contend that primary care physicians can play a supporting role in identifying and preventing serious depression and subsequent health decline among older people transitioning through bereavement, loss, and grief. However, there is no guarantee that professional support for older people facing challenging transitions is readily available or always necessarily of the right kind of quality.

Sinclair et al. (2017), based on a review of the literature on sympathy, empathy, and compassion, report a disturbing trend that highlights the decline in the relevance and importance of empathy in healthcare education and clinical practice, which has implications for overall quality of care (Hojat et al., 2009). Consequently, there is an unfortunate situation where there can be a failure to acknowledge the significance of the existential side of aging regarding issues and concerns relating to loss and grief. Facilitating the opportunity for an older person to speak more freely about loss and grief embodies the essence of compassionate care while at the same time helping the older person to feel that his / her presence as a person is valued (Bourgeois-Guérin et al., 2021).

Compassion may be seen as a humane quality of understanding the suffering of others and rests heavily on honest and virtuous intentions ((Sinclair et al., 2017) and involves, in part, an action-oriented response of listening ethically, which entails a) being receptive to the person when they speak and b) adopting an attitude of unconditional positive regard that avoids impatience or condescension. Cole-King and Gilbert (2011) propose that "the human capacity for compassion appears to involve two "different" psychologies: on the one hand for awareness and engagement, on the other for skilled intervention in action" (p. 30). While empathy is not compassion per se, it does, however, allow for an acceptance, sharing, and understanding of the feelings and emotions of another person (Eklund & Meranius, 2021).

Empathy is essentially a necessary precursor for compassionate action (Singer & Klimecki, 2014). More attention should be given to the fact that empathy and compassion can co-jointly promote a caring culture that facilitates the health and well=being of older adults leading to more open and humanistic ways of working with the existential side of aging. Recognition must be given to the reality that much work remains to be undertaken concerning care and support interventions relating to loss and grief (Forte et al., 2004). Boston et al. (2011), in a literature review of existential suffering in palliative care settings, provide an insightful perspective for healthcare professionals on the provision of compassionate care:

> *Knowing how to provide compassionate care requires an awareness that this may involve embracing personal and emotional risks. The notion of whole-person care calls for attention to all domains, including the physical, psychological, spiritual, and existential, with skills that demand much more from our person and that may move beyond our training in scientific and technical skills* (p. 615).

A report by Evans et al. (2019) on Navigating Transitions in Later Life highlights the possibility and, in some cases, the reality that "support is largely focused on "firefighting" the effects of negative transitions, rather than prevention to mitigate the risk" (p. 8). Sikstrom et al. (2019) point out that very little is known about the extent of grief training for physicians and emphasize the need for medical education to include opportunities for the development of skills and competencies in dealing with loss and grief that will inevitably occur as part of healthcare practice.

Palmer et al. (2020), in a study of older adults' perception of the finality of life, conclude that professional healthcare workers should adopt a life-world approach that embodies respectful dialogue that focuses on existential issues. Similar calls for meaningful and practical loss and grief medical education have been made by Zisook and Shear (2009) and Sanchez-Reilly et al. (2013). In the interest of fostering a culture of compassionate care in the caring professions, it would seem relevant to initiate more profound probing research undertakings into the extent to which professional education is committed to developing compassionate health

professionals (Bray et al., 2014). Croxall (2016) brings to light the unbelievable situation in the UK whereby bereavement support in later life is not a priority policy matter due to "socially constructed assumptions that bereavement is unproblematic for older people" (p. 131).

Davidson (1991) offers essential insights on health and aging that provide clues on how easy it is for health systems to ignore the existential issues of loss and grief among older people "Overwhelmingly, the traditional healthcare system emphasizes acute care, crises intervention, and the illness model of health. Within this system, the consumer is most often looked upon as part of a whole" (p. 178). Hillman (2012), while speaking, generally makes the point that all too often in contemporary culture, there exists a pervasive tendency whereby "We hurry people to "get on with it," "spare me the details," "get to the point" (p. 172). Christiansen et al. (2015) suggest that a combination of staff shortages, unrealistic workloads, and resultant time restraints can create an environment that values completing work duties efficiently and as soon as possible. However, it must be acknowledged that the operation of a highly efficient healthcare system by, or in itself, may very well hinder the provision of compassionate care. Zisook and Shear (2009) provide a resounding message to psychiatrists on grief and bereavement that is also applicable to all those who offer assistance to people dealing with the burden of bereavement and loss:

> *For most bereaved individuals, the arduous journey through grief will ultimately culminate in an acceptable level of adjustment to a life without their loved ones. Thus, most bereaved individuals do fine without treatment. Certainly, if someone struggling with grief seeks help, they should have access to empathic support and information that validates that their response is typical after a loss* (p. 69).

Further Thoughts on the Existential Dimension of Loss and Grief

The heterogeneity of the aging population means that each older individual is like no other, and therefore, any support interventions about loss and grief warrants respect for the uniqueness of his / her experiences. The fear of aging, including death, presents differential levels of concern among older people. Erikson et al. (1994), in their landmark study Vital Involvement in Old Age: The Experience of Old Age in Our Time, emphasize the final stage of letting go when the older person recognizes the unavoidable task of having to come "to accept the inevitability of death's enforced leave-taking" (p. 63). Seedsman (1994) argues that in pursuit of a balanced life in old age, overindulgence with thoughts of death and dying, or concerns about the possibility of future functional loss, may compromise the ability to live an authentic life. Older people experiencing major bouts of loss and grief will often have periodic encounters with an "identity crisis" which requires a satisfactory resolution to protect and stabilize a positive view of self. Unresolved aspects of loss and grief in later life can be understood as existential suffering and related to a vulnerability that deserves unmitigated consideration in delivering high-quality care. Moody (2009) provides a valuable insight into the onset of illness in later life and the likely set of existential questions arising due to the pervading sense of multiple losses:

> *Illness raises questions: Who are you when you stop doing? When you cannot be productive or are no longer indispensable to others? When you can no longer go on as before because you are sick when you lose status? Who are you when you can't be a caretaker or a boss or do your job, whatever this might be? Do you matter?* (p. 73).

Entry into old age brings forth an accumulation of losses which inevitably "brings to the surface existential questions and issues of the meaning in life" (Birren & Lanum, 1991, p. 112). According to Ivancovich and Wong (2008), "there is a venerable history in existential philosophy and psychology of focus on the central role of personal meaning in the ever-enfolding of the human drama of coping with adversities and suffering" (p. 218). Supporting the older person who is experiencing major loss and grief requires an emphatic, sensitive and compassionate intrusion into the life-world of the individual akin to getting "inside" or tapping into their existential concerns and issues. Health professionals and informal caregivers committed to the provision of compassionate care for older people suffering existential anguish with loss and grief might well consider the value of supporting the person to give voice to their feelings and suffering and, in so doing, offer the opportunity for a measure of resolution in line with the notion that "A burden shared is a burden halved" (Whyte, 2009, p. 141).

Taylor (1985) argues that "Human beings are self-interpreting animals" (p. 45), and this viewpoint lends support to the stance that it is the individual who determines the true essence of the meanings embedded in their lived experiences with loss and grief. Healthcare practitioners who are genuinely

aligned to and sensitive to the existential concerns and suffering related to loss and grief among older people enhance their potential for fostering compassionate care. At the same time, they position themselves to acquire a deeper understanding of the existential dimensions of vulnerability related to lose and grief in older age. For Morris (2020), the existential dimension of aging is intertwined with issues of "medicalization" and overall health status with implications for differential impacts on the "psychological, social, financial, familial, sexual, and so forth" (p. 204).

Laceulle (2013) reminds us that the existential vulnerability confronting older persons during times of loss "are often transformed into experiences of meaning, resulting in attitudes of wisdom and acceptance" (p. 111). Indeed, (Hildon et al., 2008) examined the relationship between adversity and resilience among older people and found that "Participants with resilient outcomes drew upon social and individual resources in the face of adversity, in particular resources that stabilized life change by providing continuity" (p. 726). For Dohmen (2013), resilience can be fostered by older people living an "engaged life" illustrated by maintaining or creating meaningful roles and activities as well as being open and willing to receive support from ongoing relationships with close family and friends. However, the COVID-19 pandemic has certainly tested the capacity for resiliency and recovery of older people, both community-dwelling and those residing in aged care facilities. In particular, the isolation directives have negatively impacted older people's overall sense of security and social connectedness, resulting in marked increases in depression, anxiety, and loss of control with implications for mental health and well-being. In particular, the pandemic has disproportionately affected aged care residents, evidenced by widespread feelings of loneliness, fear of dying, and panic caused by the difficulties associated with accessing regular medical and nursing care (Cohen et al., 2021; Goveas & Shear, 2020; Ishikawa, 2020).

Farran (1997) sees existentialism operating within a philosophical framework and, in so doing, acknowledges that human beings across all ages:

> *... have the potential to experience existential vacuum — times when one's goals are not met, times when there are feelings of nothingness, meaninglessness, anxiety, and isolation. This perspective also identifies the tension between being free to make choices while at the same time assuming responsibility for what life sets before one and the natural consequences of actions. Furthermore, it addresses the tremendous capacity that humans have to experience hope, to transcend and find meaning in the midst of difficult life experiences* (p. 252).

Later Life Losses Threatening Safety, Mastery, and Control

Later life is a forerunner for multiple transitions that have implications for the health and well-being of older people and include retirement, loss of a spouse or partner, relocation to a new living arrangement, frailty, or the onset of illness and disability. Two significant life events warrant attention as examples among many that impact the level of self-management and control in later life. The first is that a diagnosis of early-onset cognitive impairment causes significant disruption in people's lives. Alzheimer's disease or any other dementia creates existential concerns for older adults in relation to personal agency, identity, and anxiety arising from a pervading fear of losing control. Grenier and Phillipson (2013) argue that agency refers to the notion of control on the part of the individual with the suggestion that "agency exists on a continuum" (p. 72). When a personal agency is severely reduced in later life due to impairment, there exists a high potential for loss of control, and for (De Lange, 2021), "Lack of control refers to a special kind of loss, the loss of the self" (p. 367). The call for humanistic, person-centered care and support for the person living with dementia presents a clear mandate for informal carers and healthcare professionals to provide services and programs in supportive environments aligned with the following affirming approach to care:

> *In effect, what we need to do is simple. We must support people in such a way that they continue to see themselves as good, valuable individuals, surrounded by those they love and who also love them. Ultimately, those with dementia need to hold onto the sense that they are both changed yet still the same person they have always been. This is a profoundly human challenge. It is one that we must all strive to meet* (Cheston & Christopher, 2019).

A second and confronting life event surrounds an older person transitioning into residential aged care. In a call for humanistic care in residential aged care facilities, Seedsman and Seedsman (2019) stress the importance of giving adequate time to listen to older aged care residents genuinely. Failure to respect the identity and history of the older resident leads

to little interest in listening to any existential issues surrounding loss and grief. For Gierck (2018), "The opposite to listening is indifference and a painful lack of interest. It is worse than anger. It is a lack of regard for human beings" (p. 30). While the quality of life is a subjective concept, it is undoubtedly under siege when an older person enters a residential aged care environment.

Older adults facing a transition into residential aged care face new demands on their ability to adjust, made even more difficult by a series of profound changes that collectively usher in a period of disequilibrium and upheaval from a familiar life world (Schumacher et al., 1999; Zizzo et al., 2020). A change in the nature and availability of support from family and social relations can create a heightened vulnerability and sense of alienation leading to a complex mix of loss and grief experiences. The most vulnerable are the very old and those with a history of poor social relationships, including those with frailty and multiple comorbidities that impact their capacity for autonomous behavior.

Riedl et al. (2013), in a study of aged care residents in Austria, found that "To be able to cope with the demand on their identity, they need identity-forming conversations in new social networks in the nursing home as well as the support from their family members and professional helpers" (p. 8). Long-term facilities for the aged have the potential to be disempowering environments arising from managerial and organizational practices that tend to marginalize aged care residents. An interesting example is provided by the psychologist Marie de Hennezel (2011), who provides the following telling statement made by a female aged care resident "Everyone does their work according to the established protocols, without taking any account of the patient's well-being. They work with their arms, but their heads and hearts are missing" (p. 31). Likewise, in a non-related context, (Whyte, 2009) offers the following words that have some measure of explanatory power in helping to understand the failure to deliver compassionate and caring care for older people transitioning through loss and grief "... we have eyes, yet see not, ears that hear not, and hearts that neither feel nor understand" (p. 70).

Sadly, genuine person-centered care is under threat arising from "a healthcare climate in which cost-cutting is leading to significant constraints on practice" (Schumacher et al., 1999, p. 22). Therefore, it is not surprising to find situations whereby there exists little or no realistic opportunities for aged care residents to give voice to personal concerns and anxieties relating to loss and grief matters. Unfortunately, with increasing numbers of older people entering nursing homes and intensive care units, there exists the genuine possibility that healthcare professionals may fail to "honestly examine the experience of aging and dying" (Gawande, 2014, p. 9). It is not unusual for healthcare professionals to find themselves in situations where patients share their personal experiences with loss and grief, which may not always be solely focused upon end-of-life matters. For some practitioners, such situations create a sense of awkwardness and anxiety, resulting in a general feeling of inadequacy and embarrassment.

CONCLUSION

This paper aims to emphasize the need to think and act more "thoughtfully" about how to support the older person experiencing loss, grief, and bereavement. (Olsson, 2021), an experienced family-centered psychologist, contends that when a person is unable to engage in a proper grieving process, there exists a high chance that "normal grieving can turn to complicated grief, and for some, diagnosable as prolonged grief disorder" (p. 21). However, it must be recognized that the older person first and foremost represents a unique human being whose actions, beliefs, attitudes, and encounters with loss and grief are an outcome of lived experiences, including their psychological makeup and the influential aspects of society to which they belong. A particular loss experience can represent a profound life transition that remains unresolved for some older people. Neimeyer et al. (2008) make the point that the undertaking of any assessment and support for prolonged grief matters must "be guided by the character of the loss itself as well as of the client who suffers it" (p. 269). While experiences with loss and grief are part and parcel of the life journey, the entry into older age signals a deeper awareness of personal finitude (Fonseca, 2011; Fung et al., 2005) combined with a set of ongoing challenges whereby "Man [woman] has to say good-bye to many things in the course of life, but never more than in old age: the loss of physical performance and strength, the loss of psychological and mental flexibility, the loss of social and professional rank, financial means, friends and relatives" (Langle & Probst, 2000, p. 194). It is suggested that any serious psychology of aging requires improved depths of study and understanding surrounding the existential dimensions of loss and grief. On the phenomenon concerning the experience

of loss and grief in older age, there is a strong case to be made for practitioners' taking steps to better understand such existential matters from the perspective of older adults themselves. The need for empathetic and compassionate care and support is obvious during loss and grief. Perhaps the following insightful words by the American poet Maya Angelou might well help to foster a genuine reflection by healthcare professionals on the need to practice within an ethical context that treats people in a manner that respects and protects their human dignity "I have learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel" (Maya Angelou, cited in Riess, 2017, p. 74).

Efforts to understand loss, grief, and bereavement in later life must provide opportunities for the older person to express their inner feelings which are linked to change and transition and ultimately discovered in part or whole "...in the phenomenological experiences of ageing-those actual accounts of personal experience with space, time, body and social relations as lived by older persons" (Seedsman & Carmel, 2003, p. 11). Dewar (2013) reminds us that sometimes the emotional shortfalls of practitioners may prevent the delivery of compassionate care. When healthcare professionals suffer fatigue and stress through heavy workloads, there is every possibility of burnout, resulting in missed opportunities to sensitively and emphatically understand the nature and impact of transitions involving loss and grief on the "inner world" of older patients (Aronson, 2019; Lathrop, 2017). Speaking specifically from a medical point of view, Aronson (2019) argues that burnout can threaten the delivery of quality care with implications for differential levels of neglect of the patient's personhood. Baruch (2004), a strong advocate for self-care among counselors and therapists, offers valuable insights on the prevention of "compassion fatigue" (burnout) that should form part of mandatory professional development workshops.

Ramsey (1970), in his text The Patient as Person, provided ethical insights into the importance of respecting human personhood as an essential component of healthcare. There is always the danger in healthcare systems for a person's selfhood (personhood) to be neglected or "discounted," failing to connect to the inner existential needs of the patient. Taylor offers the proposition that "the way human agents interpret themselves and their situation cannot be neglected, but should be taken into account in social scientific explanations" (1989, cited in Olay, 2020, p. 123). Mutter (2018) argues that with the increasing medicalization of care for older people, the medical system often fails to attend to the condition of the whole person. Failure within the healthcare system to provide person-centered care for older patients can inadvertently deprive formal caregivers of many opportunities to address and resolve longstanding issues relating to loss and grief. Mannion (2014) argues a need for more nuanced explorations surrounding the world of healthcare and the organizational settings that hinder or nurture the practice of compassionate care. Acting from a humanistic approach (Riess, 2017), drawing upon the work of Batson et al. (2007), provides an important clue on activating an empathic and compassionate care culture by a) valuing the welfare of the person and b) adopting a "perspective-taking" approach which entails "feeling one's way into the experience of another" (p. 75). The preceding pathway to empathic and compassionate care warrants the facilitation of a sensitive and person-centered orientation while all the time is giving unconditional attention to the unfolding life story of another. Malouf (2002) provides an insightful and challenging perspective on the task at hand "... to step beyond what we are, and what we think we know and believe, into other skins and other lives, to become, in imagination and for a time, the children of other histories; to understand from within how the world might look from there, and how we might, in other circumstances, respond" (p. 6). It is important to accept that there is no single or unified theory of loss and grief. The point must be made that all too often that, little or no recognition, either intentionally or inadvertently, is given to the reality that the experience of loss is a uniquely personal process often requiring due acknowledgment and compassionate support that provides an opportunity for the individual to give voice to his / her inner turmoil and distress. To say to any person experiencing loss and grief, "I know how you are feeling," does not sit comfortably with compassionate ways of working and reflects a shortfall in the emotional intelligence of the individual using this expression. In the end, it must be emphasized that nobody can firmly assume that they understand the emotional feelings and depth of loss experienced by another individual. The following perspective offered by Weston et al. (1998) provides what they see as "unconditional positive regard for the person going through their loss and grief process:

> *Every person perceives and experiences loss in their own cultural, personal, and individual way, so*

> *what might seem an unimportant loss to us may be devastating for them. We cannot use our mind map and perceptions to judge the effects of loss for other people. There is a need to emphatically view it through their own perceptual world or frame of reference* (p. 14).

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REFERENCES

Adams, J. D., Hayes, J., & Hopson, B. (1977). *Transitions: Understanding and Managing Personal Change*. Martin Robertson.

Aronson, L. (2019). *Elderhood: Redefining Aging, Transforming Medicine, Reimagining Life*. Bloomsbury Publishing, USA.

Baars, J. (2012). *Aging and the Art of Living*. JHU Press.

Baruch, V. (2004). Self care for therapists: Prevention of compassion fatigue and burnout. *Psychotherapy in Australia, 10*(4).

Basseches, M., & Gruber, H. E. (1984). *Dialectical Thinking and Adult Development*. Ablex Pub. Corp.

Batson, C. D., Eklund, J. H., Chermok, V. L., Hoyt, J. L., & Ortiz, B. G. (2007). An additional antecedent of empathic concern: valuing the welfare of the person in need. *Journal of Personality and Social Psychology, 93*(1), 65-74. https://doi.org/10.1037/0022-3514.93.1.65

Birren, J. E., & Lanum, J. C. (1991). Metaphors of psychology and aging. In G. M. Kenyon, J. E. Birren, & J. J. F. Schroots (Eds.), *Metaphors of Aging in Science and the Humanities* (pp. 103-129). Springer Pub.

Boston, P., Bruce, A., & Schreiber, R. (2011). Existential suffering in the palliative care setting: An integrated literature review. *Journal of Pain and Symptom Management, 41*(3), 604-618. https://doi.org/10.1016/j.jpainsymman.2010.05.010

Bourgeois-Guérin, V., Millette, V., & Lachance, J. (2021). Communication and Silence Surrounding the Experience of Bereavement of Older Adults Living in Seniors' Residences. *Journal of Humanistic Psychology*. https://doi.org/10.1177/0022167821995352

Brandtstädter, J., & Greve, W. (1994). The Aging Self: Stabilizing and Protective Processes. *Developmental Review, 14*(1), 52-80. https://doi.org/10.1006/drev.1994.1003

Bray, L., O'Brien, M. R., Kirton, J., Zubairu, K., & Christiansen, A. (2014). The role of professional education in developing compassionate practitioners: a mixed methods study exploring the perceptions xof health professionals and pre-registration students. *Nurse Education Today, 34*(3), 480-486. https://doi.org/10.1016/j.nedt.2013.06.017

Cheston, R., & Christopher, G. (2019). *Confronting the Existential Threat of Dementia: An Exploration Into Emotion Regulation*. Springer.

Christiansen, A., O'Brien, M. R., Kirton, J. A., Zubairu, K., & Bray, L. (2015). Delivering compassionate care: the enablers and barriers. *British Journal of Nursing, 24*(16), 833-837. https://doi.org/10.12968/bjon.2015.24.16.833

Cohen, S., von Meding, D., & Abukhalaf, A. (2021). *Successful Pandemic and Disaster Mental Health Preparedness Requires Widespread Community Collaboration*. Academia Letters.

Cole-King, A., & Gilbert, P. (2011). Compassionate care: the theory and the reality. *Journal of Holistic Healthcare, 8*(3).

Croxall, J. (2016). Bereavement Support in Later Life: An Emerging Social Problem for the Twenty-First Century. In L. Foster & K. Woodthorpe (Eds.), *Death and Social Policy in Challenging Times* (pp. 131-149). Palgrave Macmillan UK. https://doi.org/10.1057/9781137484901_8

Davidson, W. (1991). Metaphors of health and aging: Geriatrics as metaphor. In G. M. Kenyon, J. E. Birren, & J. J. F. Schroots (Eds.), *Metaphors of Aging in Science and the Humanities* (pp. 173-184). New York: Springer Publishing.

De Hennezel, M. (2011). *The Warmth of the Heart Prevents Your Body From Rusting: Ageing Without Growing Old.* Pan Macmillan.

De Lange, F. (2021). Suffering from or in Old Age? The Existential Gravity of Ageing. *Journal of Population Ageing, 14*(3), 357-371. https://doi.org/10.1007/s12062-021-09334-6

Dewar, B. (2013). Cultivating compassionate care. .are. *Nursing Standard, 27*(34), 48-55; quiz 56. https://doi.org/10.7748/ns2013.04.27.34.48.e7460

Dohmen, J. (2013). My own life: ethics, ageing and lifestyle. *Ageing, Meaning and Social Structure: Connecting Critical and Humanistic Gerontology*, 31-54.

Duggleby, W. D., Penz, K. L., Goodridge, D. M., Wilson, D. M., Leipert, B. D., Berry, P. H., Keall, S. R., & Justice, C. J. (2010). The transition experience of rural older persons with advanced cancer and their families: A grounded theory study. *BMC Palliative Care, 9*(1), 5. https://doi.org/10.1186/1472-684X-9-5

Eklund, J. H., & Meranius, M. S. (2021). Toward a consensus on the nature of empathy: A review of reviews. *Patient Education and Counseling, 104*(2), 300-307.

Erikson, E. H., Erikson, J. M., & Kivnick, H. Q. (1994). *Vital Involvement in Old Age: The Experience of Old Age in Our Time*. WW Norton & Company.

Evans, E., Hyde, M., Davies, J., Moffatt, S., O'Brien, N., & Windle, G. (2019). *Navigating later life transitions: An evaluation of emotional and psychological interventions*. Centre for Ageing Better. https://ageing-better.org.uk/publications/later-life-transitions-evaluation-emotional-psychological-interventions

Farran, C. J. (1997). Theoretical perspectives concerning positive aspects of caring for elderly persons with dementia: stress/adaptation and existentialism. Gerontologist, 37(2), 250-256. https://doi.org/10.1093/geront/37.2.250

Firestein, S. K. (1989). Special features of grief reactions with reproductive catastrophe. *Loss, Grief & Care, 3*(3-4), 37-45.

Fonseca, J. (2011). Ageing-Towards-Death. Existential Analysis: *Journal of the Society for Existential Analysis*, 22(2).

Forte, A. L., Hill, M., Pazder, R., & Feudtner, C. (2004). Bereavement care interventions: a systematic review. *BMC Palliative Care, 3*(1), 3. https://doi.org/10.1186/1472-684X-3-3

Fung, H. H., Siu, C. M., Choy, W. C., & McBride-Chang, C. (2005). Meaning of grandparenthood: Do concerns about time and mortality matter? *Ageing International, 30*(2), 122-146.

Gawande, A. (2014). *Being Mortal: Medicine and What Matters in the End*. Metropolitan Books.

Gierck, M. (2018). Take your time to really hear others. *The Age*, 30.

Goveas, J. S., & Shear, M. K. (2020). Grief and the COVID-19 Pandemic in Older Adults. *American Journal of Geriatric Psychiatry, 28*(10), 1119-1125. https://doi.org/10.1016/j.jagp.2020.06.021

Grenier, A., & Phillipson, C. (2013). Rethinking agency in late life: Structural and interpretive approaches. *Ageing, Meaning and Social Structure: Connecting Critical and Humanistic Gerontology*, 55-79.

Hashim, S. M., Eng, T. C., Tohit, N., & Wahab, S. (2013). Bereavement in the elderly: the role of primary care. *Mental Health in Family Medicine, 10*(3), 159-162. https://www.ncbi.nlm.nih.gov/pubmed/24427183

Hildon, Z., Smith, G., Netuveli, G., & Blane, D. (2008). Understanding adversity and resilience at older ages. *Sociology of Health and Illness, 30*(5), 726-740.

Hillman, J. (2012). *The Force of Character: And the Lasting Life*. Ballantine Books.

Hojat, M., Vergare, M. J., Maxwell, K., Brainard, G., Herrine, S. K., Isenberg, G. A., Veloski, J., & Gonnella, J. S. (2009). The devil is in the third year: a longitudinal study of erosion of empathy in medical school. *Academic Medicine, 84*(9), 1182-1191.

Ishikawa, R. Z. (2020). I may never see the ocean again: Loss and grief among older adults during the COVID-19 pandemic. *Psychological Trauma: Theory, Research, Practice, and Policy, 12*(S1), S85.

Ivancovich, D. A., & Wong, T. (2008). The role of existential and spiritual coping in anticipatory grief. *Existential and Spiritual Issues in Death Attitudes*, 209-233.

Laceulle, H. (2013). Self-realisation and ageing: A spiritual perspective. *Ageing, Meaning and Social*

Structure: Connecting Critical and Humanistic Gerontology, 97-118.

Langle, A. (2001). Old age from an existential-analytical perspective. *Psychological Reports, 89*(2), 211-215. https://doi.org/10.2466/pr0.2001.89.2.211

Langle, A., & Probst, C. (2000). Existential questions of the elderly. *International Medical Journal-Tokyo-, 7*(3), 193-196.

Lathrop, D. (2017). Disenfranchised Grief and Physician Burnout. *Annals of Family Medicine, 15*(4), 375-378. https://doi.org/10.1370/afm.2074

Malouf, D. (2002). A great escape. *The Age*, 31 August.

Mannion, R. (2014). Enabling compassionate healthcare: perils, prospects and perspectives. *International Journal of Health Policy and Management, 2*(3), 115-117. https://doi.org/10.15171/ijhpm.2014.34

Moody, H. (2009). From successful aging to conscious aging. In J. Sokolovsky (Ed.), *The Cultural Context of Aging: Worldwide Perspectives* (3 ed., pp. 55–68). Praeger Publishers/Greenwood Publishing Group.

Morris, T. (2020). The Existential Dimension to Aging. *Perspectives in Biology and Medicine, 63*(1), 195-206. https://doi.org/10.1353/pbm.2020.0014

Mutter, J. (2018). Neglected in the House of Medicine. *The Hedgehog Review, 20*(3), 46-57.

Neimeyer, R. A., Holland, J. M., Currier, J. M., & Mehta, T. (2008). Meaning reconstruction in later life: Toward a cognitive-constructivist approach to grief therapy. In D. Gallagher-Thompson, A. M. Steffen, & L. W. Thompson (Eds.), *Handbook of Behavioral and Cognitive Therapies With Older Adults* (pp. 264-277). Springer Science. https://doi.org/10.1007/978-0-387-72007-4_17

O'Connor, P. A. (1988). *Understanding the Mid-Life Crisis*. Pan MacMillan.

Olay, C. (2020). Self-interpreting Language Animal: Charles Taylor's Anthropology. In Z. Kulcsár-Szabó, T. Lénárt, A. Simon, & R. Végső (Eds.), *Life After Literature: Perspectives on Biopoetics in Literature and Theory* (pp. 117-135). Springer International Publishing. https://doi.org/10.1007/978-3-030-33738-4_9

Olsson, C. (2021, September 16). *It's Inhuman To Deny People Proper Grieving*. Herald Sun (Opinion).

Palmer, L., Nystrom, M., Carlsson, G., Gillsjo, C., Eriksson, I., & Dalheim-Englund, A. C. (2020). The intertwining of reconciliation and displacement: a lifeworld hermeneutic study of older adults' perceptions of the finality of life. *International Journal of Qualitative Studies on Health and Well-Being, 15*(1), 1799588. https://doi.org/10.1080/17482631.2020.1799588

Palmér, L., Nyström, M., Carlsson, G., Gillsjö, C., Eriksson, I., & Dalheim-Englund, A.-C. (2019). The meaning of growing old: A lifeworld hermeneutic study on existential matters during the third age of life. *Healthy Aging Research, 8*(2), 1-7.

Parkes, C. M. (1988). Bereavement as a Psychosocial Transition: Processes of Adaptation to Change. *Journal of Social Issues, 44*(3), 53-65. https://doi.org/10.1111/j.1540-4560.1988.tb02076.x

Peterson, J. B. (2018). *12 Rules for Life: An Antidote to Chaos*. Penguin UK.

Ramsey, P. (1970). *The Patient as Person: Explorations in Medical Ethics*. Yale University Press.

Riedl, M., Mantovan, F., & Them, C. (2013). Being a nursing home resident: A challenge to one's identity. *Advanced Nursing Practice for Older People, 2013*, 932381.

Riess, H. (2017). The Science of Empathy. *Journal of Patient Experience, 4*(2), 74-77. https://doi.org/10.1177/2374373517699267

Robertson, G. (2014). *Transitions in Later Life: Scoping Research*. Gulbenkian Foundation, London.

Sanchez-Reilly, S., Morrison, L. J., Carey, E., Bernacki, R., O'Neill, L., Kapo, J., Periyakoil, V. S., & Thomas, J. d. (2013). Caring for oneself to care for others: physicians and their self-care. *The Journal of Supportive Oncology, 11*(2), 75. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3974630/pdf/nihms-568154.pdf

Schumacher, K. L., Jones, P. S., & Meleis, A. I. (1999). Helping elderly persons in transition: A framework for research and practice. In E. A. Swanson & T. Tripp-Reimer (Eds.), *Life Transitions in the Older Adult: Issues for Nurses and Other Health Professionals* (pp. 1-26). Springer.

Schwartz, A. (1974). A transactional view of the aging process. In I. N. Mensh & A. N. Schwartz (Eds.), *Professional Obligations and Approaches to the Aged* (1st ed., pp. 10-11). Charles C Thomas Pub.

Seedsman, T., & Carmel, S. (2003). Well being and loss: The art of old age. Grief Matters: *The Australian Journal of Grief and Bereavement, 6*(1), 11-16.

Seedsman, T., & Seedsman, B. (2019). Leaving-But Not Yet Left: A Rejection of the Perception 'God's Waiting Room'in Favour of Humanistic Residential Aged Care. *International Journal of Studies in Nursing, 4*(3), 94.

Seedsman, T. A. (1994). *Ageing Is Negotiable: A Prospectus for Vital Living in the Third Age*. Employ Working Effectively Publications.

Sikstrom, L., Saikaly, R., Ferguson, G., Mosher, P. J., Bonato, S., & Soklaridis, S. (2019). Being there: A scoping review of grief support training in medical education. *PloS One, 14*(11), e0224325. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6880967/pdf/pone.0224325.pdf

Sinclair, S., Beamer, K., Hack, T. F., McClement, S., Raffin Bouchal, S., Chochinov, H. M., & Hagen, N. A. (2017). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliative Medicine, 31*(5), 437-447. https://doi.org/10.1177/0269216316663499

Singer, T., & Klimecki, O. M. (2014). Empathy and compassion. *Current Biology, 24*(18), R875-R878. https://doi.org/10.1016/j.cub.2014.06.054

Tanner, D., Glasby, J., & McIver, S. (2015). Understanding and improving older people's experiences of service transitions: implications for social work. *The British Journal of Social Work, 45*(7), 2056-2071.

Taylor, C. (1985). Self-interpreting animals. In T. Charles (Ed.), *Human Agency and Language* (1st ed., pp. 45-76). Harvard University Press.

Vrkljan, B., Montpetit, A., Naglie, G., Rapoport, M., & Mazer, B. (2019). Interventions that support major life transitions in older adulthood: a systematic review. *International Psychogeriatrics, 31*(3), 393-415.

Weston, R., Martin, T., & Anderson, Y. (1998). *Loss and Bereavement: Managing Change*. Wiley-Blackwell.

Whyte, D. (2009). *The Three Marriages: Reimagining Work, Self and Relationship*. Penguin.

Zisook, S., & Shear, K. (2009). Grief and bereavement: what psychiatrists need to know. *World Psychiatry, 8*(2), 67. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2691160/pdf/wpa020067.pdf

Zizzo, G., Mackenzie, C., Irizarry, C., & Goodwin-Smith, I. (2020). Loss and grief: The experience of transition to residential aged care. *Australian Journal of Social Issues, 55*(4), 474-491.